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

Catherine Price,
Petitioner,

vs.

NO: 09 WC 01090

14IWCC0748

Hillsboro Rehabilitation 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, causal connection and medical expenses and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed June 7, 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: SEP 0 3 2014

David R Donohoo
Daniel R. Donohoo

Charles J. DeVriendt
Charles J. DeVriendt

Ruth W. White
Ruth W. White

o-08/26/14
drd/wj
68

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

PRICE, CATHERINE J
Employee/Petitioner

Case# **09WC001090**

14IWCC0748

HILLSBORO REHABILITATION CENTER
Employer/Respondent

On 6/7/2013, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.08% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

1539 DRUMMOND LAW OFFICE
PETE DRUMMOND
PO BOX 130
LITCHFIELD, IL 62056

1337 KNELL & KELLY LLC
MATT BREWER
504 FAYETTE ST
PEORIA, IL 61603

14IWCC0748

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

CATHERINE J. PRICE
Employee/Petitioner

v.

HILLSBORO REHABILITATION CENTER
Employer/Respondent

Case # **09** WC **01090**

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 **May 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. ☒ What temporary benefits are in dispute?
☐ TPD ☐ Maintenance ☒ TTD
L. ☒ What is the nature and extent of the injury?
M. ☐ Should penalties or fees be imposed upon Respondent?
N. ☐ Is Respondent due any credit?
O. ☐ Other _____

FINDINGS

On **9/22/08**, 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 not*** sustain an accident that arose out of and in the course of employment.

Timely notice of this accident **N/A** given to Respondent.

Petitioner's current condition of ill-being N/A causally related to the accident.

In the year preceding the injury, Petitioner earned $**17,662.32**; the average weekly wage was $**339.66**.

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

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

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

ORDER

1. The Petitioner did not sustain an accident that arose out of and in the course of her employment for the Respondent. Accordingly, the claim is denied. All other issues are moot.

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

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

Signature of Arbitrator

June 3 2013
Date

JUN - 7 2013

FINDINGS OF FACT

The Petitioner worked for the Hillsboro Rehabilitation Center (hereinafter "Respondent") as a CNA. (*Trans. p. 11*) The Petitioner's duties included working with patients who had Alzheimer's. (*Trans. p. 11*) Petitioner's duties included rehabilitating injuries and performing the general duties of a nurse. (*Trans. p. 11-12*)

The Petitioner testified she was hired by the Respondent in October 2007. (*Trans. p. 26*) Petitioner testified that she was informed thoroughly of the reporting policy when a work accident or incident occurs. (*Trans. p. 27*) The Petitioner testified that she knew the procedure which included notifying a supervisor as well as filling out the appropriate documentation. (*Trans. p. 27*)

The Petitioner testified on cross examination that she has previously filed a workers' compensation claim. (*Trans. p. 27*) As such, the Petitioner testified that she is familiar with the Application for Adjustment of Claim document. (*Trans. p. 28*) Petitioner testified that her previous work comp case involved her low back. (*Trans. p. 27*) Respondent's Exhibit 6 contains the relevant Commission information in regards to the Petitioner's previous work comp claim which was settled for 25% man as a whole on or about December 6, 1999.

On cross examination the Petitioner further testified that she was given several documents to fill out upon her being hired by the Respondent. (*Trans. p. 26*) Included in these documents was Respondent's Exhibit 3, a post offer medical history questionnaire. The Petitioner was shown Respondent's Exhibit 3 wherein she had marked prior to being hired by the Respondent that she never experienced any neck injury, neck symptoms, back injury, back symptoms, neck aches, back pains, or shoulder pain. The Petitioner also denied any prior tingling sensations in her arms and fingers. (*Resp. Ex. 3*) The Petitioner also testified that prior to her 9/22/08 incident, which is the subject of this case, she had never experienced any neck pain, neck symptoms, or any neck injury. (*Trans. p. 25, 29-31*)

Respondent's Exhibit 4 contains several medical records wherein the Petitioner complained of and treated for neck pain prior to 9/22/08. These include a 6/29/07 medical record from the Litchfield Family Practice Center wherein the Petitioner presented with neck pain which was brought on by exercising. (*Resp. Ex. 4*) Petitioner complained of constant neck pain and noted radiating pain to the shoulder. (*Id*) Petitioner presented to the Litchfield Family Practice Center on 9/1/06 and presented with a chief complaint of neck pain that had been occurring for three days and had been increasing. (*Id*) The Petitioner also presented to the Litchfield Family Practice Center on 9/7/05 with a complaint of neck pain. (*Id*) Petitioner at this time had been complaining of neck pain occurring for six months and had worsened over the past two weeks. (*Id*) Symptoms included radiation into both shoulders. (*Id*) The Petitioner's neck pain at her 9/7/05 visit was noted to be preceded by the trauma of a motor vehicle accident from 1984. (*Id*) The Petitioner also underwent cervical spine x-rays on 9/7/05 at St. Francis Hospital in Litchfield, Illinois. (*Id*) On 5/12/04 the Petitioner presented to the Litchfield Family Practice Center with a complaint of right sided neck and shoulder pain.

In regards to numbness and tingling predating the 9/22/08 incident, Respondent's Exhibit 1 reveals the Petitioner in fact had pain in her hands along with weakness in her grip dating back to April of 1997.

The Petitioner filed her Application for Adjustment of Claim on 12/31/08. (*Arb. Ex. 2*) The Petitioner's Application for Adjustment of Claim reveals a date of accident of 9/22/08. (*Id*) Petitioner's Application also alleges injury to the shoulder and arm in the form of a strain. (*Id*) The Petitioner testified on cross examination that at the time she filed her Application for Adjustment of Claim she made no allegation to a neck injury, or a low back injury. (*Trans. p. 32-33*) The petitioner testified that she cannot remember the date of her alleged incident took place. (*Trans. p. 12, 32*)

The Petitioner testified that her injury occurred when she was moving a combative Alzheimer's patient from his bed to a wheelchair. (*Trans. p. 13-14*) Petitioner testified that she felt a stinging sensation in her hand and arm and reported this to a nurse named Jan immediately. (*Trans. p. 13*)

On cross examination the Petitioner testified that she did appear at the Hillsboro Area Hospital on 9/22/08, the alleged date of her incident. (*Trans. p. 34*) Respondent's Exhibit 18 are the Petitioner's medical records from Hillsboro Area Hospital. These records show that on 9/22/08, the day the Petitioner alleges her neck injury to have occurred, she presented to Hillsboro Area Hospital with complaints of pain in her right middle finger. (*Resp. Ex. 18*) The Petitioner testified on cross examination that she had jammed her finger on this date which was the reason she presented for treatment. (*Trans. p. 35*) The Hillsboro Area Hospital record of 9/22/08 reveals no neck, shoulder, arm, or hand complaints. (*Resp. Ex. 18*) Additionally, this record shows no mention of any work injury or incident lifting a resident. (*Id*) On the day of the Petitioner's alleged incident, her presentation to the emergency room was for an injury that took place outside of work and involved a body part completely unrelated to the body part claimed to be injured by the Petitioner. Additionally, it should be noted that the Petitioner's Application states an injury to the left arm and shoulder on 9/22/08, while the treatment received on 9/22/08 was for the middle finger on the right hand. (*Arb. Ex. 2; Resp. Ex. 18*)

The Petitioner on cross examination testified that she did not actually seek treatment for neck and shoulder pain until 10/10/08. (*Trans. p. 35-36*) Respondent's Exhibit 18 shows an emergency room record at Hillsboro Area Hospital on 10/10/08 with the Petitioner presenting with neck and upper back pain which began one week prior to this visit. (*Resp. Ex. 18*) This would put the onset of the Petitioner's back pain around 10/3/08. This record also states that the cause of the symptoms the Petitioner was experiencing were *not the result of any known injury.*

(*Id*) The Petitioner was diagnosed with a neck strain and left shoulder strain and was discharged. (*Id*) Additionally, the Petitioner underwent a CT scan of her cervical spine on 10/10/08. (*Id*) The results of the CT scan revealed degenerative bony changes with bony spurring and no other abnormality seen. (*Id*)

The Petitioner testified that she could not recall the last day she worked for the Respondent. (*Trans. p. 37*) Petitioner's Exhibit 7 reveals the time logs for the Petitioner's employment with the Respondent and show the last day the Petitioner worked at the Respondent's facility was 11/9/08. The Petitioner testified at trial that she could not recall meeting with Dr. Soriano for an independent medical examination. (*Trans. p. 37-38*) Respondent's Exhibit 9 shows the Petitioner did in fact present to Dr. Soriano for an independent medical examination in October of 2009. The Petitioner could not recall the history which she provided Dr. Soriano at this time; however Dr. Soriano's 10/19/09 report reveals the Petitioner gave a date of accident of 11/10/08. (*Trans. p. 38; Resp. Ex. 9*) The Petitioner was clearly confused as to whether she had sustained another injury on 11/10/08. (*Trans. p. 38-39*) However, it should be noted that as of 11/10/08 the Petitioner was no longer logging hours and actively working for the Respondent. (*Pet. Ex. 7*)

The Petitioner did present to the Litchfield Family Practice Center on 11/10/08. (*Trans. p. 39*) Respondent's Exhibit 14 contains the Litchfield Family Practice Center record from this date. The Petitioner presented at that time for a possible urinary tract infection. (*Resp. Ex. 14*) The Petitioner in addition to that described a generalized muscle pain which had been occurring in a persistent pattern for three weeks. (*Id*) The 11/10/08 record from the Litchfield Family Practice Center contains no history of a work injury or accident. (*Id*)

The Petitioner next treated with the Litchfield Family Practice Center on December 18, 2008. (*Id*) At this time the Petitioner presented with a cough. (*Id*) At this visit the Petitioner

did not complain of any neck, shoulder, arm, or hand symptoms. (*Id*) Additionally, no work injury is mentioned. (*Id*) The Petitioner also presented to the Litchfield Family Practice Center on March 17, 2009. (*Id*) The Petitioner at this visit was demanding a referral to Dr. Kennedy in St. Louis for neck and shoulder pain. (*Id*) The history given by the Petitioner at this time reveals that she was experiencing muscle pain in her neck and shoulder the onset of which was sudden and had been occurring in a persistent pattern for three weeks. (*Id*) This would put the onset of the Petitioner's symptoms around 2/24/09. In fact, the Petitioner testified that in February of 2009 she had an accident that required her to seek treatment for her neck and shoulder in March of 2009. (*Trans. p. 41*)

Following the Petitioner's employment for the Respondent she did work for a brief period of time with Litchfield Terrace. (*Trans. p. 18*) Respondent's Exhibit 7 reveals the Petitioner worked for Litchfield Terrace from 11/18/08 through 12/11/08.

The Petitioner also met with Dr. Pineda on 3/9/09. (*Resp. Ex. 19*) Dr. Pineda suggested a pain management doctor and did not recommend any aggressive surgery. (*Id*) Dr. Pineda noted the Petitioner's pain was in the center of her neck while the herniated disc at C6-7 was to the right. (*Id*) Petitioner testified on cross examination that she met with Dr. Pineda she filled out a patient history intake form. (*Trans. p. 41*) Respondent's Exhibit 19 contains this form which shows the Petitioner was alleging the date of injury on 9/12/08 or 9/14/08. It should also be noted the intake form for Dr. Gornet's office revealed the Petitioner to allege an incident on 9/12/08 or 9/14/08. (*Resp. Ex. 17*) The Petitioner could not testify whether her accident occurred on either of those dates, or the date she alleged in her Application for Adjustment of Claim. (*Trans. p. 12, 32*)

On 8/25/09 the Petitioner did undergo a microdiscectomy at C5-6 and C6-7 and a disc replacement at C5-6 and C6-7 by Dr. Gornet. (*Pet. Ex. 2*) Subsequent to the Petitioner's

surgery, she was released to return to work full duty with no restrictions as of 12/7/09. (*Resp. Ex. 17*) The Petitioner was placed at maximum medical improvement by Dr. Gornet on 3/4/10. (*Pet. Ex. 2*) The Petitioner testified that as of the date of trial she has good and bad days with regards to her neck. (*Trans. p. 22*) Petitioner testified that overall she feels as though she has had a good result from Dr. Gornet's surgery. (*Id*)

The Petitioner testified that when she reported her injury to the nurse, she informed Jan she had injured her hand and arm. (*Trans. p. 23*) Petitioner also testified that she did not mention to Jan the incident lifting the Alzheimer's resident. (*Id*) Petitioner testified at the time of trial that she suffered a stroke eight months prior to the trial date. (*Trans. p. 24*) As such, the Petitioner testified she has difficulty remembering dates and names. (*Id*)

Tracy Craige was called to testify at the time of trial. Tracy Craige was the Director of Nursing for the Respondent. (*Trans. p. 57*) Ms. Craige was the Director of Nursing for the Respondent in the fall of 2008 when the Petitioner's alleged incident occurrence. (*Trans. p. 56-57*) Ms. Craige testified that she is familiar with the Petitioner and would work with her often. (*Trans. p. 57*) Ms. Craige testified that in the fall of 2008 she was the Petitioner's boss. (*Trans. p. 57*) Ms. Craige testified that she is familiar with the accident reporting policy for the Respondent. (*Trans. p. 58*) Ms. Craige described this policy as requiring reporting the incident verbally to their supervisor and filling out the appropriate documents which included an incident report. (*Id*) Ms. Craige testified at no time did the Petitioner fill out an incident report involving her alleged injury. (*Trans. p. 58-59*) Additionally, Ms. Craige testified that the Petitioner at no time mentioned an incident when lifting a resident in the Alzheimer's unit. (*Trans. p. 58, 60*) Ms. Craig also testified that the Petitioner never made any neck, shoulder, or arm complaints. (*Trans. p. 59*) Ms. Craige further testified that her position as the Director of Nursing would make her the person to see if a work accident occurred. (*Trans. p. 59-60*) Ms. Craige testified

she is no longer employed by the Respondent. (*Trans. p. 60*) Ms. Craig testified she was brought to trial via subpoena. (*Trans. p. 60*)

Ms. Jana McArthur also testified at the time of trial. Ms. McArthur testified that she also goes by the name Jan. (*Trans. p. 67*) Ms. McArthur is an LPN for the Respondent and has worked there for 12 years. (*Trans. p. 68*) Ms. McArthur testified that she is familiar with the Petitioner and worked with her in the fall of 2008. (*Id*) Ms. McArthur testified that at no time did the Petitioner report an injury after lifting a resident. (*Id*) Ms. McArthur testified the Petitioner had casually at some point asked Ms. McArthur about carpal tunnel syndrome. (*Trans. p. 70*) Ms. McArthur testified that the Petitioner herself did not believe that the carpal tunnel symptoms she was experiencing were in any way related to a work incident. (*Trans. p. 70*) Ms. McArthur testified that she asked the Petitioner whether her carpal tunnel symptoms were related to an injury to which the Petitioner denied. (*Id*) Although the Petitioner testified that she could not recall the last name of the nurse that she reported her alleged incident to; Ms. McArthur testified that at no time during her employment for the Respondent has there ever been another nurse named Jan. (*Trans. p. 74*)

The Petitioner did mention carpal tunnel symptoms to Ms. McArthur. (*Trans. p. 70*) Ms. McArthur asked the Petitioner whether these symptoms were a result of the work injury and the Petitioner said no. (*Trans. p. 74*) Additionally, the Petitioner did not report a work accident involving lifting a resident at any time to Ms. McArthur. (*Trans. p. 68*)

The Respondent also called Edith Crouch to testify at the time of trial. Ms. Crouch is a CNA for the Respondent and has worked there for 15 years. (*Trans. p. 76*) Ms. Crouch testified that she was the Petitioner's partner and worked with her several times a week. (*Trans. p. 77*) Ms. Crouch testified that at no time did the Petitioner any mention any work injury. (*Trans. p. 78*) Petitioner never complained of any neck, shoulder, arm, or hand symptoms to Mrs. Crouch.

(*Trans. p. 78*) Ms. Crouch testified that at no time did the Petitioner mention an incident involving lifting a resident. (*Trans. p. 78*)

Dr. Gornet testified he is an orthopedic surgeon whose practice is devoted to spine surgery. Dr. Gornet had a chance to see Catherine Price on May 14, 2009. Dr. Gornet took a history from the Petitioner that she was 48 years old and was referred by Dr. Johnson in Litchfield. Petitioner presented with complaint of low back pain into both buttocks, both legs, with tingling into her feet. Petitioner had neck pain, shoulder pain, and headaches.

Dr. Gornet took a history that the Petitioner's problems began in September when she was working in a nursing home. Petitioner was pulling a patient up to move them from a bed to a wheelchair when she felt a pull in her neck and shoulder as well as her low back. Petitioner felt it was simply a pulled muscle but when it did not improve she reported it. Several days later the Petitioner went to the emergency room due to the pain. Petitioner had an MRI of the neck and low back. Petitioner did give a history of prior back problems dating back to 1994 and had undergone previous surgery by Dr. Kennedy with an L2-3 fusion.

Petitioner indicated she had seen a chiropractor intermittently anywhere from two to six months prior to the injury. Petitioner told Dr. Gornet since the accident she had had a dramatic increase in pain and symptoms which affected her ability to sleep and her ability to function.

On physical examination the Petitioner had full strength in all muscle groups with a mild decrease in her triceps on the right at 4/5. Petitioner was diagnosed with potential irritation of the C7 nerve root on the right and cervical spine. Dr. Gornet testified that the February 23, 2009 MRI scan of the lumbar spine revealed a disc herniation and annular tear at L2-3 and an annular tear far left at L4-5. The cervical MRI from February 23, 2009 revealed disc herniation at C6-7 correlating with the Petitioner's symptoms.

Dr. Gornet testified that he felt that the Petitioner had structural injury to the cervical and lumbar spine and that her symptoms were causally related to her work injury. Dr. Gornet placed the Petitioner on light duty with her previous restrictions and recommended conservative care, including physical therapy and injection at C6-7 on the right. Dr. Gornet told the Petitioner if her neck did not improve he might have to place her off work.

Dr. Gornet saw the Petitioner again on July 9, 2009 following an injection which helped her briefly. CT scan performed that day showed no evidence of facet abnormalities; therefore Dr. Gornet felt the Petitioner was a candidate for disc replacement surgery.

Dr. Gornet saw Petitioner again on August 10, 2009 where a new MRI clearly showed disc pathology at C5-6 and C6-7, indicating that Petitioner's problem had clearly progressed and he recommended treating both levels.

Dr. Gornet performed a procedure in the form of a microdiscectomy C5-6 and C6-7 and disc replacement C5-6 and C6-7 on August 5, 2009.

Following surgery the Petitioner was doing well with neck pain, headaches, and arm symptoms all improved. Petitioner was kept off work. Dr. Gornet saw Petitioner on October 12, 2009 where her radiographs looked excellent. Dr. Gornet recommended mild physical therapy with upper extremity strengthening and to follow up with plain x-rays and CT scan in six weeks. Dr. Gornet kept her off work during this time.

Dr. Gornet saw Petitioner on December 3, 2009 and she continued to do well. Petitioner had good range of motion with no abnormalities on radiographs or CT scan. Dr. Gornet returned the Petitioner to full work duty as of December 7, 2009.

Dr. Gornet saw the Petitioner for a six month follow-up on March 4, 2010 and Petitioner continued to do well but still had intermittent aches and pains. Dr. Gornet placed Petitioner at maximum medical improvement.

Dr. Soriano, a neurosurgeon, performed an independent medical evaluation on 10/7/09. Upon presentation, Petitioner gave a history of some time on or about 11/10/08, suddenly experiencing numbness in the fingers at work and reporting that to the nurse on duty. Petitioner returned to work on her Alzheimer's unit and then in the process of turning a combative patient over in bed, she reported pain, numbness and tingling in her neck and equally down both arms. Petitioner stated that at that time she did not think she reported any injury.

Dr. Soriano testified petitioner did not report a history of accident occurring on or about 9/22/08. In fact, Dr. Soriano inquired as to whether or not the accident date was 11/10/08, and petitioner confirmed that.

Upon presentation petitioner gave complaints of having depression, which she had had for a long time on an intermittent basis. Petitioner complained of numbness and tingling in all ten fingers, neck pain, and bilateral arm pain. Petitioner reported experiencing everything she had prior to surgery.

Dr. Soriano testified to reviewing numerous medical records and actual x-ray films in conjunction with his report. Dr. Soriano testified he reviewed records of Springfield Clinic, Neuroscience Institute, St. Francis Hospital, records of Dr. Daus, and records of Dr. Kennedy. With regard to Springfield Clinic records, Dr. Soriano reviewed records of Dr. Gill and Dr. Pineda. Also, Dr. Soriano reviewed records of Litchfield Family Practice, Dr. Gornet, and records of Hillsboro Area Hospital.

In addition to those medical records, Dr. Soriano reviewed an Application for Adjustment of Claim which alleged a date of accident of 9/22/09.

Dr. Soriano testified it was his understanding that on 8/25/09, petitioner underwent surgery including a two level fusion with disc removal at C5-6 and C6-7 and fusion at that level.

Dr. Soriano reviewed a cervical MRI film of 2/23/09. Dr. Soriano's interpretation of that was a herniated disc at C6-7 which was broad based and more to the right. In addition, Dr. Soriano reviewed lumbosacral x-rays of 5/14/09 and cervical spine x-rays of 5/14/09. Dr. Soriano testified the neck x-rays of 5/14/09 factored in his opinion because it shows that whatever disc was operated on the C6-7 likely on the basis of a degenerative spur and not a ruptured disc. The disc was collapsed as of 2/2/09, which would indicate a long standing problem.

Dr. Soriano did perform a physical examination as well. Petitioner demonstrated a limitation of left lateral tilting, globe distribution loss pinprick on the top and bottom of hands up to the wrist, and slight difference between brachial radialis reflex being +1 on the right and +2 on the left. The remainder of the examination was completely normal.

Dr. Soriano testified that taking into consideration his physical examination, review of records and history provided to him by Petitioner, his diagnosis consistent with preexisting degenerative disc disease and subjective complaints of numbness and tingling down both arms prior to moving the patient in bed, and then ongoing symptoms of pain, numbness and tingling down both arms after moving the patient in bed, and that her diagnosis for those subjective complaints. Her diagnosis was consistent with preexisting degenerative collapse of the disc at C6-7 and apparently an annular tear or some minor finding of the disc at C5-6. Dr. Soriano testified that the alleged accident of on or about 11/10/08 did not result in a need for treatment that was listed in the records as occurring after that date. Dr. Soriano testified Petitioner had been complaining of numbness and tingling down both arms before wrestling or turning over the patient. Dr. Soriano testified that the radiological findings and physical exam findings by the treating physicians were not consistent with anything pushing on the spinal cord and acute injury

and the MRI does not show anything that would be consistent with an acute injury. Petitioner admitted having a long history of neck pain prior to her injuries.

Dr. Soriano testified that at the time he saw her Petitioner was capable of full unrestricted work activities and had reached maximum medical improvement.

CONCLUSIONS OF LAW

The Petitioner testified that she suffered a stroke eight months prior to the hearing which affected her memory. Accordingly, the Arbitrator is not going to attach much weight to the inconsistencies contained in her testimony and her inability to remember things, such as her earlier cervical care noted above. It is entirely reasonable that she would have trouble recalling the date of her alleged accident which is the basis of her claim. However, on December 31, 2008 she filed and presumably signed an Application for Adjustment of Claim stating that she had injured her left shoulder and arm lifting a patient on September 22, 2008. The evidence at Arbitration proved that such an accident did not occur, and as such, she has failed to prove her claim.

There were many facts shown at the hearing which were inconsistent with the Petitioner's claimed accident. First of all, the Petitioner was aware of how to report an accident while working for the Respondent. Ms. Craige testified that new employees were trained on how to report an accident when they were hired and the Petitioner was hired in October 2007. The Petitioner acknowledged having this knowledge, yet she did not fill out any accident reports.

Secondly, Edith Crouch, her co-worker and partner on the job who worked with her on a daily basis, knew nothing of the Petitioner's claimed accident. She said that she never saw the Petitioner injure herself in the fall of 2008 and was never told by the Petitioner that an accident

had occurred. Given her relationship with the Petitioner, it seems likely that if the Petitioner had injured her arm transferring an Alzheimer's patient, Ms. Crouch would have known of it.

Third, Nurse McArthur, whom the Petitioner said she reported her accident to when it happened, denied ever being told that the Petitioner had injured herself at work. Nurse McArthur did acknowledge that the Petitioner once told her that her hands and wrists were hurting, but she said that during that conversation the Petitioner denied hurting herself at work. Nothing contained in Nurse McArthur's written statement impeaches that testimony.

Finally, and most importantly, there is no mention of any accident or occurrence at work on any date in the histories provided by the Petitioner to her medical providers until March of 2009 when she saw Dr. Pineda after her MRI had been performed. The Petitioner testified that her accident occurred several days before she went to the Hillsboro Hospital ER, which was on October 10, 2008. She said that she was involved in a specific accident lifting a patient, and that her symptoms progressively worsened, causing her to seek treatment. One would think that under those circumstances there would be some mention in the emergency room records of those facts, but there was not. Medical histories for subsequent treatment also fail to contain any reference to a work injury. When she saw Kristi Lee, the Nurse Practitioner for her family doctor on November 10, 2008, she simply reported that she'd had shoulder and upper arm pain for three weeks. There was also no mention of a work accident in early 2009 when she saw Dr. Gill, after which time an MRI was done showing a cervical disc herniation. She first mentioned her work as a possible cause when she completed a history form for Dr. Pineda, several months after her claim had been filed.

Despite the fact that she had suffered a stroke, the Petitioner still had the burden of proving an accident traceable to a definite time, place and cause related to her employment. She is claiming a specific accident. Nothing was introduced to corroborate her testimony. Her closest

co-worker knew nothing of the accident; nor did the charge nurse on her floor. The contemporaneous medical histories also do not support her version of the facts. Under the circumstances, the Arbitrator finds that she has failed to meet her burden of proving an accident arising out of her employment, and as such, her claims denied. All other issues are moot.

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Dominique Kay,

Petitioner,

14IWCC0749

vs.

NO: 05 WC 5517

Centegra Health system and Northern Illinois Medical Center,

Respondent,

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of causal connection, medical 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 is entitled to 50% of a person as a whole. The Petitioner has no work restrictions, is multilingual and highly educated. The Commission views the evidence differently than the Arbitrator.

All else is affirmed and adopted.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $512.26 per week for a period of 41 4/7 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 $460.80 per week for a period of 250 weeks, as provided in §8(d)(2) of the Act, for the reason that the injuries sustained caused the loss of use of the person as a whole.

14IWCC0749

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $21,802.12 for medical expenses under §8(a) of the Act subject to the fee schedule.

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

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

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $75,000.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: SEP 0 3 2014

Charles J. DeVriendt

Daniel R. Donohoo

Ruth W. White

HSF
O: 7/2/14
049

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

KAY, DOMINQUE
Employee/Petitioner

Case# **05WC005517**

NORTHERN ILLINOIS MEDICAL CENTER AND CENTRAL HEALTH SYSTEM
Employer/Respondent

14IWCC0749

On 12/17/2010, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.19% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0206 GAINES & GAINES
39 S LASALLE ST
SUITE 1215
CHICAGO, IL 60603

0481 MACIOROWSKI SACKMANN & ULRICH
10 S RIVERSIDE PLAZA
SUITE 2290
CHICAGO, IL 60606

STATE OF ILLINOIS)
)SS.
COUNTY OF MCHENRY)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Dominique Kay
Employee/Petitioner

Case # 05 WC 05517

v.

Northern Illinois Medical Center and Centegra Health System
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 Woodstock, on October 8, 2010. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On October 6, 2004, Respondents Centegra Health System and Northern Illinois Medical Center were operating under and subject to the provisions of the Act.

On this date, an employee-employer relationship did exist between Petitioner and Respondents Centegra Health System and Northern Illinois Medical Center.

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 Respondents Centegra Health System and Northern Illinois Medical Center.

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

In the year preceding the injury, Petitioner earned $39,936.00; the average weekly wage was $768.00.

On the date of accident, Petitioner was 37 years of age, single with three (3) dependent children.

Respondents have not paid all appropriate charges for medical services.

Respondent shall be given a credit of $34,002.41 for TTD and TPD paid; $ -0- for maintenance, and $ -0- for other benefits, for a total credit of $34,002.41.

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

Respondents Centegra Health System and Northern Illinois Medical Center are found to be the joint employers under the Act.

ORDER

Respondents Centegra Health System and Northern Illinois Medical Center, joint employers, are to make payment of the medical bills in the amount of $21,802.12 as provided in Sec 8(a) of the Act subject to the fee schedule.

Respondents Centegra Health System and Northern Illinois Medical Center shall pay the petitioner the sum of $460.80 a week for a further period of 300 weeks as provided in Section 8(d2) of the Act, because the injuries sustained caused the complete loss of use on a person as a whole basis to the extent of 60% thereof.

Respondents shall pay TTD benefits of $512.26 for 41 4/7 weeks commencing 10/7/04 though 10/26/04, from 04/04/05 through 05/18/05, from 10/18/05 through 11/15/05, from 11/17/05 through 12/27/05, from09/05/06 through10/25/06, and from 04/06/07 through 07/29/07 as provided in Sec 8(b) of the Act.

Respondents Centegra Health System and Northern Illinois Medical Center shall pay petitioner compensation that has accrued from 10/6/04 through present and shall pay the reminder of the award in weekly payments.

Petitioner's claim for penalties is denied.

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

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

Signature of Arbitrator

12/16/10
Date

DEC 17 2010

Dominique Kay v. Centegra Health System and Northern Illinois Medical Center
05 WC 05517

As to the issue of employer/employee relationship, the Arbitrator finds the following:

The petitioner, at the time of hearing, alleges that the sole employer was Northern Illinois Medical Center and Respondent alleges that Northern Illinois Medical Center and Centegra Health System were one in the same, joint employers or fell into a loaning-borrowing relationship.

The original Application for Adjustment of Claim filed by the petitioner through her attorney, identified Centegra Health System as the employer and alleges an accidental injury date of October 6, 2004 (Res. Non Medical Exhibit No. 11).

The petitioner on August 17, 2001, applied for employment with Centegra Health System, McHenry location (Res. Non Medical Exhibit No. 1).

The petitioner on August 20, 2001, wrote a letter to Judy Bjurstrom providing a resume and a written desire to be part of a team in the laboratory (Res. Non Medical Exhibit No. 2).

The petitioner on September 1, 2001, received a letter from Charalen Choklad, Recruiter, Human Resources, Centegra Health System, offering her the position as a MLT with Centegra Health System (Res. Non Medical Exhibit No. 3).

The petitioner's job description was captioned "Centegra Health System, Medical Laboratory Technician" (Res. Non Medical Exhibit No. 4). The petitioner testified at the hearing that this was her job description. Jim Adamson from Centegra Health System testified that it was the same job description used throughout Centegra Health System and it described the manner in which Centegra Health System and Northern Illinois Medical Center expected Ms. Kay's work to be performed in the lab.

The petitioner's knowledge of the equipment she worked with and basic maintenance was verified on Centegra Health System's Department of Pathology and Laboratory Medicine Northern Illinois Medical Center check list (Res. Non Medical Exhibit No. 5).

The petitioner's W2 was from Northern Illinois Medical Center (Res. Non Medical Exhibit No. 6). Jim Adamson testified that Centegra Health System funds the payroll for Northern Illinois Medical Center Associates with money it receives from its affiliates, including monies received from Northern Illinois Medical Center. He testified that Centegra Health System and its affiliates use a treasury management sweep program. Through this program, funds are swept from Northern Illinois Medical Center and other affiliates into a Centegra Health System account. This Centegra Health System account is then used to fund the payroll for associates such as Dominique Kay. Jim Adamson identified a letter from First Midwest Bank dated August 29, 2007, describing the "sweep structure" that has been used by Centegra Health System and its affiliates since 2001 (Res. Non Medical Exhibit No. 15).

Copies of petitioner's payroll stubs are not accessible from the respondents or petitioner, but respondent has produced copies of payroll checks of other employees from Northern Illinois Medical and Memorial Medical which on the front side shows Centegra Health System and on the back side Memorial Medical Center or Northern Illinois Medical Center (Res. Ex. No. 27). A non payroll check dated September 21, 2006 and payable to the petitioner was offered as Respondent Non Medical Exhibit No. 8 containing the name Centegra Health System and Northern Illinois Medical Center.

The petitioner applied to Judy Bjurstrom, Manager of NIMC for a change in job status from 1.0 to 0.9 and said request for change was received by and approved by Centegra Health System on September 4, 2003, signed by both Judy Bjurstrom (Manager NIMC Laboratory), and Charlen Choklad (Person who originally offered her employment with Centegra Health System (Exhibit No. 10, see also Exhibit No. 3). Jim Adamson testified that changes in employment status were handled by both Centegra Health System and Northern Illinois Medical Center. He testified that in order for a change of employment status, the request must first go to Northern Illinois Medical Center's Lab Manager, Judy Bjurstrom, and then to Human Resources for Centegra Health

System. He testified that in order for the change to be approved, both must sign off on the request.

The petitioner, on April 29, 2007, filed an Amended Application for Adjustment of Claim – 06 WC 32115 – on August 29, 2007, changing Respondent from Centegra Health System to Northern Illinois Medical Center (Res. Non Medical Exhibit No. 12), documenting to the Arbitrator that prior to this date, the petitioner believed her employer to be Centegra Health System.

The petitioner testified that when she worked at the laboratory at Northern Illinois Medical Center, she would work on specimens and samples from that facility as well as all other affiliates to include the laboratory in Woodstock. She testified that on occasion, she would work at the laboratory in Woodstock and at that location, she would also work on specimens from all affiliates and campuses and that her singular ID badge allowed her access to all facilities and campuses.

The petitioner testified that when she was placed in the alternative work program after her injury, she actually worked at another location for another affiliate. She testified that when the alternative work program ended, she was able to go into the Centegra Health System and apply for jobs at all affiliates, not limited to Northern Illinois Medical Center.

Jim Adamson testified on behalf of Centegra Health System. His position was that of Director of Risk and Regulatory Matters. He testified that he was familiar with the relationship between Centegra Health System and Northern Illinois Medical Center and he was familiar with the relationship between Dominique Kay and Centegra Health System and Northern Illinois Medical Center.

He testified that Centegra Health System was an Illinois Not-For-Profit Corporation organized for the purpose of providing support to its affiliates such as Northern Illinois Medical Center, allowing those affiliates to fulfill their purpose. He testified that Northern Illinois Medical Center was an Illinois Not-For-Profit Corporation licensed to operate a hospital in McHenry, Illinois. He testified that Northern Illinois Medical Center is an affiliated hospital with Centegra

Health System. He testified that Centegra Health System was the sole member of the Not-For-Profit Corporation Northern Illinois Medical Center.

He testified that Centegra Health System's duties as set forth in the Northern Illinois Medical Center By-Laws include appointing directors of NIMC, approving the amendments to the Articles of Incorporation, approving incurrence of debt, approving capital and obtaining budgets and other functions.

Jim Adamson testified that the petitioner, Dominique Kay, was an associate who worked at Northern Illinois Medical Center Campus which was part of Centegra Health System. He testified that she worked for both Centegra Health System and Northern Illinois Medical Center. He testified that both Centegra Health System and Northern Illinois Medical Center controlled the manner in which the petitioner's work was performed.

He testified that at the time of the injury, the petitioner performed her work under Lab Manager Judy Bjurstrom. He testified as to a organizational table outlining the reporting structure within Centegra Health System and its affiliate Northern Illinois Medical Center, pointing out that the manager of the laboratory services was noted in the chart near the middle of the page, second box down (Res. Non Medical Exhibit No. 13). He testified that the position reports to the Vice President of Operations from Northern Illinois Medical Center, the Senior Vice President of Northern Illinois Medical Center, and the President/CEO of Centegra Health System.

Jim Adamson testified that the petitioner, Dominique Kay, was governed by the Centegra Health System policies. He testified that those policies were adopted at the Senior Vice President level at the affiliates and approved by the President/CEO of Centegra Health System. He identified Respondent's Non Medical Exhibit No. 14 which was the cover sheet to the policies that governed Centegra Health System Associates in October of 2004, and the signatures that appeared on that sheet. The signatures on that sheet belonged to the Senior Vice President and Sight Administrator of Memorial Medical Center, the Senior Vice President and Sight Administrator of Northern Illinois Medical Center, and the President/CEO of Centegra Health System. He testified that the policies include policies on competence assessment, accrued time off, the Associate Assistance Program, Short Term Disability, Family Medical Leave, Sexual

Harassment and Drug-Free Workplace. He testified that as set forth in the By-Laws, Centegra Health System and Northern Illinois Medical Center worked together to create and enforce the practices, policies and procedures that are going to be put in place.

Jim Adamson testified that both Northern Illinois Medical Center and Centegra Health System played a role in paying the petitioner, Dominique Kay. He testified that Centegra Health System supplies and maintains the benefit plans for Centegra Health System and for Northern Illinois Medical Center. He testified for accounting purposes, it is an expense under Northern Illinois Medical Center's budget. He testified that Centegra Health System funds the payroll for Northern Illinois Medical Center associates with monies it receives from its affiliates, including monies received from Northern Illinois Medical Center. He described the treasury management sweep program in place since 2001 wherein through the program, funds are "swept" from Northern Illinois Medical Center and other affiliates into a Centegra Health System account. He testified that the Centegra Health System account is then used to fund the payroll for associates such as the petitioner, Dominique Kay. He testified to a letter from Beth Ragsdale of First Midwest Bank to Centegra Health System documenting that system since 2001 (Res. Non Medical Exhibit No. 15). He testified that not all of the funds in the Centegra Health System account originate from Northern Illinois Medical Center. He testified that funds that are available to pay Northern Illinois Medical Center budget expenses such as salaries of associates deployed to the Northern Illinois Medical Center all come from the Centegra central account that is funded through the cash sweep process.

He testified that both Centegra Health System and Northern Illinois Medical Center played a role in hiring and have a right to discharge the petitioner, Dominique Kay. He testified that changes in her employment status were handled by both Centegra Health System and Northern Illinois Medical Center. To support that position, he referred to Respondent Non Medical Exhibit Nos. 9 and 10, where the petitioner's request for change in employment status was approved not only by Northern Illinois Medical Center but by Centegra Health System.

Respondent's Non Medical Exhibit No. 16 is Centegra Health System Performance Appraisal Evaluation for the petitioner, Dominique Kay. The Reviewer was Judy Bjurstrom, her supervisor and captioned as Centegra Health System. In that document, the petitioner affirms that she has

reviewed the Centegra Health System Patient Rights Policy, Confidentially and Access to Information Policy, Applicable Privacy and Security Policies, and the Service Excellent Standards.

Jim Adamson testified that both Centegra Health System and Northern Illinois Medical Center played a role in furnishing the tools, materials and equipment used by Dominique Kay and other associates. It was his understanding that she tripped on a cord connected to a piece of equipment in the Chemistry section of the lab at Northern Illinois Medical Center. The petitioner, in her testimony, confirmed that she tripped on a cord connected to a piece of equipment. He testified that the purchase of equipment in the lab is decided by both Northern Illinois Medical Center and Centegra Health System. He testified that Northern Illinois Medical Center had an operating budget and that operating budget included funding for necessary equipment. He testified that the operating budget was created between Northern Illinois Medical Center and Centegra Health System. Jim Adamson identified Respondent's Non Medical Exhibit No. 17 as the Transfer and Assumption Agreement concerning the piece of equipment that the petitioner, Dominique Kay, claimed she was injured near. That document demonstrates that the owner of the equipment remains the manufacturer, Dade Behring, that the equipment is located at Northern Illinois Medical Center and that Northern Illinois Medical Center is then obligated to purchase Reagent which is used to operate the Analyzer. The invoice for that equipment was addressed to Northern Illinois Medical Center. Jim Adamson testified that funds from both Centegra Health System and Northern Illinois Medical Center were used to obtain that equipment.

Jim Adamson testified that both Centegra Health System and Northern Illinois Medical Center benefit from the petitioner's work. He used the example of when she works as a Medical Lab Technician at either the McHenry or Woodstock location, she performs work on in-patients or out-patients for all facilities within the system, not just for the location where she is performing the work.

Respondent Non Medical Exhibit Nos. 19, 20, 21, 22, 23, and 24 document that Centegra Health System has been identified by the State of Illinois Self Insurers Advisory Board as the self insured for itself and affiliates Memorial Medical Center, Northern Illinois Medical Center, Centegra Primary Care, Centegra Management Services, Healthbridge Corporation, Horizons

Professional Services, P.C., and Horizons Behavioral Health, LLC, and by the excess carrier with payments made through check by Centegra Health System, 4201 Medical Center Drive, McHenry, Illinois 60050. The Arbitrator would note that the address for Centegra Health System is the same address that the petitioner testified she worked at for Northern Illinois Medical Center, that being 4201 Medical Center Drive, McHenry, Illinois.

Michael Benedeck was called to testify on behalf of Centegra Health System. He testified that he was employed by Centegra Health System and he was responsible for workers' compensation for Centegra Health System at all of its locations. He testified that he was the contact person at Centegra Health System in terms of the petitioner's, Dominique Kay's, workers' compensation injuries. He testified that he was the person who assisted Dominique Kay in being placed in the Alternative Work Program and that the procedure was to first try to place the person in their own department and then at any other department within the various locations, campuses of Centegra Health System. The petitioner testified that Mr. Benedeck was the person that she dealt with at her employer, and in fact, when the Alternative Work Program ended for her, he was the individual who she contacted about alternative placement within the Centegra Health System.

The petitioner offered into evidence several exhibits. The Arbitrator would note that Petitioner's Exhibit No. 1 is a subpoena directed to Northern Illinois Medical Center and was captioned by the petitioner as Dominique Kay v. Centegra Health System, 05 WC 05517 and 06 WC 32115. That subpoena was issued November 10, 2008.

Petitioner's Exhibit No. 3 was a subpoena issued by the petitioner's attorney for records from Mercy Crystal Lake Medical Center on October 27, 2008, with the caption being Dominique Kay v. Centegra Health System, 05 WC 05517 and 06 WC 32115.

Petitioner's Exhibit No. 4 was a subpoena directed to Mercy Health System on October 27, 2008, and was captioned Dominique Kay v. Centegra Health System, 05 WC 05517 and 06 WC 32115.

Petitioner's Exhibit No. 5 was a subpoena issued to Lake County Orthopedic Associates on October 27, 2008, and was captioned Dominique Kay v. Centegra Health System, 05 WC 05517 and 06 WC 32115.

Petitioner's Exhibit No. 6 is a subpoena issued by the petitioner on October 27, 2008 to Center for Neurology, captioned Dominique Kay v. Centegra Health System, 05 WC 05517 and 06 WC 32115.

Petitioner's Exhibit No. 7 is a subpoena issued by the petitioner for records of Paradigm Health Care Consultants, Inc., captioned Dominique Kay v. Centegra Health System, 05 WC 05517 and 06 WC 32115.

Petitioner's Exhibit No. 8 is a subpoena issued to Barrington Rehabilitation Center on October 27, 2008, captioned Dominique Kay v. Centegra Health System, 05 WC 05517 and 06 WC 32115.

Petitioner's Exhibit No. 10 is a subpoena issued to Barrington Family Medicine on November 26, 2008, captioned Dominique Kay v. Centegra Health System, 05 WC 05517 and 06 WC 32115.

Petitioner's Exhibit No. 23 is a letter from the third party administrator, Gallagher Bassett Services, addressed to George Gaines, dated May 18, 2005, captioned Dominique Kay v. Centegra Health System.

Petitioner's Exhibit No. 26 is a State of Illinois Articles of Amendment to Articles of Incorporation Northern Illinois Medical Center dated July 16, 1991. The Articles of Amendment name Northern Illinois Medical Center as a Not-For-Profit Corporation. On April 8, 1996, the State of Illinois Articles of Incorporation were amended to indicate that Article 1 shall be amended to read as follows: "the name of the Corporation is Centegra Health System."

The petitioner offered into evidence State of Illinois Department of Public Health License Permit for Northern Illinois Medical Center for purposes of general hospital effective July 1, 2004.

Petitioner's Petition for Penalties asked for penalties against Centegra Health System and Centegra Northern Illinois Medical Center.

Petitioner's Exhibit No. 29 is the restated Corporate By-Laws of Centegra Health System with life member including Northern Illinois Medical Center.

Petitioner's Exhibit No. 30 is documentation from Marsh to Mr. Eric Zomow, Centegra Health System, 4201 Medical Center Drive, McHenry, Illinois, as to property policy, excess workers' compensation policy, auto employers liability policy, showing the employer to be Centegra Health System, Memorial Medical Center, Northern Illinois Medical Center at 4201 Medical Center Drive, McHenry, Illinois.

Petitioner's Exhibit No. 32 is the Centegra Health System policies signed by Memorial Medical Center, Northern Illinois Medical Center and Centegra Health System, showing the interrelationship between the three.

Petitioner's Exhibit No. 33 is the Centegra Health System Organizational Chart that shows Northern Illinois Medical, Memorial Medical, and Centegra Health System as part of the same corporate organization.

Petitioner's Exhibit No. 34 is the Purchase Order for Laboratory Equipment directed to Northern Illinois Medical Center at 4201 Medical Center Drive, McHenry, Illinois.

The Arbitrator, in hearing the testimony of the witnesses and reviewing all of the parties non medical documents, finds that the control of the petitioner, Dominique Kay, was shared by both Centegra Health System and Northern Illinois Medical Center, and therefore, for purposes of workers' compensation, she is considered to be a joint employee of both Centegra Health System and Northern Illinois Medical Center. Each and every document offered showed that Centegra Health System and Northern Illinois Medical Center were, in a sense, one, with Northern Illinois Medical Center being merely a campus or employment site for Centegra Health System with everything from the Application of Employment, letter of hiring, request for change in job status, wages, policies, business structure, benefits, direction of Dominique Kay's employment activities, and ability to fire, coming from both Centegra Health System and Northern Illinois Medical Center. The Arbitrator in so deciding, relies on the case of Freeman v Augustine's, Inc.,

46 Ill. App3rd 230, 360 N.E.2d 1245, 4 Ill. Dec. 870 (March 2, 1997), where the court found that more than one employer may be liable for the same injury under the Act, and, therefore, immune from common law liability. Under Freeman where the control of an employee is shared by two employers and both benefit from the work, the worker is considered to be an employee of both or a joint employee (American Stevedores Co. v. Industrial Commission, 408 Ill. 445, 97 N.E.2d 329 (1951). The arbitrator in this case finds that there was control exercised by both Centegra Health System and Northern Illinois Medical Center and both Centegra Health System and Northern Illinois Medical Center benefited from the work of the petitioner, Dominique Kay.

If the Arbitrator were to find one employer, he would find Centegra Health System the employer in this case based on the fact that she applied for work at Centegra Health System and received the letter of hire from Centegra Health System. If Centegra Health System and Northern Illinois Medical Center were truly separate and distinct, then a loaning and borrowing employer situation would exist, if in fact the general employer (Master-Centegra Health System) has resigned control of the servant-Kay to Northern Illinois Medical Center for the time being (Highway Insurance Company v. Sears Roebuck & Company, 92 Ill. App. 2d 214, 235 N.E.2d 309 (1968). If this were the case, then both Centegra Health System and Northern Illinois Medical would have the same immunity from common law liability that they share as joint employers.

The Arbitrator finds that the petitioner, Dominique Kay, was employed jointly by Centegra Health System and Northern Illinois Medical Center in that each clearly at all times shared control over her and both benefitted from her work in the laboratories in which she worked.

As to the Arbitrator's decision relating to nature and extent of the petitioner's injury and causal connection, the Arbitrator finds the following facts:

The petitioner was born in Switzerland and went to Feusi College in Bern, Switzerland, receiving a degree in Economic Services in 1987. She then moved to the United States in 1988, first residing in Fredericksburg, Virginia. She attended and received a degree in Applied Sciences from Coastal Carolina Community College in Jacksonville, North Carolina in 1999. She received a ASCP Board Certification in 1996. She moved to Illinois where she attended Elgin

Community College, receiving a Certification in Medical Coding. She testified that she also attended off and on some classes at McHenry Junior College.

She testified that she was fluent in English, German and French. She testified that she was limited in Italian.

Prior to going to work for Centegra Health System and Northern Illinois Medical Center, she worked in Sales and just prior to working for the Respondents, she worked in the laboratory at Good Shepherd Hospital. She testified that her sales experience was in car sales, doing that for a year and a half to two years.

She testified that prior to the injury in question, she had been treated by Dr. Gumidyala with electrical shock therapy and medication for a condition diagnosed as bipolar depression. She testified that she was treated for that condition from 2001 through 2004.

The petitioner testified that on two occasions – December 27, 2001 and January 7, 2002 – she was admitted to Centegra Woodstock Hospital for suicide attempts.

She testified that she previously saw Dr. Nager, a neurosurgeon, in 2002 for a spinal tap.

The petitioner began her employment with the Respondents in August of 2001. The facts and circumstances regarding her employment were covered sufficiently in another section of this decision.

The petitioner on October 6, 2004, was employed for the Respondents at the medical laboratory located at Northern Illinois Medical Center. She testified as to her specific duties which included preparing specimens for analysis, distributing them to different work areas and performing daily maintenance on the laboratory machines. She testified that she would work with blood, stool, urine, spinal fluids, swabs of all kinds. She testified that on the date in question, she was working the night shift.

She testified that on October 6, 2004, she tripped while holding dirty test tubes in her right hand. She testified that she had a tube rack, in her left hand. She testified that when she fell, she injured her right upper extremity with the glass shattering, causing puncture wounds to the fleshy area of her right palm.

The petitioner testified that she received her initial care at the emergency room of Northern Illinois Medical Center.

The records from Northern Illinois Medical Center were introduced into evidence as Petitioner's Exhibit No. 1. The records show that the petitioner had three small punctures or lacerations, palmer aspect of the right hand, with the examination revealing normal sensation, normal motor, no vascular compromise. The diagnosis was laceration.

The medical records of Dr. Marko Krpan were introduced into evidence as Petitioner's Exhibit No. 3. On October 8, 2004, Dr. Krpan performed an incision and debridement, right hypothenar eminence and obtained cultures for pre-operative and post-operative diagnosis of cellulitis/abscess, right hypothenar eminence, status post laceration.

The petitioner returned to the emergency room on October 9, 2004, with a history of "cut self on dirty lab ware at work, developing abscess." The diagnosis was cellulitis.

Dr. Krpan on October 11, 2004, performed a repeat I and D of abscess. The impression was status post incision and drainage of abscess of the right hand.

The petitioner returned to Dr. Krpan on October 19, 2004 and there was no evidence of erythma or drainage. The impression was right hand abscess.

The petitioner returned to Dr. Krpan on October 26, 2004, she was status post incision and drainage of abscess, right hand, Guyon's canal neuropathy, secondary to inflammation. She was released to return to work October 27, 2004.

The petitioner returned to Dr. Krpan on November 16, 2004, indicating that she regained most of her motion of her hand, but still had significant amount of pain, especially with prolonged activity. Examination revealed tenderness over the Guyon's canal, within the site of the surgery. The impression was status post incision and drainage of abscess, right hand, hypothenar eminence.

The petitioner remained under the care of Dr. Krpan and on January 25, 2005, the petitioner was diagnosed as having ulnar nerve neuritis. The petitioner was seen on February 9, 2005, and Dr. Krpan recommended an MRI of the hand. On February 24, 2005, he diagnosed the petitioner with Guyon's canal ulnar nerve entrapment, right wrist, secondary to foreign body and cellulitis from previous injury, as well as cubital tunnel syndrome, right elbow. An EMG was recommended.

An EMG was performed and Dr. Krpan on March 15, 2005, indicated that it demonstrated a compression of the ulnar nerve at the Guyon's canal. At this time, the doctor recommended release of Guyon's canal and release of the carpal tunnel to prevent medial nerve compression. Those surgeries were performed on April 4, 2005.

Dr. Krpan saw the petitioner on April 26, 2005, and he began her on occupational therapy, indicating that she should gradually begin to increase her activity as tolerated.

The petitioner was seen by Dr. Michael Vender on May 17, 2005. Petitioner testified that Dr. Vender felt she was capable of doing work, limited use of the right hand. The petitioner testified that her physician disagreed with the release, but she did return to work.

The petitioner was seen by Dr. Krpan on May 24, 2005 and he noted the release to return to work and he agreed with the current work restrictions.

The petitioner on July 5, 2005, went to Dr. Cummins for a second opinion. The records of Dr. Cummins were admitted into evidence as Petitioner's Exhibit No. 5. His initial diagnosis was cubital tunnel syndrome, shoulder/hand syndrome. He felt that as a result of the laceration sustained at work, she sustained an injury to the ulnar nerve at the Guyon's canal. He indicated

that she developed an infection with ID on two occasions and recommended antibiotics followed by the release of the ulnar nerve at the Guyon's canal. He felt that she should undergo an ulnar nerve decompression and an anterior transposition.

The petitioner returned to Dr. Krpan on August 16, 2005 and his impression was traumatic cubital tunnel syndrome, right elbow. He felt that she should be limited to left-handed only duty until surgery.

The petitioner on October 28, 2005, underwent a right cubital tunnel transposition. This surgery was performed by Dr. Krpan at Centegra Health System/Northern Illinois Medical Center. The petitioner was disabled from work and paid temporary total disability benefits from October 28, 2005 through November 15, 2005.

Dr. Vender re-evaluated the petitioner on November 8, 2005, with a recommendation of limited use to left hand, post operative.

On November 17, 2005, the petitioner was seen at Northern Illinois Medical Center by Dr. Benjamin Nager. The petitioner gave a history of working early this morning and having a severe headache for several days that worsened. Dr. Nager's impression was that the CT of the brain was normal. He felt that she presented at the time with what sounds like a possible seizure. Apparently, the petitioner did have electroconvulsive therapy about four years ago, and may have had a seizure following that treatment. He did review the petitioner's EEG which was performed earlier on November 17, 2005, and the study did show swelling of the background rhythm over the posterior head regions and rear right posterior temporal sharp waves were identified with secondary diagnosis being migraine headaches. The plan was to proceed with an MRI scan. She was started on Topax.

The petitioner was admitted to the hospital on November 17, 2005 with the MRI brain scan, with and without contrast, being normal, with the CT cervical spine with contrast being normal, with the CT head without contrast on November 17, 2005 being normal. Dr. Nager never opined that the condition was related to an early release to work. He related it to a prior pre-existing condition.

The petitioner on November 22, 2005, complained about Dr. Nager and Dr. Krpan sent her to see Dr. Amarish David.

The records of Dr. David were introduced into evidence as Petitioner's Exhibit No. 4. There was no comment by the doctor as to causal connection between her injury, release to return to work or her seizures. She was seen by a Dr. Lisa Ferley on December 22, 2005 and Dr. Ferley noted that she apparently had her first seizure twenty (20) years ago with a feeling that the seizure in question may have been associated with some sleep deprivation. The petitioner was seen by this physician for her seizure disorder through August 20, 2008, with the impression being simple and partial complex seizures controlled.

The petitioner returned to restricted duties December 28, 2005. This was based upon a release given to her by Dr. Krpan to five-hour shifts beginning December 28, 2005.

The petitioner returned to Dr. Krpan on January 31, 2006. At this time, the petitioner had marked improvements with respect to the ulnar neuropathy. It was noted that she was currently working six-hour shifts. The impression was status post ulnar nerve decompression, right wrist and right elbow, right shoulder impingement syndrome, and adhesive capsulitis. He advised the petitioner that she could start eight-hour shifts beginning February 19, 2006.

The petitioner was seen by Dr. Krpan on May 11, 2006. She complained of difficulty with handling the test tubes and blood draws. The diagnosis was right upper arm neuritis with impingement syndrome, right shoulder.

The petitioner was seen by Dr. Michael Vender on June 8, 2006. Dr. Vender's report was put into evidence as Respondent's Medical Exhibit No. 1. Dr. Vender in his report noted that petitioner at the time of his November 8, 2005 exam, was recently post operative for right elbow surgery. The petitioner, at this time, gave somewhat diffuse complaints as to the right upper extremity. Dr. Vender examined her and diagnosed her with status post ulnar nerve surgery, right elbow. Dr. Vender felt that she should be evaluated with new electro diagnostic studies. He felt that there was a strong possibility of psychosocial influences on the overall progress of

her medical state, indicating that he would be hesitant in providing any aggressive medical care in the future, such as surgery. He felt that it was reasonable for her to continue to perform her work activities with appropriate lifting restrictions. On June 16, 2006, he wrote a letter to Linda Pugliese indicating that there was no need to limit the number of hours that she worked, merely limit lifting of no more than ten (10) pounds (Res. Medical Exhibit No. 2).

The petitioner was seen by Dr. Krpan on June 20, 2006. Dr. Krpan noted that Dr. Vender recommended an EMG and that the petitioner may require a submuscular ulnar nerve transposition for which he recommended that she see Dr. Cummins. The plan was to see her back after the EMG.

An EMG was performed by Dr. David on July 18, 2006. The impression was chronic neurogenic changes in the ulnar innervated foreign muscles with reduced recruitment with the nerve conduction of the ulnar and medial nerves normal. The findings, according to Dr. David, were most consistent with chronic ulnar neuropathy at the elbow.

The petitioner returned to Dr. Krpan on July 27, 2006 and he made the referral to Dr. Cummins. The petitioner was continued on restricted duty. This was the last time Dr. Krpan saw the petitioner.

The petitioner was seen by Dr. Cummins on August 3, 2006. The plan was to perform surgery.

Dr. Cummins on September 6, 2006 performed a revision, right ulnar nerve decompression with anterior submuscular transposition for a pre-operative and post-operative diagnosis of right recurrent ulnar neuropathy at the elbow, status post subcutaneous anterior ulnar nerve transposition. The petitioner was off work for that condition from September5, 2006 through October 25, 2006. Dr. Cummins was the one who released the petitioner to light duty work on October 17, 2006, no use of the right arm and only four hours a day for three days per week. The petitioner did receive temporary partial disability benefits for the period of time she missed from work.

The petitioner continued to follow with Dr. Cummins. Dr. Cummins on March 5, 2007 recommended that the petitioner submit to an FCE. The FCE was done at Work Well on March 19 and 20, 2007. The FCE found that the petitioner functioned at the light work level. Dr. Cummins felt that she could work eight (8) hours a day, five days a week. He recommended more extensive and intense work conditioning to increase function. The indication was that she may not achieve the dexterity and endurance necessary to work in a fast-pace precision lab environment. It showed that she was capable of lifting from five to twenty pounds and push static, pull static 43 to 45 pounds. The person(s) who performed the FCE did not go out to the workplace to review the job demands but per information from the employee and employer, they felt "she met every possible work activity with the exception of handling fine motor on the right and gripping on the right which was noted to be rare in the workplace."

The petitioner testified that after her September 2006 surgery, she actually went to work for Respondents at a different hospital in Woodstock. She testified that her job was sitting at the front desk for four hours. She testified that it was Michael Benedeck who assigned her to this position. She testified that she began in this position on October 26, 2006. She testified that her job was to greet customers, greet patients as they walk in, asking where they needed to go and then walking them toward where they needed to go. She testified that after about a week, she moved to the emergency room desk at Woodstock Memorial and would sit at the desk and asked patients what they were here for and give them a little piece of paper where they would write down their name when they came to ER. She testified that she would hand that paper to a nurse who would put it into a computer. She testified that in the performance of these duties, she also had to call for Spanish interpreters if they had any Spanish-speaking patients, and that they would let her enter some of the patients' names in the computer if it wasn't too busy. She testified that maybe 5% to 10% of her time was keyboarding. She testified that Gil Restreppo was her supervisor and that he was the one who was monitoring her activities. It is noted by the Arbitrator that Mr. Restreppo worked at Woodstock Memorial, not Northern Illinois Medical Center. She testified that she was off work again April 6 through July 29, 2007. She testified that on April 5, 2007, she was advised by Gil Restreppo and Mr. Benedeck that her temporary assignment ended. The petitioner was put back on temporary total disability benefits during this period of time.

The petitioner was assigned David Patsaves as a vocational counselor and his first evaluation was May 11, 2007. His initial report was introduced into evidence as Respondent's Medical Exhibit No. 10. Mr. Patsavas in his report noted his initial meeting with the petitioner and her attorney on April 25, 2007. He obtained personal, social, medical status, education, vocational history, and started the vocational process. It was his feeling that she was an ideal candidate for vocational rehabilitation services and that she should have no trouble obtaining employment in a relatively short period of time, able to earn close to her former wage.

The second report by Mr. Patsavas was introduced as Respondent's Medical Exhibit No. 11, and it showed the progress that they were making in job placement. The petitioner at this time indicated that she felt comfortable with Microsoft Word and Excel.

The third report by Mr. Patsavas was introduced as Respondent's Medical Exhibit No. 12. It was noted that she had interviewed for a reception position at a new dermatologist office opening in Barrington, Illinois. Her starting pay was $14.00 an hour and according to the petitioner, it would probably move into a higher-paying position.

The petitioner on her own did find the job at Barrington Family Medicine and testified that she began working there on July 29, 2007. She testified that she worked there for approximately 1-1/2 years. Petitioner during this period of time was being paid wage loss.

David Patsavas continued to follow the petitioner in terms of vocational rehabilitation after the petitioner obtained that job with reports dated August 18, 2007, October 4, 2007, November 26, 2007, December 31, 2007, July 31, 2008, August 30, 2008, October 1, 2008, November 7, 2008, December 18, 2008, and January 28, 2009 (Respondent's Medical Exhibit Nos. 13 through 22). The Arbitrator would note that in the body of these reports, it is noted that it was difficult for the petitioner to be placed elsewhere because they were concerned about identifying the petitioner's current employer out of fear that her current employer may find out about the fact that she was looking and fire her and the fact that it was difficult at times to schedule appointments or meet because of her work schedule.

The petitioner last saw Dr. Cummins on May 20, 2008 and he indicated that there was no clear evidence of a surgical issue. He did not feel any further surgery would be beneficial for her elbow, and in fact, her elbow symptoms were quite mild. There was no current off-work slip provided.

The petitioner did submit to an EMG by Dr. Kenneth Vatz on June 30, 2008 (Res. Medical Exhibit No. 3). The impression was chronic right ulnar neuropathy of mild to moderate degree. In view of the previous surgery at the Guyon's canal (prior to the first EMG in this laboratory), and the two surgical procedures at the elbow subsequent to the first EMG at this laboratory, the sites of the lesion in the ulnar nerve cannot be determined with certainty and could be at the elbow, the wrist, on both sides. There was no electro diagnostic evidence for distal medial neuropathy at the wrist.

The petitioner returned to Dr. Michael Vender for purposes of an evaluation on June 30, 2008 (Res. Medical Exhibit No. 4). Dr. Vender noted that he had not seen the petitioner since June of 2006. He noted that the petitioner has not had any further surgeries. He noted some conservative treatment. She complained of pain in the right elbow. Range of motion of the elbow was initially self limited. Eventually there was essential full extension, possible 10-degree loss of full extension. Flexion was essentially normal. Range of motion of the wrist was 35/80. X-rays of the right elbow were taken and were interpreted within normal limits. Dr. Vender indicated that the nature of her current complaints at today's evaluation were similar to those noted in the past, that is there are complaints to the upper extremity involving the elbow region and the wrist region. New electro diagnostic studies obtained did not demonstrate any new changes. He felt that she had reached maximum medical improvement. He felt that she could participate in a normal work schedule. He indicated that determining the need for restrictions is somewhat difficult as a lot of her current problems are more related to subjective complaints rather than objective findings. He felt that it would not be unreasonable to have some limitations based on subjective complaints and considered her at the medium level of work activities.

The petitioner returned to Dr. Vender on October 27, 2008 (Res. Medical Exhibit No. 5). Her main complaints were related to the wrist. X-rays were taken. He indicated that the nature of her complaints have changed since the last evaluation. At that time, her complaints were mostly at

the elbow and only recently have been at the wrist. She had more complaints at the wrist with no definite symptoms specifically at the elbow. Dr. Vender's opinion was that she had plateaued with regards to her previous diagnosis and treatment. He felt that she was at maximum medical improvement. The doctor indicated that he is unfamiliar with seizures being secondary to painful upper extremity conditions. He did not consider the petitioner a candidate for pain clinic.

On December 13, 2008, a job analysis was performed of the petitioner's specific job – Medical Laboratory Technician/Medical Technologist. That evaluation was prepared by David A. Patsavas and the petitioner's supervisor (Res. Medical Exhibit No. 7).

Dr. Vender on February 13, 2009, had an opportunity to review that job analysis. He prepared a report indicating that he would expect the petitioner to be able to perform the work activities described. Dr. Vender's opinion was not challenged by any subsequent reports from either Dr. Krpan, Dr. Cummins or any other upper-extremity specialist.

The petitioner testified that the she stopped working in February of 2009. She testified at that point in time, she was having too many problems with her hand at work. She testified that during the course of her employment with Barrington Family Medicine, that she received care and treatment from Dr. Bartolomeo. The Respondent subpoenaed the records from Barrington Family Medicine and they were offered into evidence as Respondent Medical Exhibit No. 25. Those subpoenaed records showed no documented treatment. The petitioner testified that she received care off the record and Dr. Bartolomeo documented same in a letter allegedly produced by subpoena.

The petitioner testified that she contacted Mr. Benedeck about work on March 30, 2009. She testified that she applied for the position in the laboratory admitting that at that point in time, it was not posted. The petitioner testified that she has not applied for jobs at Centegra Health System since that time.

She testified that she then came under the care of Sherman Hospital Pain Clinic. The Arbitrator would note that the doctor put the petitioner on restricted duty effective February 13, 2009, limited use of the hand, limited pinch/grip, limited repetitive motion, with restrictions in effect

until March 13, 2009. The records from Sherman Health Center (Pet. Exhibit No. 12), showed that the treatment actually started February 24, 2009. It should be noted from the physician's records that the doctor gave the petitioner these restrictions. The last treatment was September 8, 2009 with a notation that the doctor wanted to stop the medication or giver her a smaller dose but the petitioner prefers to continue with this medication as she has excellent pain relief.

As to the question of what she notices about herself, she testified that it is essentially with the right arm that the problems are. She testified that she has bought electrical appliances such as an automatic can opener so that she can open jars. She testified that she plans her medication around her driving because she doesn't drive well. She testified that her arm was painful, stabbing pain and a lot of hypersensitivity on the skin with burning. She testified that because of that, she takes medication. She testified that her fingers were swollen a lot during the day and grasping was difficult. She testified that she has problems holding onto things. She complained of shooting pain into her elbow.

ACCIDENT and CAUSAL CONNECTION

As to the issue of accident and causal connection, the Arbitrator finds that the petitioner did sustain injuries to her right arm and elbow that resulted in the surgical procedures identified in the treating records.

MEDICAL

Petitioner was heavily restricted by Dr. Cummins and per the findings of the FCE. The condition of her arm was so severe that Dr. Cummins contemplated a third operative procedure to the ulnar nerve at the elbow. In light of the foregoing, as well as Petitioner=s significant, and undisputed, subjective complaints, pain management as recommended by Dr. Cummins, and others, was reasonable.

Moreover, Dr. Guman, while providing such care, discovered a neuroma at the surgical site which required injection and laser removalBservices he provided. He adjusted her medications to a tolerable level. After undergoing the therapy he prescribed, and ceasing work, Petitioner=s condition improve somewhatBshe was able to partake in simple activities of daily living like putting on makeup. The psychological counseling Petitioner underwent at Family Services of Mc Henry

County cites her arm and hand complaints and the frustration therewith. Such findings are expected in light of Petitioner=s long course of care, with numerous setbacks, which rendered poor results.

All these services further support the following finding: Petitioner has proven that the following medical services, provided to her, were reasonable and necessary, the cost of which are hereby awarded to Petitioner pursuant to Sec. 8a of the Act: American Home Health, $193; Sherman Hospital, $10,122.80; FCE (NIMC) $1,754.24; Healthcare and Family Services $3172.08; Family Services Mc Henry County $6,560 and Meijer $767.57. Total: $21,802.12.

TEMPORARY TOTAL DISABILITY

The following periods of temporary total disability were stipulated to by Respondent: 10-07-04 through 10-26-04, 4-4-05 through 5-18-05, 10-28-05 through 11-15-05; 09-05-06 through 10-25-06 and 04-06-07 through 07-29-07 (The arbitrator finds ample evidence of such entitlement in the medical record findings explained above.) The period of 11-17-05 through 12-27-05 is disputed.

Although the disputed period involved Petitioner=s suffering from the effects of a seizure, it is clear that she was concurrently temporarily totally disabled due to her upper extremity condition. Petitioner had surgery, ulnar nerve decompression and anterior transposition, three weeks prior, or on 10-28-05. Dr. Krpan, the surgeon, strongly objected to her returning to work three days before the seizure, citing the need to use two hands for such work and the unclean environment of the lab. He made clear that the incision was not yet healed. No medical evidence supports a finding to the contrary. His fears were realized when an abscess developed at the incision site. Petitioner was not discharged to any work by her treating doctors until the end of December, and to no lifting greater than one pound. In short, despite the connection of the seizure to the case at hand, Petitioner was disabled from her employment due to the condition of her right upper extremity during this time frame.

Petitioner has proven, and the arbitrator hereby finds that Petitioner was temporarily totally disabled from 11-17-05 through12-27-05, inclusive, in addition to the stipulated periods cited above, by a preponderance of the evidence.

NATURE AND EXTENT

Due to the Petitioner's injuries and subsequent surgeries her right arm is weakened and in frequent pain or numbness which prevents her from returning to the type of work she previously performed. The Arbitrator did not find Dr. Vender's opinion credible. Moreover, the Arbitrator finds the Petitioner's injury to be career altering and award 60% loss on a person as a whole basis.

PENALTIES

As to the issue of whether penalties or fees should be imposed upon Respondents, the Arbitrator has reviewed petitioner's Exhibit No. 28, which contains letter to the adjuster dated December 1, 2005 requesting TTD beginning November 23, 2005, letter to the respondent's attorney dated November 27, 2008 asking for authorization of pain clinic, letters dated February 20, 2009 and February 27, 2009 asking for temporary total disability benefits based upon pain doctor's off-work slip, and a letter dated March 12, 2009 that explains or attempts to explain Dr. Bartolomeo's treatment on an informal basis, with form penalty petitions, not specific in nature, filed by petitioner's attorney. As to the request for temporary total disability benefits beginning November 23, 2005, the respondent took the position that the petitioner was off from work for the non-work related seizure and had justification in disputing those benefits. As to the temporary total disability benefits disputed for the one month release from work, one-handed duty, by the pain management physician, February 18, 2009 through March 13, 2009, the arbitrator would note that that release was given by the doctor begrudgingly and that the petitioner was advised, as noted in their own penalty exhibit, of Dr. Vender's release to full duty. As to the letter regarding authorization of pain management, Dr. Vender, on behalf of the respondent, ruled out the need for same in his October 27, 2008 report. The arbitrator would note the respondent paid all periods of lost time except for the disputed period beginning November 17, 2005 through December 27, 2005 and from February 13, 2009 through March 13, 2009, with valid reasons for same. That respondent was given leave to respond to the penalty petition and has tendered to the arbitrator as Respondent

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

14IWCC0750

Dominique Kay,

Petitioner,

vs. NO: 06 WC 32115

Centegra Health System and Northern Illinois Medical 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, employment, medical, notice, temporary disability, permanent disability, penalties and attorney 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 December 17, 2010, 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.

14IWCC0750

The party commencing the 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 3 2014

Charles J. DeVriendt

Daniel R. Donohoo

Ruth W. White

HSF
O: 7/2/14
049

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

KAY, DOMINIQUE
Employee/Petitioner

Case# **06WC032115**

14IWCC0750

CENTEGRA HEALTH SYSTEM AND NORTHERN ILLINOIS MEDICAL CENTER
Employer/Respondent

On 12/17/2010, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.19% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0206 GAINES & GAINES
39 S LASALLE ST
SUITE 1215
CHICAGO, IL 60603

0481 MACIOROWSKI SACKMANN & ULRICH
10 S RIVERSIDE PLAZA
SUITE 2290
CHICAGO, IL 60606

14IWCC0750

STATE OF ILLINOIS)
)SS.
COUNTY OF MCHENRY)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Dominique Kay
Employee/Petitioner
v.
Centegra Health System and Northern Illinois Medical Center
Employer/Respondent

Case # 06 WC 32115

An *Application for Adjustment 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 Woodstock, on October 8, 2010. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On July 19, 2006, Respondents Centegra Health System and Northern Illinois Medical Center were operating under and subject to the provisions of the Act.

On this date, an employee-employer relationship did exist between Petitioner and Respondents Centegra Health System and Northern Illinois Medical Center.

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 Respondents Centegra Health System and Northern Illinois Medical Center.

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

In the year preceding the injury, Petitioner earned $39,936.00; the average weekly wage was $768.00.

On the date of accident, Petitioner was 39 years of age, single with three dependent children.

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

ORDER

RESPONDENTS Centegra Health System and Northern Illinois Medical Center are joint employers. See 05 WC O5517 as to Arbitrator's specific finding.

Claim for compensation 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.

Edward Lee — Signature of Arbitrator

12/16/10 — Date

DEC 17 2010

As to whether there was an employer/employee relationship, the Arbitrator finds that Centegra Health System and Northern Illinois Medical Center were joint employers. See reasoning 05 WC 5517.

As to the issue of current condition of ill-being and whether it is causally related to the injury in question, the Arbitrator finds that the petitioner on July 19, 2006, did sustain accidental injuries arising out and in the course of her employment. The petitioner on this date, testified that she was at work and had her elbow brace on, maintaining one of the machines when her elbow brace got caught in the machine sustaining an electrical sensation.

The petitioner was initially treated at Northern Illinois Medical Center on July 19, 2006 and those records were introduced into evidence as Petitioner's Exhibit No. 1. Those records show that on this date, she was working in the lab, doing maintenance on a machine, when she received an electrical shock. The indication was that the brace was stuck in between the machine and she could not extricate herself. Other lab employers had to do so. She complained afterwards of feeling lethargic and dazed. When she was brought to the emergency room she was awake and alert, but her CPK was elevated. The history was of having seizures in the past. The EKG showed normal sinus rhythm. The impression was electrical shock which the patient withstood, Grand Mall seizure, probably precipitated by electric shock, consult with Dr. Ferley and Dr. Nager. There was no evidence of any cranial injury.

The records of Dr. Ferley were admitted into evidence as Petitioner's Exhibit No. 6. The records contained a prior admission and treatment for seizure on November 17, 2005 with a history of same going back four years. The evaluation performed on December 22, 2005 revealed that the petitioner's first seizure occurred 20 years ago. The diagnosis was seizure disorder, epileptic focus occurring in the right posterior temporal region, and bipolar disease. It was noted by the Arbitrator that the petitioner testified to receiving electrical shock treatment for bipolar disease by Dr. Nager dating back to 2001, 2002, 2003, 2004. The notation by Dr. Ferley on July 20, 2006, was status post electrical shock injury to the right upper extremity without residual symptoms or signs. Breakthrough seizure immediately following the shock, otherwise the patient's seizures have been controlled on Lamictal. She was seen again by Dr. Ferley on July 23, 2007, with no alteration of consciousness or lapse of consciousness. Her mental status examination revealed a patient who was alert and appropriate. The

impression was temporal lobes seizures. The petitioner was last seen on August 20, 2008 with the diagnosis being simple and partial complex seizures controlled.

The petitioner's treating records from Dr. Nager were introduced into evidence as to his evaluation on November 17, 2005 as part of the records from Northern Illinois Medical Center. Dr. Nager was copied on the records from Dr. Farley for his subsequent care and Dr. Nager's records for treatment or care after July 19, 2006 were not introduced into evidence.

As to the nature and extent of injury, the Arbitrator finds that the petitioner sustained a temporary aggravation of a pre-existing seizure disorder for which she has returned to baseline with neither Dr. Ferley nor Dr. Nager suggesting residual disability from the incident in question.

As to the issue of temporary total disability benefits, no claim under this case was made. Reference should be made to case number 05 WC 05517 as to temporary total disability benefits claimed and paid.

As to the issue of whether medical services that were provided to the petitioner were reasonable and necessary, the Arbitrator notes no claim for unpaid medical concerning this matter.

As to the issue of penalties, there is no penalty petition that pertains to the above-captioned matter and there has been no indication that any medical or lost time was not paid as a result of the injury in question.

STATE OF ILLINOIS)
) SS.
COUNTY OF KANE)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Jennifer L. Prim,

Petitioner,

vs.

NO: 10 WC 44170

14IWCC0751

Bark Avenue Salon,

Respondent,

DECISION AND OPINION ON REVIEW

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

The Commission finds that the Arbitrator inadvertently forgot to give the Respondent credit for temporary disability payments of $2,851.31.

All else is affirmed and adopted.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed July 27, 2011, is hereby affirmed and adopted.

14IWCC0751

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 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: SEP 0 3 2014

Charles J. DeVriendt

Daniel R. Donohoo

Ruth W. White

HSF
O: 7/2/14
049

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

PRIM, JENNIFER L
Employee/Petitioner

Case# **10WC044170**

14IWCC0751

BARK AVENUE SALON
Employer/Respondent

On 7/27/2011, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.10% 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:

4037 CHRISTINE M ORY PC
511 W WESLEY ST
WHEATON, IL 60187

0507 RUSIN MACIOROWSKI & FRIEDMAN
10 S RIVERSIDE PLAZA
SUITE 1530
CHICAGO, IL 60606

14IWCC0751

STATE OF ILLINOIS)
)SS.
COUNTY OF KANE)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

Jennifer L. Prim
Employee/Petitioner

v.

Bark Avenue Salon
Employer/Respondent

Case # **10** WC **44170**

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 **J. Kinnaman**, Arbitrator of the Commission, in the city of **Geneva, IL**, on **6/15/2011**. 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. [x] Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. [ ] What was the date of the accident?
E. [ ] Was timely notice of the accident given to Respondent?
F. [x] Is Petitioner's current condition of ill-being causally related to the injury?
G. [ ] What were Petitioner's earnings?
H. [ ] What was Petitioner's age at the time of the accident?
I. [ ] What was Petitioner's marital status at the time of the accident?
J. [x] Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. [x] Is Petitioner entitled to any prospective medical care?
L. [x] What temporary benefits are in dispute?
[ ] TPD [ ] Maintenance [x] TTD
M. [ ] Should penalties or fees be imposed upon Respondent?
N. [ ] Is Respondent due any credit?
O. [ ] Other _____

FINDINGS

On the date of accident, **9/24/2010**, 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 part***.

In the year preceding the injury, Petitioner earned **$29,999.84**; the average weekly wage was **$576.92**.

On the date of accident, Petitioner was **31** years of age, ***single*** with **0** dependent children.

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

Respondent shall be given a credit of **$2,151.31** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$2,151.31**.

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 **$384.61**/week for **4-4/7** weeks, commencing **9/25/2010** through **10/26/2010**, as provided in Section 8(b) of the Act.
Respondent shall pay reasonable and necessary medical services of **$310.74**, as provided in Sections 8(a) and 8.2 of the Act.

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

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

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

Signature of Arbitrator

July 25, 2011
Date

ICArbDec19(b)

JUL 27 2011

Petitioner testified the as of Sept. 24, 2010, she had been employed by Respondent for about two and a half years as a pet groomer. She testified she had been bitten at work before Sept. 24, 2010 and experienced no complications. She had no problems with her neck, shoulder or hand prior to that date.

Petitioner testified that on Sept. 24, 2010 at about 11:00 AM, she began grooming a German shepherd mixed with black lab. She estimated the dog weighted 55 to 65 lbs. but she had worked with dogs of similar size before. Petitioner put the dog on the table and put its head in a noose that hooks to an arm above the table. As she started to groom, the dog freaked out. It defecated and then jumped off the table with its head still in noose. The dog was thrashing so she picked it up by the back side. Normally, dogs freeze when that happens but this dog went off the other side of the table. Meanwhile, Bob Maas reached for paper towels to clean up the poop. Petitioner put the dog back on the table a second time. He was still crazy and jumped off the front of the table. He was dangling from the noose and circling in the air. Petitioner reached overhead to lift the weight of the dog with her right arm and to unlatch the noose. But the weight was too much. She then reached down to the dog to unhook the noose. That's when the dog bit her on the forearm. The noose broke and the dog ran.

Petitioner testified her wound was in the forearm. There was a big one at the top and two small ones on the bottom. She was focused on the bite wound itself, but felt there was something else wrong because she'd never had that kind of pain before. She told Rick she needed to go to hospital.

Robert Maas testified pursuant to subpoena. He's been employed at Bark Ave. Salon for almost three years. He worked with Petitioner four days a week. They are both pet groomers. Mass identified PX9, a letter dated March 24, 2011 which he prepared at Petitioner's request. She asked him if he would submit a letter saying how he knew her, what they did and what happened on Sept. 24, 2010. The third paragraph describes what happened. The incident was mid-day, between 10:00 AM and 1:00 PM, he didn't remember exactly. The grooming room has three tables. That day he was at the first and Jennifer was at the third; no one was at the middle table. There was maybe eight feet between them. Petitioner was working on a larger breed, maybe a shepherd. They had never worked with that dog before. He had his back to Petitioner as she was putting the dog on her table, but he realized there was a problem and turned around. He saw that the dog had jumped off table. The noose was around the dog's neck. The dog was dangling and then the noose came off. The dog was on the floor. Mass testified the dog had jumped off the table once before, but he didn't see that. He saw Petitioner put the dog back on the table the second time. Maas doesn't know whether Petitioner was bitten the first time or the second time, He didn't see her get bit but heard her say "oh my God it's really deep" and then begin to cry. Maas has been bitten before himself. If they know a dog is a biter, they'll put a muzzle on. This dog didn't show a tendency to bite before this incident. They were working in a very small room so there weren't many places the dog could go. You try not to let a dog jump off, but if it does, you put it on the table. Maas

testified he has never known Petitioner to be dishonest. They have had conversations about what happened, as friends. Petitioner did not tell him what to say. On cross-examination, Maas testified PX9 is a complete and accurate account of what occurred. It does not include any specific reference to Petitioner's shoulder.

Rick Ritchie testified for respondent. He owns Bark Ave. Salon and takes care of all the "back room stuff" doing everything but the actual grooming. Petitioner worked for him as a groomer. He didn't see what happened on Sept. 24, 2010. Petitioner came back to his desk and said she got bit and that she thought it was bad. She did not say anything about her shoulder. She said she was in very bad pain. Ritchie had Tracey, their bather, drive Petitioner to Dreyer Clinic (DMS). Richie saw the dog and estimated it weighed about 50 lbs. Prior to the accident, Petitioner was complaining of headaches. He did not think she complained on a weekly basis, but thought it was more often that someone should. Her headaches were so bad she was crying. She has not been back to work since the accident. As a groomer, Petitioner would have to lift 50 to 60 lbs. but not 100 lbs. He learned Petitioner was claiming an injury to her right shoulder on Oct. 13, 2010 when he got a call and Petitioner said the therapist was starting PT on the shoulder. On cross-examination, Ritchie testified he could not remember Petitioner calling after the accident but before Oct. 13, 2010. He did not get a fax from Dr. Velagapudi because there is no fax in the store. He did get something from the doctor, but can't remember what. Ritchie was in the hearing room during Petitioner's testimony and heard it. He testified she told him pretty much what she testified to. He doesn't have a problem with Petitioner's honesty. Petitioner told him what happened as far within minutes of when she got bit. She was crying so he doesn't know when all the details came out, but they did. He doesn't know of Petitioner having any shoulder problems before the accident. He did not fill out an accident report; he just called the insurance company and gave them the details.

Petitioner testified she was taken to DMS and that she gave them the entire story about wrestling with the dog and that she picked up the dog two or three times. The DMS records show Petitioner was seen Sept. 24, 2010 for treatment of a dog bite to her right forearm. The subjective history portion of the records shows she reported being bit at work about 30 minutes before coming in by a lab/shepherd mix. She was teary-eyed, quite upset and in a lot of pain that travelled up into her elbow and into her wrist. The wound was cleansed, Petitioner was given medication and she was released. PX2.

Petitioner testified the wound healed very quickly, within two or three days. There was no swelling; it looked perfect. But she was on pain pills. When the pain medication wore off, she noticed pain in her arm and shoulder.

On Oct. 1, 2010, Petitioner went to Dr. Gustafson at Rush Copley medical group based on the recommendation of a friend and not a doctor's referral. She testified she described the incident with the dog to the doctor. The history noted in Dr. Gustafson's record indicates she was seen for evaluation of skin lesion(s) one week earlier. Petitioner's job as a groomer was noted as well as her bite on the right forearm. Dr. Gustafson noted:

"has constant ache in arm. Feels tender if rotates arm. On exam, the doctor noted puncture wounds on the right forearm; no erythema, no drainage and mild bruising of the right forearm; tender to palpation over puncture wound. Under "Musculoskeletal" Dr. Gustafson noted right forearm pain with supination. She told Petitioner to finish her antibiotics and see an ortho if the pain persisted. PX3.

Petitioner testified Dr. Gustafson referred her to Dr. Velagapudi. She saw the doctor on Oct. 8, 2010 and explained everything as far as the dog jumping off the table, wrestling with the dog and the bite. She testified the doctor did testing of her elbow movement, wrist movement and fingers and tested for tingling. He did not have her raise her arms and did no x-rays.

PX4, Dr. Velagapudi's records, include a questionnaire dated Oct. 8, 2010 signed by Petitioner. On the first page, she noted Dr. Gustafson's referral. In answer to the question "Why are you seeing the doctor today?" Petitioner checked boxes indicating the right arm but not the right shoulder. In his note of Oct. 8, 2010, Dr. Velagapudi also acknowledged Dr. Gustafson's referral for evaluation of right forearm dog bite on Sept.24, 3010. Petitioner complained of pain, stiffness and weakness with use of her arm, the pain increased. On exam, Petitioner had "excellent motion related to her neck with no radicular pattern of pain. She is able to move her shoulders, elbows and wrist well." The doctor noted the dog bite but Petitioner had normal rotation of the forearm, excellent motion of the wrist and excellent intrinsic and extrinsic strength. There was a negative Tinel's in the right hand. Dr. Velagapudi prescribed physical therapy (PT), and medication. She was released to work with a 10 lb. lifting restriction. The doctor's diagnosis on the Work status Sheet was "dog bite".

Petitioner testified on cross-examination that Dr. Velagapudi dictated his office note of Oct. 8, 2010 in her presence. She would not be surprised if there was no mention of her shoulder in his note as she did not hear him say anything about her shoulder except that she could move it well. However, on re-direct examination, Petitioner reviewed the doctor's notes of that date. It was not the same information she heard him dictate at the physical. She thinks his records are not complete. He mentioned the dog jumping off the table when she heard him. She is angry because he did not examine her shoulder; the therapist was the first to examine the shoulder.

Petitioner identified PX1 as the questionnaire she completed for PT. It is not dated, but she did it the first day of PT. The document also is part of PX4, Dr. Velagapudi's records which also include an initial occupational therapy evaluation dated Oct. 14, 2010. On the questionnaire, Petitioner indicated her current complaints are "pain in whole arm-tendons in wrist and hand-shoulder pain- elbow pain." On his evaluation, the physical therapist noted pain with range of motion of the right shoulder.PX4. Petitioner testified that when the therapist had her lift up her arms, she could only lift her right arm half way. That was the first time any medical provider had done that test. She was given therapy only for the shoulder.

Petitioner returned to Dr. Velagapudi on Oct. 26, 2010. She testified she went back because the therapist wanted the doctor to examine the shoulder because of her pain. She said the visit did not go well. She told Dr. Velagapudi he hadn't examined her shoulder and then showed him that she couldn't hold her left arm straight up. He examined her shoulder that day but told her she could see another orthopod if she didn't feel comfortable with him. After his examination, he prescribed three weeks of PT.

Dr. Velagapudi's office note of Oct. 26, 2010 reflects the conversation with Petitioner from his point of view. He noted Petitioner was concerned about whether he was listening to her at the last visit and whether he examined her shoulder and neck or not. He referred to his notes of that visit indicating both were examined and wrote that his notes were contemporaneous and dictated in the patient's presence. His examination notes of Oct. 26, 2010 show excellent motion of the neck with a negative Spurling's but some discomfort in the right rhomboids with lateral rotation to the left. Shoulder abduction was to about 120 degrees, forward flexion to 140 degrees and internal rotation adduction to the level of T12. Passively she had full range of motion; excellent muscle strength; no atrophy of the shoulder; no winging of the scapula. The tooth marks were completely healed and there was no particular tenderness or Tinel's in the area and no atrophy in the right forearm. Dr. Velagapudi's impression was apparent right shoulder and rhomboids pain following a dog bite with unclear etiology. He noted Petitioner reported picking up the dog, weighing about 65 lbs. She also wondered if the dog pulled her arm when he bit her. Dr. Velagapudi did not think there was any suggestion of shear, "speaking against" that theory. His diagnosis was healed dog bit marks and some residual right shoulder pain. He prescribed more therapy. PX4.

Respondent did not authorize further PT and TTD benefits stopped. Petitioner's next medical treatment was at DuPage Convenient Care. She was seen Nov. 13 and 24, 2010, complaining of right shoulder pain. Medications for pain and anxiety were prescribed at both visits. At the Nov. 24, 2010 visit she was referred to Orthopaedic Associates of DuPage for follow-up. Petitioner went to Central DuPage Hospital on Dec. 3, 2010 complaining of chronic pain in her right shoulder. She described the incident of Sept. 24, 2010. On examination she was noted to be anxious, tearful and angry. The primary diagnoses were anger and rotator cuff tear/sprain/rupture. Her Norco prescription was renewed. PX7.

Petitioner saw Dr. Anderson at Stratford Family Physicians on Dec. 7, 2010.She was complaining of right arm and shoulder pain from a dog bite on Sept. 23, 2010. She described the scene with the dog that day. Dr. Anderson suspected rotator cuff tendonitis or tear and prescribed steroid medication and no work. He advised her to see an orthopedist and prescribed an MRI of the right shoulder. Dr. Anderson refilled Petitioner's medications on Dec. 13 and 23, 2010 and Jan. 5, 2011. She saw him again on Feb. 21, 2011. He prescribed additional medication. PX6.

Petitioner saw Dr. Sterba at Orthopaedics Associates of DuPage on Dec. 10, 2010. Petitioner had treated with Dr. Thomas at OAD in 2008 for an earlier dog bite. At the upper right corner of the record for that date is noted: "Referring: Selected None." In the HPI section of the records, the notes show "Work related: Yes". Petitioner described the incident of Sept. 24, 2010. She complained of pain from the shoulder which radiated down to the hand with numbness and tingling in all fingers of the hand. She also had chest pain, pain in the upper trapezius and into the neck. Dr. Sterba noted Petitioner had a bad experience at another orthopedic clinic. The doctor found Petitioner's right shoulder very limited; there was full range of motion of the elbow and wrist, but with pain; the neck was stiff. His assessment was cervical radiculopathy versus rotator cuff syndrome. He prescribed a cervical and right shoulder MRI. These were done Dec. 23, 2010. The cervical MRI showed a small posterior focal disc protrusion at C6/7 without significant central canal stenosis, according to the radiologist. The right shoulder MRI showed a partial thickness intrasubstance tear of the distal supraspinatus tendon with tendinosis. There was mild arthrosis of the acromioclavicular joint. PX5.

Petitioner returned to Dr. Thomas at Dr. Sterba's referral, on Dec. 23, 2010. She was complaining of pain in the wrist and over the proximal forearm near the elbow. She also complained of pain going into her shoulder and neck. Following his examination, Dr. Thomas' assessment was open wound of the arm without complication. He advised Petitioner he thought her work-related puncture wound from the dog bites were fully healed with no functional consequence or disability. He thought she could return to work as far as her work injury. PX5.

On Jan. 10, 2011, Petitioner saw Dr. Mayer for consultation regarding her neck and radicular symptoms. She described her struggle with the dog on Sept. 24, 2010. "She reports later that day she began getting diffuse arm pain from the shoulder all the way down her arm into the hand." She told Dr. Mayer about her prior treatment and PT, describing it as for her distal extremity doing desensitization but the therapist sent her back to the doctor after noticing symptoms from the neck and shoulder. It was unclear to Dr. Mayer what was going on between the time Petitioner left Dr. Velagapudi's care and her appointment with Dr. Sterba Dec. 10, 2010. Based on his examination and review of the MRIs, Dr. Mayer's primary assessment was myofascial pain, with cervical radiculitis and rotator cuff syndrome as well. He recommended "first and foremost" a six to 12 week course of PT two or three times a week. He wanted to rule out the possibility of a brachial plexopathy "which can certainly happen under circumstances of fighting with a dog with her arm." He did not think the stenosis seen on her cervical MRI was overly impressive. Dr. Mayer prescribed Lyrica and a 20 lb. lifting restriction. PX5.

Petitioner was examined by Dr. Levin at Respondent's request on Jan. 12, 2011. He testified by deposition that she described the incident with the dog on Sept. 23(sic), 2010. She told the doctor she had pain in her entire right arm into her right shoulder blade and the right side of her neck later that night. She summarized her subsequent medical treatment. Dr. Levin reviewed RX2, the Dreyer Medical Clinic record of Sept. 24, 2010

and saw no reference to complaints of the right shoulder or arm, other than the dog bite. He also reviewed Dr. Gustafson's record of her Oct. 1, 2010 exam, RX3, and saw no reference to a right shoulder or arm complaint other than the dog bite. Similarly, there was no complaint documented by Dr. Velagapudi in RX4, his note of Oct. 8, 2010. With respect to Dr. Velagapudi's record of Oct. 26, 2010 indicating Petitioner's dog bite marks show no evidence of shear, Dr. Levin testified that if the area of penetration is sheared, it indicated some type of rotation or traction force at the time of the bite. Following his examination and review of the diagnostic tests and subsequent medical records, Dr. Levin's diagnosis was dog bite, right forearm. He did not believe there was a direct relationship between the events of Sept. 24, 2010 and her right shoulder complaints. If the pathology seen on the right shoulder MRI were related to the accident, he would expect her to have pain within several days. He did not see evidence of shoulder complaints he would consider contemporaneous with the dog bite. On cross-examination, the doctor testified his diagnosis of Petitioner's right shoulder condition was right shoulder rotator cuff tendonitis with a partial thickness tear of the articular surface of the cuff. Based on Petitioner's clinic complaints, he thought she may not be able to work as a dog groomer. He did not think Petitioner had a cervical condition. If the only condition Dr. Velagapudi saw when he examined Petitioner on Oct. 8, 2010 was the dog bite, then it would not have been appropriate for him to order PT for her shoulder. For the dog bite, either no PT or soft tissue treatment with range of motion of the portion of the extremity affected by the dog bit would have been appropriate. In general, Dr. Levin was of the opinion that wrestling and lifting a dog weighing 65 lbs. onto the back of a grooming table two to three times could cause the pathology he saw in Petitioner's right shoulder.

Petitioner testified she notices pain in the shoulder and all the way down the arm. Muscle relaxers help her relax her tension, but she still has pain in the right shoulder blade. Sometimes it runs down her whole arm. She also has many headaches. She had headaches before, but not so frequently. No one has released her to go back to her job as a dog groomer. She has been looking for office work where she wouldn't need to use her right shoulder or arm.

PX8 is comprised of Petitioner's medical bills. She is claiming a total of $6,869.05. The parties agree the amounts shown reflect the amounts that would be due pursuant to sec. 8.2 of the Act, the medical fee schedule, if liability were found.

The Arbitrator concludes:

1. Petitioner sustained a compensable accident on Sept. 24, 2010 when she was bitten by a dog. Petitioner's testimony describing the incident was credible and corroborated by her co-worker, Robert Maas, both in writing and in live testimony. Her employer, Rick Ritchie, heard Petitioner testify and testified himself that on Sept. 24, 2010, she described the scene the same way when she asked to go to a doctor.

2. Petitioner's dog bite is causally related to her accident of Sept. 24, 2010 but she failed to prove causal connection to her right shoulder condition. All the medical and testimonial evidence shows Petitioner sustained a dog bite on Sept. 24, 2010. However, her right shoulder complaints are not documented until Oct. 26, 2010 although Petitioner saw doctors at Dreyer Medical Services, Rush Copley Hospital and Castle Orthopedics. It is very plausible that Petitioner was focused on the dog bite when she went to Dreyer Medical Services after the accident and she testified the shoulder pain did not appear until later in the evening that date; she also testified the pain did not appear until the medications wore off. But Dr. Gustafson did not document shoulder or neck complaints when she saw Petitioner on Oct. 1, 2010. The doctor's records indicate she saw Petitioner for evaluation of skin lesions on the right forearm. Although she noted Petitioner complained of pain in her arm, the doctor's examination was limited to the forearm. Her notes show she rotated Petitioner's arm, not her shoulder. Petitioner saw Dr. Velagapudi on Oct. 8, 2010 and did not note right shoulder or neck pain on her patient questionnaire. Furthermore, Dr. Velagapudi did not document complaints of the shoulder or neck although he dictated his notes in Petitioner's presence. Both Dr. Gustafson and Dr. Velagapudi were Petitioner's chosen providers so there is no reason either would have omitted reference to shoulder complaints if Petitioner had mentioned them. Dr. Velagapudi's records show he examined Petitioner's neck and right shoulder, although Petitioner disputes this. It would be naïve to pretend doctors' notes are infallible. But treating medical records are considered so reliable they are admitted in evidence notwithstanding the fact they are hearsay. This Arbitrator needs a credible explanation why Dr. Velagapudi would note Petitioner could move her neck and shoulder well and had no radiculopathy if he never examined either. There being no explanation, the Arbitrator concludes the records accurately reflect Dr. Velagapudi's examination and that the first mention of neck and shoulder pain were on Oct. 14, 2010 when Petitioner completed a questionnaire for her PT evaluation. She was eventually evaluated by Dr. Sterba whose notes say "yes" to the question of whether Petitioner had a work related injury. But those notes refer to both the dog bite as well as her neck and shoulder complaints and this causal connection opinion could refer to one or all of these conditions. The remaining causal connection opinion in the treating medical records is that of Dr. Mayer who thought a brachial plexopathy could result from the accident Petitioner described. But that diagnosis has not been established and Dr. Mayer was not asked for a specific causally connection opinion. On this record, Dr. Levin's opinion that there is no causal connection is the most credible.
3. Petitioner was temporarily totally disabled commencing Sept. 25, 2010 through Oct. 26, 2010, the date Dr. Velagapudi thought Petitioner's dog bite had healed and Dr. Levin thought she reached MMI.
4. Petitioner is entitled to medical expenses of $310.74 pursuant to sec. 8(a) and 8.2 of the Act for the expenses of her treatment at Dreyer Medical Services on Sept. 24, 2010 ($238.82) and prescription expenses incurred before Oct. 26, 2010 ($71.92). This treatment was related to Petitioner's dog bite. Dreyer Medical

Services provided emergency services and Petitioner's treatment there does not count as a choice of provider. Petitioner chose Dr. Gustafson who referred her to Dr. Velagapudi.

5. All other issues are moot.

STATE OF ILLINOIS)	☐ Affirm and adopt	☐ Injured Workers' Benefit Fund (§4(d))
) SS.	☐ Affirm with changes	☐ Rate Adjustment Fund (§8(g))
COUNTY OF COOK)	☒ Reverse	☐ Second Injury Fund (§8(e)18)
		☐ PTD/Fatal denied
	☐ Modify	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Leslie Williams,

Petitioner,

14IWCC0752

vs.

NO: 08 WC 34818

Progressive Logistics,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by Respondent herein and notice given to all parties, the Commission, after considering the issues of medical expenses, TTD and PPD and being advised of the facts and law, reverses the August 5, 2013, Decision of the Arbitrator on the issue of causal connection as stated below and, subsequently vacates the TTD and PPD benefits awarded in said decision.

The presiding Arbitrator found Petitioner testified credibly that, after being released from Concentra Medical Center on March 27, 2008, he continued to experience problems with his right knee. The Commission finds otherwise.

Petitioner, following his February 2, 2008, accident treated at Concentra Medical Center until March 27, 2008. On March 27, 2008, Petitioner's physical therapist, Bhavani Patel, reported Petitioner as declaring himself to have had a "resolution of symptoms" and a "restoration of pre-injury status." Petitioner's treating physician, Dr. Alysia Ogburia, indicated Petitioner had no pain and also that she could find no exacerbating factors. Despite these statements to the contrary, Petitioner maintained that he continued to be symptomatic in his right knee following his March 27, 2008, discharge from Concentra Medical Center. The Commission, however, finds Petitioner's claims of continuing dysfunction to be inconsistent with his medical records.

During his arbitration hearing, Petitioner was asked about what he noticed about his right knee between the time he was released from Concentra Medical Center on March 27, 2008, until the time he first saw Dr. Michael Durkin on August 18, 2010, and testified that he still experienced "some clicking and stuff like that all the time." That Petitioner would claim to "still" be experiencing clicking in his right knee is curious as there is nothing in Petitioner's records as recorded by Mr. Patel and Dr. Ogburia of him ever complaining of experiencing any clicking in his right knee. Dr. Ogburia's March 27, 2008, record, the last record taken before Petitioner was discharged from care, indicates Petitioner explicitly denied having any clicking in his right knee. Also curious is Petitioner's statement concerning "stuff like that." The Commission is uncertain as to what Petitioner meant by that comment as Petitioner was not asked to expound on that statement. Reviewing Petitioner's medical records, it is noted Petitioner, on March 11, 2008, complained of "still" having increased pain when climbing stairs. The Commission, however, finds no record of Petitioner having complained of pain while stair climbing before March 11, 2008, that would indicate stair climbing had been previously painful. The Commission also does not find any record of Petitioner after March 11, 2008, complaining of pain with stair climbing. The Commission finds Petitioner's testimony, alone, insufficient to find he continued to be symptomatic in his right knee at the time he was released from Concentra Medical Center on March 27, 2008.

The Commission finds no medical records to corroborate Petitioner's claim of remaining symptomatic in the months that followed his March 27, 2008, discharge from Concentra Medical Center. Petitioner was asked, "[F]rom March 27, 2008, until July [2008], you had no treatment for your right knee?" To which Petitioner answered, "No treatment to my right knee? No, I believe I was off on disability or something like that, something was going on." When asked a variation of that same question, Petitioner responded, "If the records reflect I don't [sic], it's not there." The lack of medical records indicating treatment and Petitioner's evasive answers to straight forward questions leaves the Commission with the impression that Petitioner did not treat his right knee any time between March 27, 2008, and July 5, 2008.

The Commission also differs with the presiding Arbitrator with respect to the testimony and opinions of Petitioner's treating physicians, Dr. Howard Freedberg and Dr. Durkin. Unlike the Arbitrator, the Commission did not find them to be sufficiently credible, reliable or persuasive.

Dr. Freedberg, when provided with Concentra Medical Records that indicated Petitioner was symptom-free in his right leg as of March 27, 2008, opined that Petitioner still might have had an underlying meniscal tear even if he was asymptomatic. He testified that he understood Petitioner complained of waxing and waning knee pain from February 2008 through September 9, 2009. It is unclear how Dr. Freedberg arrived at this understanding as he acknowledged that he had not reviewed any of Petitioner's medical records that were created between March 28, 2008, and July 2008. It is noted further that Dr. Freedberg's own records made no mention of Petitioner experiencing any waxing and waning of symptoms but of a six to eight week period in which Petitioner claimed to be asymptomatic with respect to his right knee.

As was Dr. Freedberg, Dr. Durkin was presented with Petitioner's Concentra Medical Center records, which indicated Petitioner was discharged from both medical treatment and

physical therapy as he was pain free. In spite of this, Dr. Durkin believed Petitioner's right knee pain never completely abated but, instead, waxed and waned between late March 2008 and late July 2008. He provided no explanation as to why he found this to be so.

The Commission finds, in both instances, Dr. Freedberg and Dr. Durkin ignored Petitioner's documented medical history and create an unsubstantiated history of waxing and waning pain in Petitioner's right knee. The known medical history is that Petitioner was discharged from medical and physical therapy treatment on March 27, 2008, with no subjective complaints whatsoever. Yet, he claimed to be at his pre-February 8, 2008, status. Instead, they, independent of each other, assert Petitioner might have experienced waxing and waning of symptoms. These assertions cannot be based on Petitioner's medical record from between March 27, 2008, through July 2008 because none exist. These assertions cannot be based on the history each of them took from Petitioner because they never recorded a history of Petitioner having complaints of waxing and waning symptoms. The Commission finds the testimony of Dr. Freedberg and Dr. Durkin strayed from the factual medical history and, as a result, cannot find either of their causal connection opinions credible.

The Commission, in the absence of any credible evidence to the contrary, concludes Petitioner to have fully recovered from the injury he sustained to his right knee on February 8, 2008, no later than March 27, 2008, as evidenced by the medical records from Concentra Medical Center. The subsequent complaints of symptoms in Petitioner's right knee after that date were not proven to be causally connected to his accident of February 8, 2008.

Addressing the period of temporary total disability that followed Petitioner's February 8, 2008, accident, the Commission finds Petitioner failed to prove that he was ever temporarily totally disabled between the dates of his accident and the date he was discharged from care at Concentra Medical Center. Petitioner did not even claim he was unable to work between the date he was injured, February 8, 2008, and the date he first sought medical care, February 12, 2008.

Petitioner testified Concentra Medical Center allowed him to return to work, albeit with light duty status, on February 27, 2008. In reviewing the records from Concentra Medical Center, it is revealed that Petitioner was found capable of returning to work by the medical staff at Concentra Medical Center as early as the same day he was first seen, February 12, 2008, though with restrictions. Absent from the record is anything that would indicate that Petitioner was not allowed to return to work, even in a light duty capacity, by either any medical professional or Respondent on February 12, 2008, or any time thereafter. Therefore, the Commission concludes, Petitioner's absence from work from February 12, 2008, and February 27, 2008, was voluntary and not the result of his being temporarily totally disabled.

It is axiomatic that not working is not analogous to being unable to work. In the instant matter, all evidence indicates Petitioner was capable of working immediately following his February 8, 2008, accident. He simply did not do so. The Commission, therefore, finds Petitioner failed to prove that he was temporarily totally disabled and, consequently, vacates the awarded temporary total disability benefits for the time period of February 8, 2008, through February 27, 2008.

14IWCC0752

The Commission also vacates the temporary total disability benefits awarded for the time period of June 19, 2010, through March 23, 2011. The Commission finds that, if the Petitioner was temporarily totally disabled during this time, his disability was not related to the injury he sustained on February 8, 2008, as that injury has been found to have been completely resolved more than two years earlier.

Also vacated are the permanent partial disability benefits of 35% loss of the right leg. Medical records from March 27, 2008, reveal Petitioner claimed that his right leg had been restored to its pre-accident condition. The Commission, therefore, finds any subsequent impairment of Petitioner's right knee to be unrelated to his February 8, 2008, accident.

IT IS THEREFORE ORDERED BY THE COMMISSION that all benefits conferred upon Petitioner in the August 5, 2013, Decision of Arbitrator are vacated.

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

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

DATED: SEP 0 4 2014
KWL/mav
O: 07/08/14
42

Kevin W. Lamborn

Thomas J. Tyrrell

Michael J. Brennan

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

14IWCC0752

WILLIAMS, LESLIE
Employee/Petitioner

Case# **08WC034818**

08WC034820

PROGRESSIVE LOGISTICS
Employer/Respondent

On 8/5/2013, 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 0.06% 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:

1315 DWORKIN AND MACIARIELLO
THOMAS GAYLE
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0075 POWER & CRONIN LTD
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STATE OF ILLINOIS)
)SS.
COUNTY OF COOK)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

14IWCC0752

Leslie Williams
Employee/Petitioner

Case # **08** WC **34818**

v.

Consolidated cases: **08** WC **34820**

Progressive Logistics
Employer/Respondent

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Anthony C. Erbacci**, Arbitrator of the Commission, in the city of **Chicago**, 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 **February 8, 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 **$16,672.76**; the average weekly wage was **$320.63**.

On the date of accident, Petitioner was **52** 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 **$467.21** for Temporary Total Disability benefits.

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

ORDER

Respondent shall pay reasonable and necessary medical services of **$59,677.37**, as provided in Sections 8(a) and 8.2 of the Act. The Respondent shall be entitled to credit for the medical expenses it has paid on behalf of the Petitioner.

Respondent shall pay Petitioner temporary total disability benefits of **$230.00**/week for **42 4/7** weeks, commencing **February 8, 2008** through **February 27, 2008**, and from **June 19, 2010** through **March 23, 2011**, as provided in Section 8(b) of the Act.

Respondent shall be given a credit of **$467.21** for temporary total disability benefits that have been paid.

Respondent shall pay Petitioner permanent partial disability benefits of **$230.00**/week for **75.25** weeks, because the injuries sustained caused the **35%** loss of the **right leg**, as provided in Section 8(e) of the Act.

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

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

Arbitrator Anthony C. Erbacci

July 26, 2013
Date

AUG 5 - 2013

FACTS:

The Petitioner sustained undisputed accidental injuries arising out of and in the course of his employment with the Respondent on February 8, 2008. The Petitioner testified that on February 8, 2008, he was wrapping a pallet of merchandise, and he stepped sideways and twisted and popped his right knee. The Petitioner testified that he continued to work the rest of his shift and then went home and went to sleep. The Petitioner testified that he went to Concentra a couple days later with complaints of pain in his knee. The Petitioner testified that he had never experienced this type of pain or problem with his knee before and that prior to this date he was in a general state of good health.

The records of Concentra demonstrate that the Petitioner was seen there on February 12, 2008 with complaints of right knee pain for four days. He gave a history of twisting his right knee and hearing a pop and he complained of pain in the back of his knee. The Petitioner followed up at Concentra on February 27, 2008 and it was noted that the Petitioner reported feeling 75% better but complained of popping and cracking in the knee. On March 7, 2008 it was noted that the Petitioner reported severe posterior knee pain especially with sitting with his knee extended and on March 11, 2008 it was noted that the Petitioner had increased pain with climbing stairs. On March 14, 2008 it was noted that the Petitioner reported that he was feeling much better without medial or posterior pain but that he did feel some pulling and pinching in the knee especially when going up stairs or walking distances. On March 21, 2008 the Petitioner again reported that he was feeling better but he reported stiffness which was not improved and was worse with walking a lot. On March 25, 2008 and on March 27, 2008, it was noted that the Petitioner reported a complete resolution of his symptoms. On March 27, 2008 the Petitioner was released from care and returned to full duty work.

The Petitioner testified that he returned to regular duty work for the Respondent, Road Link, and that the company name was subsequently changed to Progressive Logistics. The Petitioner continued to perform his regular work for the Respondent until July 1, 2008 when he sustained another undisputed work injury to his neck and right shoulder. That neck and right shoulder injury is the subject of a separate Arbitration Decision issued in Case number 08 WC 34818. The Petitioner testified that he did not reinjure or aggravate his right knee on July 1, 2008.

On July 2, 2008, the Petitioner went to Concentra for his neck and shoulders condition. The July 1, 2008 injury was noted and the assessment was a strain of the right trapezius. No right knee complaints or treatment was noted. The Petitioner returned to Concentra for the problems with his neck and shoulder on July 5, 2008, July 7, 2008, July 9, 2008, and July 11, 2008. No right knee complaints or treatment was noted on any of those occasions.

On July 22, 2008 the Petitioner underwent a cervical MRI and on July 23, 2008 he began treating with Dr. Todd Sinai, a Chiropractor, for his neck and shoulder. Dr. Sinai referred the Petitioner to Dr. Bruce Montella for his neck and shoulder condition and he ultimately referred the Petitioner to Dr. Howard Freedberg for orthopedic evaluation of the

right knee.

The Petitioner saw Dr. Freedberg on September 9, 2008. Dr. Freedberg noted a history of knee pain since an injury in February 2008 which "worsened one week ago with walking on stairs". A right knee MRI was completed on September 22, 2008 and was reported to demonstrate a popliteal cyst, degenerative joint disease and mild soft tissue swelling. The anterior cruciate and posterior cruciate ligaments appeared within normal limits with no evidence of tear and the medial collateral and lateral collateral complexes appeared unremarkable. Dr. Freedberg recommended ongoing conservative treatment and on January 27, 2009 Dr. Freedberg recommended an arthroscopic knee surgery for the Petitioner based upon his clinical diagnosis of a meniscal tear On September 10, 2009 Dr, Freedberg's diagnoses were osteoarthritis and a meniscal tear.

Dr. Freedberg testified that he reviewed the medical records of Concentra and Dr. Sinai, and that the symptoms the Petitioner reported to him were essentially the same with minor variations. He testified that the history of a twisting and popping of the knee usually describes the mechanism of injury to produce a medial meniscal tear and that the twisting and popping could produce a meniscal flap tear which is rarely picked up by MRI. Dr. Freedberg opined that the Petitioner suffered an acute meniscal tear and/or an aggravation of an existing osteoarthritic condition as a result of the twisting injury of February 8, 2008.

The Petitioner next sought treatment for his knee with Dr. Steven Sclamberg on November 16, 2009. Dr. Sclamberg recorded a history of a right knee twisting injury when loading pallets in July 2008. The Petitioner testified that he did not sustain a knee injury in July 2008 and that his only knee injury was February 2008. He testified that he believed that Dr. Sclamberg erred in charting July 2008 as the date of the knee injury. Dr. Sclamberg diagnosed the Petitioner as having osteoarthritis in his right knee and he recommended a right total knee arthroscopy for the Petitioner. Dr. Sclamberg treated the Petitioner for his right knee as well as his right shoulder and he ultimately referred the Petitioner to Dr. Michael Durkin for surgical care of the right knee.

On August 18, 2010 the Petitioner was examined by Dr. Durkin. The initial history recorded by Dr. Durkin indicates a February 2008 twisting injury to the right knee at work. Dr. Durkin prescribed a total knee arthroplasty and the surgery was performed on October 6, 2010 at Hinsdale Hospital. The records demonstrate that the Petitioner's post-operative recovery was progressed well and a course of physical therapy was completed. On March 7, 2011 Dr. Durkin recommended a Functional Capacity Evaluation which was completed on March 23, 2011 at Achieve Manual Physical Therapy. The evaluation was reported to be valid and to demonstrate that the Petitioner was able to frequently lift 50lbs., carry 30lbs, shoulder lift 46lbs., and push 60lbs. The Petitioner testified that, following the knee surgery, he had great improvement in his mechanical symptoms and pain and that, as of the date of hearing, he had maintained improvement and his knee felt good.

In his deposition testimony of May 12, 2011, Dr. Durkin opined that Petitioner had a knee that was deteriorating on its own but that the twisting and popping tore cartilage in the

knee and set the condition on a downward slope. He opined that the twisting and popping of the knee was a competent cause of the Petitioner's condition and that by the time he saw the Petitioner the condition had progressed to "bone on bone" with pain. Dr. Durkin opined that the Petitioner had some pre-existing knee arthritis that was then exacerbated by the accident of February 2008 and necessitated a total knee replacement. Dr. Durkin noted that the Petitioner was fully functioning prior to the accident and there was a fairly clear accident with obvious knee strain and probable torn meniscus from twisting and popping.

At the request of the Respondent, the Petitioner was examined by Dr. Brian Neal in March of 2009. Dr. Neal gave deposition testimony on two dates, October 2, 2009 and May 20, 2011. Dr. Neal testified that the Petitioner's diagnosis was osteoarthritis of the right knee. He noted that the initial treatment records of Concentra did not mention any symptoms of instability and were not consistent with a meniscal tear. He testified that the accident did not cause an aggravation or acceleration of the arthritic condition and that surgery for the arthritic condition was not related. Dr. Neal opined that the Petitioner's injury was a soft tissue type strain to the knee which was not consistent with a meniscal tear, and which resolved completely, shortly after the injury occurred. Dr. Neal opined that the surgery recommended for the Petitioner by Dr. Freedberg was reasonable and necessary medical treatment but that it was not related to the Petitioner's February 2008 work injury.

In Support of the Arbitrator's Decision relating to (F.), Is Petitioner's current condition of ill-being causally related to the injury, the Arbitrator finds and concludes as follows:

It is axiomatic that the Petitioner bears the burden of proving all of the elements of his claim by a preponderance of the credible evidence. While the Arbitrator notes the testimony and opinions of Dr. Neal, the Respondent's examining physician, the Arbitrator finds that the testimony and opinions of Dr. Freedberg and Dr. Durkin, the Petitioner's treating physicians, are sufficiently credible, reliable, and persuasive to satisfy the Petitioner's burden of proof. In so finding, the Arbitrator notes that the gap in treatment between the end of March 2008 and July 2008 does not preclude the finding of a causal connection between the condition and the accident. The Petitioner consistently reported a twisting and popping injury to his right knee and he consistently reported that incident as the event which precipitated his right knee pain and problems. There were no intervening accidents and the Petitioner testified credibly that after being released from Concentra in March 2008 he did continue to have problems with his right knee.

Based upon the foregoing, and having considered the totality of the credible evidence adduced at hearing, the Arbitrator finds that the Petitioner's right knee condition, including the condition necessitating the total knee replacement is causally related to the work accident of February 2, 2008.

In Support of the Arbitrator's Decision relating to (J.), Were the medical services that were provided to Petitioner reasonable and necessary/Has Respondent paid all appropriate charges for all reasonable and necessary medical services, the Arbitrator finds and concludes as follows:

The Arbitrator has determined that Petitioner's right knee condition is causally related to the February 8, 2008 work accident. It is not disputed that the medical care and treatment that the Petitioner underwent while treating with Concentra between February 12, 2008 and March 27, 2008 for his right knee is reasonable, necessary, and causally related to the February 8, 2008 work accident. Subsequent to his treatment at Concentra, the Petitioner underwent treatment with Oakton Chiropractic from July 28, 2008 to November 4, 2009. This treatment included therapeutic modalities and chiropractic manipulation but appears to have been primarily directed to the Petitioner neck and shoulders rather than his right knee. Between September 9, 2008 and November 4, 2008 the Petitioner was examined, diagnosed, and treated by Dr. Freedberg for his right knee. Between November 16, 2009 and June 18, 2010 the Petitioner was examined, diagnosed, and treated by Dr. Sclamberg. The Petitioner underwent physical therapy for his right knee from April 7, 2010 to April 19, 2010 at Total Rehab PC. Between August 18, 2010 and March 7, 2011 the Petitioner was examined, diagnosed, and treated by Dr. Durkin. Dr. Durkin performed a total right knee replacement surgery on the Petitioner on October 16, 2010. That right knee replacement was performed at Adventist Hinsdale Hospital. The Petitioner received prescription medications through Comp Today Meds between March 22, 2010 and March 7, 2011 for his right knee condition. On March 23, 2011 the Petitioner underwent a Functional Capacity Evaluation at Achieve Manual Physical Therapy on the recommendation of Dr. Durkin.

Dr. Durkin testified that the conservative treatment that was provided to the Petitioner prior to the knee replacement surgery and the knee replacement surgery that was eventually performed on the Petitioner was reasonable and necessary medical care that was causally related to the Petitioner's right knee injury of February 8, 2008.

The Arbitrator notes that Petitioner testified that the therapeutic modalities, physical therapy, and surgical intervention about his right knee helped his right knee condition improve to the extent that as of the date of hearing his right knee was doing well and he felt that his condition had been resolved.

The Arbitrator also notes that although he opined that the treatment was not causally related to the work injury, Dr. Neal, the Respondent's examining physician, testified that conservative care and the total knee replacement the Petitioner received were reasonable and necessary,. As noted above, the Arbitrator has found that there is a causal connection between the Petitioner's right knee injury of February 8, 2008 and the need for the right knee replacement surgery.

Based upon the foregoing, and having considered the totality of the credible evidence adduced at hearing, the Arbitrator finds that the concludes that the medical care and surgical

care provided to the Petitioner for his right knee by Concentra, Dr. Freedberg, Dr. Sclamberg, Total Rehab PC., Dr. Durkin, Adventist Hinsdale Hospital, Comp Today Meds, and Achieve Manual Physical Therapy was reasonable, necessary, and causally related to the Petitioner's right knee injury of February 8, 2008.

Respondent shall pay the following medical expenses, subject to the limitations of the Illinois Workers' Compensation Fee Schedule rate to the Petitioner:

Suburban Orthopedics	$1,651.00
Orthopedics of the North Shore, Dr. Sclamberg	$3,789.32
Total Rehab PC	$719.31
Hinsdale Orthopedics, Dr. Durkin	$10,811.65
Adventist Hinsdale Hospital	$40,896.65
Home Medical Express	$299.68
Achieve Manual Physical Therapy	$1,509.76
Total	$59,677.37

In Support of the Arbitrator's Decision relating to (K.), What temporary benefits are due, the Arbitrator finds and concludes as follows:

It is not disputed that the Petitioner was temporarily and totally disabled between February 8, 2008 and February 27, 2008 as ordered by Concentra. The Petitioner then returned to work for Road Link. Subsequent to his return to work for Road Link the employer underwent a change in name to Progressive Logistics. The Petitioner had the same or similar job duties under the new company Progressive Logistics. On July 1, 2008 the Petitioner suffered an injury to his neck and shoulders while working with Progressive Logistics. That injury is the subject of a separate Decision issued in Case number 08 WC 34820. The July 1, 2008 injury did not affect the Petitioner's right knee.

On September 9, 2008, while the Petitioner was off work due to his neck and shoulder condition, the Petitioner was ordered by Dr. Freedberg to remain off of work due to the right knee condition. The Respondent Road Link did not authorize temporary benefits for this lost time; however, the Petitioner did receive temporary benefits for this period due to his neck and shoulder injury. The Petitioner again worked light duty from September 12, 2008 to September 27, 2008 and December 4, 2008 to December 17, 2008. The Petitioner has not worked since December 17, 2008. Following December 17, 2008 the Petitioner remained under the care of Dr. Freedberg and Dr. Sclamberg and he was continued off of work. The Petitioner was also being continued off work for his neck and shoulder condition. The Petitioner reached maximum medical improvement from his neck and shoulder injuries on June 18, 2010, but was continued off work due to his knee condition thereafter. The Arbitrator

notes that the Petitioner was awarded Temporary Total Disability benefits in case number 08 WC 34820 from December 18, 2008 through June 18, 2010, the date he reached maximum medical improvement from his neck and shoulder injuries.

Dr. Sclamberg referred Petitioner to Dr. Durkin on August 18, 2010 for surgical treatment of the right knee. Dr. Durkin continued the Petitioner's off work status and on March 23, 1011 the Petitioner underwent a Functional Capacity Evaluation that was prescribed by Dr. Durkin. That Functional Capacity Evaluation was reported to be valid and to demonstrate that the Petitioner was able to frequently lift 50lbs., carry 30lbs, shoulder lift 46lbs., and push 60lbs. Following the March 23, 1011 Functional Capacity Evaluation, the Petitioner self-terminated medical care for his knee condition. The Petitioner did not perform a job search within the Functional Capacity Evaluation restrictions and instead remained on Social Security Disability and worked in a volunteer position as a pastor. Given these facts the Arbitrator concludes that Petitioner reached a maximum medical improvement with respect to his knee condition as of March 23, 1011. The Arbitrator finds that the Petitioner has not proven entitlement to any temporary benefits after that date.

Based upon the foregoing, and having considered the totality of the credible evidence adduced at hearing, the Arbitrator finds that the Petitioner is entitled to Temporary Total Disability due to his right knee condition for the periods of February 8, 2008 through February 27, 2008 and from June 19, 2010 through March 23, 2011, a total period of 42 4/7 weeks.

In Support of the Arbitrator's Decision relating to (L.), What is the nature and extent of the injury, the Arbitrator finds and concludes as follows:

The Petitioner was diagnosed clinically with meniscus tear and aggravated/accelerated degenerative joint disease. Following a course of conservative treatment, the Petitioner underwent a total knee replacement under the care of Dr. Durkin. The Petitioner completed post-operative care and a Functional Capacity Evaluation performed on March 23, 2011 was reported to demonstrate that the Petitioner was able to frequently lift 50lbs., carry 30lbs, shoulder lift 46lbs., and push 60lbs.

At hearing, the Petitioner testified that his right knee was improved with the total knee replacement and that he is doing well. He testified that he does not currently have problems with his knee if he remains within the physical restrictions given in his Functional Capacity Evaluation.

Based upon the foregoing, and having considered the totality of the credible evidence adduced at hearing, the Arbitrator finds that as a result of the injury of February 8, 2008, the Petitioner suffered a 35% loss of use of the right knee.

STATE OF ILLINOIS)
) SS.
COUNTY OF WINNEBAGO)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

TERRY STEINER,

Petitioner,

14IWCC0753

vs.

NO: 08 WC 37819

RENTECH ENERGY MIDWEST CORPORATION,

Respondent.

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 accident, notice, causal connection, medical expenses, nature and extent, and penalties and attorneys' fees, and being advised of the facts and law, affirms the Arbitrator's finding as to accident, but reverses the Decision of the Arbitrator with regard to the issues of notice, medical expenses, temporary total disability benefits, and permanent partial disability for the reasons specified below.

Findings of Fact and Conclusions of Law

1) On August 26, 2008, Petitioner filed an Application for Adjustment of Claim, alleging repetitive trauma injuries to both hand and body, and a date of accident of July 1, 2007. (ARB EX3). At the time of hearing, Petitioner made an oral motion to amend the Application for Adjustment of Claim to reflect a date of accident of May 7, 2007. (ARB EX1). Petitioner's motion to amend the date of accident was granted. (T7-8).

2) Petitioner testified he began his employment with Respondent on August 27, 1974. Petitioner testified that in 2007 he was working for Respondent as an "A" UREA operator, and was responsible for maintaining temperatures, pressures, operating three

CO2 compressors and eight pumps. Petitioner testified his job required the use of 36-inch cheater bars to open and close 24 to 48 inch valves, 18-inch cheater bars, 1-inch air-driven wrenches, a channellock, small pipe wrench, and a small ballast wrench. Petitioner testified that in May of 207 he was using high impact wrenches to remove nuts and bolts off vessels, and turning a lot of valves when he noticed weakness and tingling in his fingers. (T9-15). Petitioner also testified that the job description and DVD (RX5) tendered into evidence by Respondent failed to accurately depict his job duties and failed to include his more strenuous job duties required with plant outages and turnarounds. (T22-28).

3) Petitioner testified he sought treatment with Dr. Field on May 7, 2007, was referred for an EMG test, which was performed May 14, 2007. Petitioner testified that from 2007 through September of 2008 he continued working his regular duties, but that during that period he noticed his hands were falling asleep, going numb, and waking him at night because of the shock-like sensation in his hands, worse on the right side than left. (T15-16).

4) Petitioner testified on cross examination that he probably did not advise anyone at work that he thought his hand problems were related to his work duties, that he did not know if he advised Respondent of his bilateral hand complaints between the period of May 7, 2007, when he first sought medical care, and September 25, 2008, when he next sought medical care, and that he never filled out an accident report with Respondent to advise of his workers compensation claim. (T68-72).

5) Petitioner testified he underwent an evaluation with Dr. Foad, pursuant to Respondent's request. (T16). On November 19, 2008, Dr. Foad examined Petitioner, opined his carpal tunnel syndrome was causally connected to his work duties, which Petitioner described as requiring significant repetitive gripping and grasping and fair amount of exposure to vibrator motion, and opined surgery was indicated. (PX4, Dep EX3). On January 26, 2009, Dr. Foad issued a supplemental report upon his review of an AIGCS Physical Job Description/Job Analysis & Job Description and Requirements. Dr. Foad opined that there was no change in opinion on causation, that the turning of valves with large tools could in effect produce carpal tunnel syndrome, and that if the valves vibrated while turning, that could even further exacerbate symptoms of carpal tunnel syndrome. (PX4, Dep EX4).

6) Dr. Field performed right hand carpal tunnel surgery on December 10, 2008. Petitioner was authorized off work by Dr. Field from December 10, 2008 through December 21, 2008, and then provided light duty work. Petitioner underwent left hand carpal tunnel surgery on January 14, 2009, and was authorized off work from that date through January 25, 2009, after which he returned to work light duty for Respondent. (PX2, T16-20). Petitioner testified he returned to work full duty, and

then was released from Dr. Field's care in June of 2009. Petitioner testified that he continues to perform his same work duties as an "A" UREA operator. (T20-22).

7) Dr. Field testified Petitioner's carpal tunnel syndrome was caused, aggravated or exacerbated by his work duties, that he was not aware of any other condition that he would attributed to Petitioner's carpal tunnel syndrome, and that the surgeries performed were related to the condition he diagnosed. (PX3, T26-28).

8) On October 25, 2011, Petitioner was examined by Dr. Coe at his attorneys' request. Dr. Coe testified that based upon Petitioner's history, medical records, and DVD of Petitioner's work duties, that Petitioner's bilateral carpal tunnel syndrome and need for surgical repair was causally related to his work duties. (PX4, T25-26).

9) Larry Flogel, Respondent's safety supervisor, testified the typical job duties performed by Petitioner involved exposure to vibration from compressor pockets and turning of valves, and required use of channellocks, gas torch, cheater bars, pipe wrenches, impact wrenches, grinders, chain operated boring tool, slugging wrenches. He also admitted that on a significant outage the employee was required to turn 75 to 100 valves during the course of a few hours to a few days while draining all the vessels. (T110-116).

10) John Williams, Respondent's operations manager, testified that an operator would typically turn 25 to 30 valves by hand per shift, sometimes easy to turn and sometimes difficult and requiring an extension, turn up to 150 valves during an outage, and use pipe wrenches, sledge hammers and other hand tools during course of day. He also admitted the job was hand intensive, manual labor. (T180, 191-193).

11) Petitioner testified that Respondent pays part of the premium for its employee group medical insurance through United Health Care, that PX1 contains the medical bills related to his treatment for his carpal tunnel syndrome, that some bills were paid by United Health Care, that some small fees were paid by him, and that some of the bills were remained unpaid. (T19-20).

12) Subpoenaed records from United Health Care, the provider of the group health medical insurance plan contributed to by the Respondent, covering the period of May 1, 2007 through November 1, 2010, contain numerous medical bills paid by United Health Care, including a carpal tunnel related medical bill from Dr. Field for a date of service of June 30, 2009 in the amount of $81.95. (PX5). These records, as well as the subpoenaed records from Dr. Field, document the June 30, 2009 date of service medical bill was paid by the group health carrier on August 12, 2009. (PX5, PX1).

The Commission affirms the Arbitrator's finding that Petitioner sustained repetitive trauma injuries to both hands arising out of and in the course of his employment, and that his current condition of ill-being is causally connected to those work duties, based upon witness testimony as to Petitioner's job duties, and the testimony of Petitioner's treating and examining physicians, Dr. Field and Dr. Coe.

However, on the threshold issue of notice, the Arbitrator found that Petitioner failed to prove timely notice, relying on the fact that Petitioner filed his application on August 26, 2008, at which time he initially alleged a date of accident of July 1, 2007, which was subsequently amended on the date of hearing to reflect a date of accident of May 7, 2007, and that Petitioner failed to offer any evidence or testimony that he provided notice within 45 days of the accident date. The Arbitrator found Petitioner failed to provide notice of his accident until after he filed his Application, which was after August 26, 2008, beyond the 45 days required by statute. The Commission reverses the Arbitrator's finding with regard to the issue of notice, and instead finds that Petitioner provided timely notice.

The Commission finds that Petitioner's claim falls under section 8(j) of the Act (Ill. Rev. Stat. 1971, ch. 48, par. 138.8(j)):

> "(j) 1. In the event the injured employee receives benefits, including medical, surgical or hospital benefits under any group plan covering non-occupational disabilities contributed to wholly or partially by the employer, which benefits should not have been payable if any rights of recovery existed under this Act, then such amounts so paid to the employee from any such group plan as shall be consistent with, and limited to, the provisions of Paragraph 2 hereof, shall be credited to or against any compensation payment for temporary total incapacity for work or any medical, surgical or hospital benefits made or to be made under this Act. In such event, the period of time for giving notice of accidental injury and filing application for adjustment of claim does not commence to run until the termination of such payments."

Although Petitioner failed to provide notice of his May 7, 2007 work-related injury under Section 6(c) of the Act until the filing of the Application for Adjustment of Claim on August 26, 2008, the payment of medical bills pursuant to Section 8(j) of the Act has been found to toll the time to provide notice, as set out in Crow's Hybrid Corn v. IC, 72 Ill.2d 168(1978). In Crow, the Court found that the period of time to provide notice does not commence to run until termination of the 8(j) payments. The record establishes that insurance payments were made under the group policy the Respondent had with United Health Care during the period from May 7, 2007 until August 12, 2009. Respondent received Petitioner's filed Application for Adjustment of Claim on or about August 26, 2008. This plan covered non-occupational disabilities. The Commission finds Respondent received timely notice of Petitioner's injury from the filing of the Application for Adjustment of Claim on August 26, 2008, at which time the time to provide notice was still being tolled. Accordingly, Petitioner's notice of accident was sufficient and timely.

14IWCC0753

Based upon the Commission's finding of accident, notice and causal connection herein, and the medical records containing the appropriate off work authorizations, the Commission finds Petitioner is entitled to an award of temporary total disability benefits for the period of December 10, 2008 through December 21, 2008, and January 14, 2009 through January 25, 2009, for a period of 3-3/7 weeks, that being the period of temporary total incapacity for work under §8(b).

With regard to the issue of medical expenses, the Commission awards Petitioner the outstanding medical bills listed in Petitioner's Exhibit 1: $8,714.40 The Finley Hospital; $25.25 Westside Orthopaedics; $1,010.00 Dodge Street Anesthesiologists; and, $156.25 as reimbursement for Petitioner's out-of-pocket payments. The Commission further finds that Respondent is entitled to a credit for related medical bills paid by Respondent's group health insurance carrier, pursuant to Section 8(j), and that Respondent shall hold Petitioner harmless from any and all claims or liabilities that may be made against him by reason of having received such payments only to the extent of such credit.

Based upon the findings of accident, notice, and causal connection herein, the supporting medical records, and Petitioner's credible testimony as to his continuing symptoms of bilateral hand weakness and the Commission finds Petitioner it entitled to an award of 12.5% loss of use of the right hand, and 12.5% loss of use of the left hand under Section 8(e).

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed January 27, 2014, is hereby affirmed with regard to findings of accident and causal connection, and reversed with regard to all other issues for the reasons stated herein.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay to the Petitioner the sum of $727.12 per week for a period of 3-3/7 weeks, for the period of December 10, 2008 through December 21, 2008, and January 14, 2009 through January 25, 2009, that being the period of temporary total incapacity for work under §8(b).

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $9,749.75 for outstanding medical expenses, and reimburse Petitioner for his out-of pocket payments in the amount of $156.25, pursuant to §8(a) and §8.2 of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $619.97 per week for a period of 51.25 weeks, as provided in §8(e) of the Act, for the reason that the injuries sustained caused the Petitioner 12.5% loss of use of the left hand, and 12.5% loss of use of the right hand.

IT IS FURTHER ORDERED BY THE COMMISSION that Petitioner's Petition for Penalties and Attorneys' fees is 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.

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 $44,300.00. 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: SEP 0 4 2014
KWL/kmt
O-07/08/14
42

Thomas J. Tyrrell

Michael J. Brennan

DISSENT

I respectfully dissent from the decision of the majority. Arbitrator Holland's decision was thorough, well reasoned, and grounded in the evidence. I would affirm and adopt it in its entirety.

Kevin W. Lamborn

ILLINOIS WORKERS' COMPENSATION COMMISSION

NOTICE OF ARBITRATOR DECISION

14IWCC0753

STEINER, TERRY
Employee/Petitioner

Case# **08WC037819**

12WC004860

RENTECH ENERGY MIDWEST CORP
Employer/Respondent

On 7/9/2013, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

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

0293 KATZ FRIEDMAN EAGLE ET AL
FRANK J BERTUCA
77 W WASHINGTON ST 20TH FL
CHICAGO, IL 60602

0507 RUSIN MACIOROWSKI & FRIEDMAN LTD
JIGAR DESAI
10 S RIVERSIDE PLZ SUITE 1530
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

14IWCC0753

Terry Steiner
Employee/Petitioner

v.

Rentech Energy Midwest Corp.
Employer/Respondent

Case # 08 WC 37819

Consolidated cases: 12WC4860

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Douglas J. Holland**, Arbitrator of the Commission, in the city of **Rockford**, on **June 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

14IWCC0753

On **May 7, 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 not* given to Respondent.

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

In the year preceding the injury, Petitioner earned **$56,718.37**; the average weekly wage was **$1,090.68.**

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

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

To date, **$0** has been paid for TTD and maintenance benefits.

ORDER

Petitioner's claim for compensation is denied for failure to prove timely notice, and claim 12WC4860 is dismissed because it was filed in excess of three years of the statute of limitations, or 2 years after the payment of benefits.

RULES REGARDING APPEALS Unless a party files a *Petition for Review* within 30 days after receipt of this decision, and perfects a review in accordance with the Act and Rules, then this decision shall be entered as the decision of the Commission.
STATEMENT OF INTEREST RATE If the Commission reviews this award, interest at the rate set forth on the *Notice of Decision of Arbitrator* shall accrue from the date listed below to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

Douglas J Holland

Signature of Arbitrator

7-3-13
Date

ICArbDec p. 2

JUL 9 – 2013

Terry Steiner v. Rentech Energy Midwest Corp.
Case No.: 08 WC 37819

Findings of Fact

Petitioner amended the Application for Adjustment of Claim for case number 08 WC 15082 to an accident date of May 7, 2007, which the Arbitrator allowed over Respondent's objection. Respondent objected to Petitioner's subsequent filing, case number 12 WC 4860, with an alleged accident date of September 25, 2008, which the Arbitrator dismissed, as it was filed in excess of three years of the statute of limitations, or 2 years after the payment of a benefit.

Petitioner, a 52 year old male, testified he began working at Respondent's facility in 1974. The facility was bought and sold approximately six times and is presently owned by Rentech Energy Midwest Corp. Petitioner's job title is "A" Urea Operator ("Operator"). His general job duties involve maintaining and operating compressors, pumps, recycler pumps, a reactor system, ammonia pumps and performing system maintenance on May 7, 2007. Petitioner was examined at Westside Orthopedics by Physician's Assistant, Michael Schmid, complaining of numbness and tingling in both hands, worse at night, frequently waking him. Examination revealed no wasting of the thenar eminence bilaterally, negative Tinel's sign over the carpal tunnel bilaterally and negative Phalen's test. The impression was 1) MRI documented cervical degenerative changes and 2) History and physical consistent with carpal tunnel syndrome. There was a discussion of the symptomatology, potentially coming from the neck or from carpal tunnel syndrome, and EMG studies were recommended. An EMG was completed on May 14, 2007, revealing right median entrapment of moderate severity at the wrist and left median entrapment of mild to moderate severity at the wrist. On May 22, 2007, the doctor's office notes a conversation with Petitioner regarding the above information, that he planned to schedule

surgery in September and that the nurse offered a splint and anti-inflammatory medication as needed.

In April, 2007, Dr. Compton, Petitioner's primary care physician, ordered an MRI of the cervical spine due to hand complaints, which revealed degenerative changes.

Petitioner's bills were submitted and paid by his group medical insurance, which was paid, in part, by his employer. Petitioner continued working the same job duties for Respondent. On September 25, 2008, Petitioner was seen again at Westside Orthopedics, wishing to proceed with carpal tunnel decompression, right side first, as his symptoms awaken him at night. A note from Physician's Assistant, Michael Schmid, noted "We will recommend a workmans' comp. if they allow us to proceed with carpal tunnel decompression. We will plan on doing the right first. The left would be approximately 6 weeks after the right. This was okayed verbally with Dr. Field." (PX 2)

In November, 2008, Respondent had Petitioner examined by Dr. Foad, who examined Petitioner in Clinton, Iowa.

On December 5, 2008, Dr. David S. Field performed right carpal tunnel release. Petitioner was provided light duty work and was off work from December 10, 2008 through December 21, 2008 and did not receive any wages or disability insurance benefits.

On January 14, 2009, Dr. Field performed a left carpal tunnel release and Petitioner was off work through January 25, 2009. On March 30, 2009, Dr. Field noted Petitioner was satisfied with the progress of the carpal tunnel releases to date, however, he has difficulty with opening boxes and large valves, and the vibrations in those areas sometimes seems to aggravate his symptoms. Strengthening exercises were recommended. (PX 2)

On June 30, 2009, Dr. Field noted Petitioner reported good relief of his night time discomfort, but still has some pain and achiness with work activities and vibration. He noted Petitioner was experiencing some gradual, steady improvement. Examination revealed some apparent thenar muscle wasting on the right side. (PX 2) Dr. Field testified in the October 29, 2012 evidence deposition, diagnosing Petitioner's bilateral carpal tunnel syndrome, which he found to be causally related to Petitioner's job duties. (PX 3, pp. 26, 27) Dr. Field noted he had the opportunity to treat many patients from this particular facility and was quite aware of some of the stress to their hands and upper extremities from the work they perform, including twisting and wrenching of valves that are stuck and pulling with hands, hand work repeatedly, putting particular pressure on the palm and hand areas. He noted it would not be atypical to develop hand problems over time. (PX 3, p. 29) Dr. Field was also aware that the work load increases for the workers when the plant has outages. (PX 3, p. 31) Dr. Field did not review Respondent's DVD of the Operator's job. (PX 3, p. 53)

On October 25, 2011, Petitioner was examined by Dr. Jeffrey Coe, a board certified occupational medicine specialist, at the request of his attorney. Dr. Coe's evidence deposition was completed on February 3, 2012. (PX 4) According to the history taken by Dr. Coe, Petitioner operated a multi-stage compressor with a number of valves that required opening and closing throughout the course of the compressor operation, and that the compressor valves were stiff, and at times difficult to turn, in part, because of the high force of the gas within the system, and that he would often use a cheater bar placed within the valve to assist in turning. He would open and close valves several times each day, which required a forceful grip and that significant vibration of the compressor system was noticed when he gripped pipes and valves, subjecting his hands to vibration. (PX 4, pp. 9, 10) Petitioner noted in 2007 numbness in both hands and that

over time the numbness began to increase to where it would awaken him from sleep at night and cause him difficulty with forceful gripping. He sought treatment through Dr. Compton, who prescribed an MRI scan of the cervical spine to rule out cervical radiculopathy as a cause of the numbness. The MRI revealed some disc protrusions and disc narrowing, but no obvious cervical nerve root impingement. Further evaluation of the hand was done, including EMG testing, which was completed on May 14, 2007, and was positive. Regarding potential risk factors for carpal tunnel syndrome, Mr. Steiner denied significant injuries or symptoms to his hands, along with conditions such as diabetes, mellitis, thyroid disease, collagen and vascular diseases or acute direct injuries to the hands and wrists, like a broken wrist or a penetrating wound of the hand or wrist, or hand intensive home activities, such as motorcycle riding or weight lifting.

(PX 4, PX 4, p. 13) Dr. Coe testified that he reviewed the report of November 19, 2008 from Dr. Foad, Respondent's first examining doctor. He noted that according to Dr. Foad's report, Petitioner's job involved operation of compressors and pumps and work that requires significant gripping and grasping, and it was also described as having a fair amount of vibratory motion and sanders, and that Dr. Foad also reviewed the treating medical records and rendered a diagnosis of bilateral carpal tunnel syndrome. (PX 4, pp. 14 – 16) He stated that Dr. Foad, in his report, found that surgery was reasonable and that there was a causal relationship between Petitioner's work and the development of carpal tunnel syndrome. (PX 4, p. 16) Dr. Coe noted he also reviewed the January 16, 2009 supplemental report of Dr. Foad noting that Dr. Foad was provided a job description from Rentech Energy Midwest for the position of "A" Operator, noting that it required Petitioner to tighten valves, which was done with large tools, and that there was significant vibration from the valves. According to Dr. Coe, after Dr. Foad reviewed the additional information, he continued to note a causal relationship between the work activity

described in Respondent's job analysis and the development of Petitioner's carpal tunnel syndrome. (PX 4, pp. 17, 18) Dr. Coe also reviewed the report of Dr. Vender, Respondent's second examining doctor, from April 29, 2009, in which Dr. Vender discusses reviewing a DVD or CD video depiction of job duties. (PX 4, p. 21) Dr. Coe noted he reviewed Dr. Vender's summary of the video job depiction and discussed Dr. Vender's summary with Petitioner. (PX 4, p. 21) Dr. Coe diagnosed bilateral carpal tunnel syndrome (PX 4, p. 25) which he causally related to Petitioner's work activities. (PX 4, p. 26) Dr. Coe relied on the medical records and reports he reviewed as a basis of his opinion. (PX 4, 17) The carpal tunnel surgery was reasonable and carpal tunnel syndrome caused some permanent partial impairment in the hands. (PX 4, pp. 27, 28) Dr. Coe acknowledged that Petitioner told him he would turn valves a few times per day and said there was some repetition and the system had considerable vibration when the system was energized. (PX 4, p. 31)

On January 4, 2013, Dr. Michael Vender was deposed. (RX 3) Dr. Vender noted for determining whether a work activity was a contributing factor to carpal tunnel, he was focusing on forceful activities on a regular persistent basis throughout the work day, something that would cause fatigue if performed on a persistent basis. (RX 3, p. 8) From the history noted, Dr. Vender concluded this was a non-exertional job and was not certain whether he would use the term "supervisory" or "observational", but it did not sound like it was a manual labor type of job. (RX 3, pp. 9, 10) Dr. Vender noted he reviewed written job information and a CD labeled "Rentech Video." He summarized the video as revealing a gentleman walking in the office with a clipboard looking at screens, monitors and various meters. He would walk outdoors, visually inspecting and write on a clipboard. He further noted fingertip activities, rather than gripping or grasping. At times a valve would be turned and would utilize the whole hand for grasping and

turning. At one point, a worker utilized a hose to wash down an area. (RX 3, pp. 12, 13) Dr. Vender noted that the activity shown on the video was not a causative factor for the carpal tunnel syndrome, lacking forceful and persistent use. (RX 3, pp. 14, 15) Dr. Vender noted that valve turning did not appear forceful in this case, from what he observed. On cross examination, Dr. Vender acknowledged the job description he relied upon was the March 31, 2009 letter written by Larry G. Flogel. (RX 3, p. 18) Dr. Vender asked Petitioner very little about his job duties. Dr. Vender admitted it was not an in depth conversation, as he knew that more job information was coming from Mr. Rusin, Respondent's attorney. (RX 3, pp. 23, 24) Dr. Vender agreed on cross-examination, when presented with deposition exhibit number 6, Respondent's job description (PX 7), that he had never seen the document before. (RX 3, p. 29) Dr. Vender agreed that his conclusions were based upon the accuracy of the job video accurately depicting Petitioner's job. (RX 3, p. 32)

With respect to Deposition Exhibit #6 (PX 7), Respondent's job description, Dr. Vender agreed the job video did not depict the worker lifting 21 – 50 pounds, or carrying 51 – 100 pounds, turning valves with two hands or using a cheater bar to open and close valves. (RX 3, pp. 35 – 36) Dr. Vender had no knowledge of what a cheater bar is. (RX 3, p. 36) Dr. Vender agreed the job video did not depict "job duties during those outages where heavier maintenance type of work is required", as listed in Respondent's job description. (RX 3, p. 38) According to Dr. Vender, he would not want to see these activities, as they are not part of the regular job. (RX 3, p. 39) Dr. Vender agreed he had no information about any vibrational forces Petitioner was exposed to. (RX 3, p. 43) He did agree that vibration is a modifier as being a potential risk factor to be considered when rendering an opinion on causation. Dr. Vender agreed that Mr.

Flogel's description of the job was how he performed it, not a description of what he saw Petitioner do. (RX 3, p. 48)

Respondent retained Mr. James Jegeriehner, a certified professional ergonomist, to review certain job duties and render an opinion. Mr. Jegeriehner provided his deposition testimony on March 6, 2013. (RX 4) He testified he job shadowed Rod Henry, an employee, in January, 2012, which lasted approximately 27 minutes. His observations included checking pressure and temperature gauges, opening and closing three different valves and going outside to elevator platforms, performing pretty much the same activities, checking motors and feeling them for hot spots, looking at gauges and recording information on the checklist on a clipboard. (RX 4, pp. 14, 15) He noted he reviewed a job video, which was similar to his tour. Following his observations, he determined that the job duties were a low risk factor for carpal tunnel syndrome.

Regarding vibration, he was not aware of any on this job. (RX 4, p. 33) He notes that vibration affects blood circulation in the capillaries. In the course of his analysis, he did not receive any information regarding any injuries reported from those performing the job (RX 4, p. 35), nor was he provided with any of the examining doctors' reports, which he agreed would be helpful in doing an ergonomic study. He agreed his opinion is limited to the information he obtained, Mr. Flogel's letter and the job video. (RX 5, 1) He agreed he did not consider the work duties that "A" Urea Operator performs during shut-down activities. His opinion does not cover risk factors while operators are performing shut-down or maintenance activities. (RX 4, p. 37) During his tour, he did not see any workers use cheater bars, but he noticed a whole wall that had a number of valves on it with cheater bars. He explained that the cheater bar gives a better mechanical advantage to open and close valves and is used when the operator needs

greater force. (RX 4, p. 37) He did not measure the turning force of any of the valves and agreed he did not see any employees use tools. He has no idea what maintenance type of work is performed by operators. He is not aware whether maintenance or shut-down work is in the job description. (RX 4, p. 41) He agreed his analysis is not a complete ergonomic analysis of the Operator's job without knowing the activities of the operators during shut-down activities. (RX 4, pp. 43, 44)

At trial, Ms. Tina Kass, Human Resources Coordinator for Respondent since October, 2007, was subpoenaed by Petitioner to testify. She testified that she was responsible for FMLA, medical issues, leave of absence issues and work injuries as part of her job duties. She agreed that a Form 45 was completed for Petitioner's workers' compensation claim, but did not know who completed it for Respondent. She testified that she opened her file for this claim in September, 2008. She confirmed that Respondent pays a portion of the group medical insurance premium for Petitioner to United Healthcare as an employee benefit. She stated that Respondent does receive statements from United Healthcare regarding benefits. She agreed the handwritten job description for Mr. Steiner was created by Respondent. (PX 7)

Petitioner reviewed Respondent's job video (RX 1) and stated it did not accurately depict the job duties of an "A" Urea Operator. He stated the work was much heavier. Regarding the March 31, 2009 statement of Safety Supervisor Larry G. Flogel, describing the "A" Urea Operator's job duties (RX 5), Petitioner also stated that the description was not accurate. Neither the job video or Mr. Flogel's statement did not address the Operator's duties monitoring the compressors and pumps in the "99" system and acid plant, where Petitioner would also open and close valves. In addition to opening and closing valves by hand, Petitioner would use a number of hand tools, including 12 inch, 18 inch and 36 inch cheater bars, which he would place inside

of the steering wheel type valves to help provide greater force to turn tight valves. He also used one and one-quarter inch to five inch channel locks, six inch pipe wrenches, valve wrenches, other pipe wrenches, impact wrenches, hand torches and commercial drills. He testified that there was no typical day in the plant due to pump and compressor failures, power outages, scheduled and unscheduled maintenance projects and scheduled turnarounds. The plant was intended to run 24 hours per day, seven days per week. During "turnarounds", the entire plant was shut down on a scheduled basis approximately every two years for significant maintenance, repair and cleaning of the system. He described disassembling large vessels, which required him to remove 48 studs per each vessel with an impact wrench, which he would notice vibration in his hands while using. Additionally, he described rodding out approximately 100 tubes, which were disassembled from the system and then cleared with a commercial drill. Vibration was also noted. No days off were allowed until the plant was running. He often adjusted compressors, which required opening and closing 23 or more wheel type valves with his hands. Additionally, pumps taken on or off line would require another 10 valves to be turned by hand. Cheater bars were used to turn stiffer valves by applying force with both hands and he used a torch to open valves that locked up. While turning valves adjacent to the compressor, he would notice vibration in his hands.

He was scheduled to work 12 hour shifts for a regular schedule of 84 hours, alternating day and night, for a two week period and worked an additional 400 hours of overtime per year. There are only four operators, including himself, performing these job duties, and at times they would be called in during outages and emergencies and would also cover for each other during vacations.

In 2007, he played racketball, but did not hold the racket in his left hand, and golfed approximately twice per week during the season. He did not complete an accident report for his employer.

Larry G. Flogel, Safety Supervisor, testified for Respondent. He began his employment in 1995 as a Load Manager, then worked as an "A" Urea Operator for two and one-half years. He next became a Supervisor, then a Safety Officer, and finally a Safety and Security Manager. He testified he had reviewed the job video and it was never intended to depict all of the job duties of the "A" Urea Operator. In his opinion, it did depict the basic day to day activities. He testified that the basic activities would involve approximately 30 – 60 minute rounds or tours through the plant every two hours. He stated that the maintenance employees left at 3:30 p.m. on weekdays and thereafter, the Operators would need to assist with and perform more maintenance projects, which were not depicted on the job video. He stated that the job duties of the Operator are very unpredictable. They include online training and watching videos, as well as interacting with other workers with control room monitoring of the system. He stated that the percentage of time to grip and turn valves and use of hand tools and impact wrenches was very difficult to estimate, but was small. In an uneventful day, an Operator would turn a minimum of 15 – 20 valves by hand, and 30 – 40 valves on an average day. He stated that the workers' were exposed to vibration from the compressor pockets and the vibration could be felt in the handle while the Operator adjusted the compressor. He stated the adjustment rate of the compressor was 20 rounds at a time, possibly more and possibly less. He testified that the Operator is not constantly working with his hands, but agreed that the Operator would use channel locks and had them with him at all times, a gas torch with a gas bottle, cheater bars, pipe wrenches, impact wrenches, four inch side grinders, "comealongs", a chain operated boring tool, slugging wrenches or a pipe

wrench attached to a stuck valve and hit with a hammer. During significant outages, the operator may turn 75 – 100 valves over the course of a few hours to a few days to drain all the vessels. He agreed that typically the Operator would grip a valve with both hands and turn while applying force. He agreed that during pipe ruptures, valve blowouts and compressor and pump failures and outages, the Operators would have to work at a faster pace. Regarding the March 31, 2009 one page job summary (RX 5), Mr. Flogel agreed his statement was intended to detail the normal day to day requirements and did not take into consideration any plant upsets or actions taken to prepare equipment for maintenance. He further agreed the frequency of shutting down or starting the system is very difficult to predict.

On redirect examination of Mr. Flogel, he agreed the job video could have been filmed on a day when heavier work was being performed. Petitioner's attorney raised a standing objection to leading questions asked by Respondent's attorney.

Mr. John Williams, Operations Manager, testified for Respondent. He has been employed by Respondent for 33 years and is familiar with the "A" Urea Operator job duties while working side by side with Operators, but never holding the position. He created an internal memo dated June 7, 2013 from data regarding "major equipment outages" defined as compressor reactor, or plant outages, providing a brief description of each event, along with the duration of the outage on any given day. (RX 2) He acknowledged that routine maintenance type events are not tracked on a daily reporting basis. Based on the data he collected from January 1, 2005 through September 30, 2008, "A" Urea Operators would be involved in 30 – 35% of the work events described. Mr. Williams agreed that his memo did not specifically list the job duties Petitioner performed or any percentage of events he worked on during his shift. He testified that the Operator's work activities typically did not exceed six to eight hours per day during an outage.

He reviewed the job video (RX 1) and believed it depicted 90 to 91% of Petitioner's typical job duties. On a typical day, he believed an Operator would turn 25 to 35 valves by hand and acknowledged that some valves were stiff to operate and would require the use of a cheater bar. During an outage, an Operator may need to turn 150 valves and he was aware that Operators would use pipe wrenches, sledge hammers and other hand tools. He agreed the job is hand intensive and manual labor in nature. He agreed the job video could have been filmed on a day heavier work was being performed.

Petitioner introduced medical bills, per Exhibit #1 (PX 1) and also the records of Petitioner's group medical insurance carrier, United Healthcare (PX 5) and a penalty petition (PX 6).

Conclusions of Law:

In support of the Arbitrator's decision relating to (D) Date of Accident and (E) Notice, the Arbitrator makes the following findings of fact and conclusions of law:

The Arbitrator finds that Petitioner failed to meet the notice requirements of the Act pursuant to Section 6(c) of the Act. Petitioner filed his application on August 26, 2008. His application initially alleged an accident date of July 1, 2007, but Petitioner amended the accident date at trial to May 7, 2007.

Petitioner failed to offer any testimony or other evidence that he provided notice within 45 days of the accident date. Based on the evidence presented, the first notice Respondent received that Petitioner had an accident at work was its receipt of the filed application at some point after August 26, 2008, which is well beyond the 45 days required by statute.

Giving of notice is jurisdictional in nature and the failure of an employee to give notice will bar the claim. Ristow v. Industrial Commission, 39 Ill.2d 410 (1968). An employee who suffers a repetitive-trauma injury still may apply for benefits under the Act, but must meet the same

standard of proof as an employee who suffers a sudden injury. Durand v. Industrial Commission, 224 Ill.2d 53, 64 (2006). That means, *inter alia,* an employee suffering from a repetitive-trauma injury must still point to a date within the limitations period on which both the injury and its causal link to the employee's work became plainly apparent to a reasonable person. Setting this so-called "manifestation date" is a fact determination. Id. at 65.

The phrase "manifests itself" signifies "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." White v. Illinois Workers' Compensation Commission, 374 Ill.App.3d 907, 910 (4th Dist., 2007). Regarding notice, the statutory element of undue prejudice to the employer is pertinent only where some notice is given in the first place. See Fenix–Scisson Construction Co. v. Industrial Commission, 27 Ill.2d 354 (1963). The purpose of the notice requirement is to enable the employer to investigate the employee's alleged industrial accident. Seiber v. Industrial Commission, 82 Ill.2d 87 (1980). Finally, an employer's mere knowledge of "some type of injury" does not establish statutory notice. White, 374 Ill.App.3d at 911.

Between May 2007 and the filing of his application in September 2008, Petitioner admitted that he did not tell anyone at Rentech about his diagnosis or alleged injury. Petitioner, however, testified that he thought his work duties were causative for his symptoms. Regardless of which manifestation date is used, the originally alleged accident date of July 1, 2007, or the amended accident date of May 7, 2007, what is clear is that Petitioner did not provide notice to his employer at Rentech within 45-days of either of those dates.

Therefore, the Arbitrator finds that Petitioner failed to provide notice within 45-days of his amended accident date of May 7, 2007. Based on the foregoing the Arbitrator finds Petitioner failed to meet the jurisdictional requirement of notice pursuant to Section 6(c) of the Act, and hereby denies compensation based on same.

The Arbitrator also notes that undue prejudice does not apply here as Petitioner failed to provide any notice of an alleged work accident until he filed his application for adjustment of claim. Even if the undue prejudice exception were to apply, the Arbitrator finds Respondent was unduly prejudiced by not receiving any indication Petitioner alleged a work injury until well past 45 days after the alleged accident or manifestation date.

In support of the Arbitrators decision relating to (C) "Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?; (F) " Is Petitioner's current condition of ill-being causally related to the injury?", The Arbitrator makes the following findings of fact and conclusions of law:

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Regarding causation, the Arbitrator finds Petitioner has established that his bilateral carpal tunnel syndrome is causally related to his work duties of May 7, 2007. The Arbitrator finds Respondent's job video (RX 1) to be a less than accurate depiction of Petitioner's regular job duties. Petitioner and Respondent's witnesses confirmed the exposure to vibration and use of cheater bars and several other hand tools. Respondent's job description (PX 7) states Petitioner is required to turn valves on a regular basis using hand tools and during occasional outages, heavier maintenance type work is required. The Arbitrator finds the causation opinions of Drs. Field and Coe to be more persuasive than the opinion of Dr. Vender. The Arbitrator notes Dr. Vender presumed the job was sedentary in nature and was more of a supervisory or observational type job, which is not consistent with the preponderance of the evidence.

In support of the Arbitrator's findings relating to **(J) "Were the medical services that were provided to Petitioner reasonable and necessary?": (K) "What temporary benefits are**

in dispute?"; (M) " Should penalties or fees be imposed upon Respondent?", the Arbitrator finds the following facts:

Based upon the Arbitrator's findings of failure to give timely notice, the above findings are rendered moot.

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Carlos A. Pivaral,

Petitioner,

vs.

NO: 12 WC 41424
14 IWCC 754

Chemi Flex,

Respondent.

ORDER OF RECALL UNDER SECTION 19(f)

Pursuant to Section 19(f) of the Act, the Commission finds that a clerical error exists in its Decision and Opinion on Review dated September 4, 2014, in the above captioned.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision and Opinion on Review dated September 4, 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 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
TJT:yl
51

Thomas J. Tyrrell

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

CARLOS A. PIVARAL,

Petitioner,

vs.

NO: 12 WC 41424
14 IWCC 754

CHEMI FLEX,

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 causal connection, medical expenses, prospective medical care and temporary total disability benefits, and being advised of the facts and law, modifies the Decision of the Arbitrator as stated below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

The Arbitrator awarded Petitioner, in pertinent part, all outstanding medical expenses and "further medical treatment." We modify the Arbitrator's decision by denying medical treatment and related expenses for the lumbar spine after September 14, 2012.

Petitioner suffered a work related accident on August 6, 2012, during which he injured his cervical and lumbar spine. Petitioner sought treatment at Concentra Medical Center the following day. After attending several physical therapy sessions, Petitioner followed up with Dr. Boarsma at Concentra on September 14, 2012. During that examination, Petitioner reported that his lumbar spine pain had resolved. Petitioner's medical treatment largely focused on his cervical spine and related complaints following that visit.

A month passed before Petitioner sought additional medical treatment for his lumbar spine with Dr. Salehi. During his treatment with Dr. Salehi, Petitioner's lumbar spine complaints varied. More importantly, Dr. Salehi diagnosed Petitioner with degenerative disc disease, which was not caused by Petitioner's work accident.

While Petitioner later sought treatment with other medical providers where he complained of intense low back pain that radiated into his legs, we find that treatment was not reasonable and necessary as related to his work injury. Therefore, we do not award Petitioner's medical expenses as related to his lumbar spine after September 14, 2012, when he reported that his lumbar spine pain had resolved quickly.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Arbitrator's decision is modified as stated herein.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $253.33 per week for a period of 26-5/7 weeks, that being the period of temporary total incapacity for work under §8(b) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner outstanding medical expenses per the medical fee schedule, excluding those to the lumbar spine after September 14, 2012, 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 $66,800.00. 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: SEP 11 2014
TJT: kg
O: 7/8/14
51

Thomas J. Tyrrell

Michael J. Brennan

Kevin W. Lamborn

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

PIVARAL, CARLOS A
Employee/Petitioner

Case# **12WC041424**

CHEMI FLEX
Employer/Respondent

14IWCC0754

On 9/25/2013, 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 0.05% 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:

1042 LAW OFFICE OF OSVALDO RODRIGUEZ PC
1010 LAKE ST
SUITE 424
OAK PARK, IL 60301

1739 STONE & JOHNSON CHARTERED
PATRICK J DUFFY
200 E RANDOLPH ST 24TH FL
CHICAGO, IL 60601

STATE OF ILLINOIS)
)SS.
COUNTY OF DUPAGE)

14IWCC0754

☐ 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)

Carlos A. Pivaral
Employee/Petitioner

v.

Chemi Flex
Employer/Respondent

Case # 12 WC 41424

Consolidated cases: _____

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Kurt Carlson**, Arbitrator of the Commission, in the city of **Wheaton**, on **08-21-13**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

14IWCC0754

FINDINGS

On the date of accident, **08-06-12**, 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 $**19,760.00**; the average weekly wage was $380.00

On the date of accident, Petitioner was **39** years of age, ***single*** with **1** dependent children.

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

Respondent shall be given a credit of $ **5,664.72** for TTD, $**0** for TPD, $**0** for maintenance, and $**0** for other benefits, for a total credit of $ **5,664.72**.

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 $253.33/week for 26 5/7 weeks, commencing 02-15-13 through 08-21-13 as provided in Section 8(a) of the Act.

Respondent shall pay reasonable and necessary medical services of $ 67,133.24, as provided in Section 8(a) of the Act.

The Arbitrator finds that the respondent shall approve further medical treatment.

No penalties are awarded in this matter.

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

09-23-13
Date

ICArbDec19(b)

SEP 25 2013

Carlos Pivaral v. Chemi Flex

14IWCC0754

FINDINGS OF FACT

The Petitioner, Carlos Pivaral, is a 40 year old laborer who worked for Chemi Flex. The parties have stipulated that the incident occurred on August 6, 2012. On that date, while at work, the Petitioner slipped on a plastic sheet and fell backwards landing onto his buttocks in a sitting position (PX 2, p. 23 & PX 3, p. 12). At Arbitration, the Petitioner testified that he had worked for Chemi Flex for approximately two years mixing ingredients to make bands. He testified that he was doing his job without any type of work restrictions.

On August 7, 2012, the Petitioner was seen at Concentra Medical Center and complained of sacral and coccyx pain and stated that he fell backwards and landed on his sacral/coccyx area. The Petitioner was diagnosed with a sacrum strain and coccyx sprain (PX 1, p. 51). The Petitioner was referred to physical therapy, three times per week for two to three weeks, and was given modified activity restrictions of no bending, squatting or kneeling (PX 1, p. 52).

On the August 8, 2012 follow up visit with Concentra Medical Center, the Petitioner complained of pain with very little improvement, "bad" headaches and neck pain. The Petitioner presented in mild distress secondary to pain. The Petitioner was diagnosed with a cervical strain (PX 1, pp. 46-47).

On the August 15, 2012 follow up visit with Concentra Medical Center, the Petitioner stated that he experienced pain when he lies down and pain in both sides of his neck with symptoms exacerbated by movement flexion and extension. The Petitioner was diagnosed with a back and lumbosacral strain. The Petitioner was ordered to continue

therapy and was given modified activity restrictions of no lifting over 20 pounds and no pushing/pulling over 20 pounds of force (PX 1, pp.35-36).

On the September 7, 2012 follow up visit, the Petitioner stated that his back pain had resolved but the neck pain was still present. The Petitioner stated that he had a cervical fusion in the past, which had not given him any problems until the fall at work on August 7, 2012. An MRI of the cervical spine was ordered. The Petitioner stated that he had attended therapy without any improvement. The Petitioner was diagnosed with cervicalgia and a sprain/strain of the neck (PX 1, pp. 28-29).

On the September 14, 2012 follow up visit, the Petitioner complained of neck pain without any feeling of improvement. The Petitioner stated that his pain was located on the lower and middle neck and that his symptoms were exacerbated by lying down. The Petitioner was again diagnosed with cervicalgia, cervical strain and sprain/strain of the neck. The Petitioner was to continue with physical therapy and was referred to a neurosurgeon (PX 1, pp.16-17).

On October 15, 2012, the Petitioner had an initial evaluation at Advanced Medical Specialists by Dr. Sean A. Salehi. The Petitioner complained of back and neck pain. The Petitioner stated that he experienced aches in his bilateral forearms and bilateral legs and that his legs felt tired. Also, the Petitioner stated that he experienced tingling in his bilateral feet. Dr. Salehi noted that the Petitioner had a motor vehicle accident in 2003 that resulted in a cervical fusion. Dr. Salehi reviewed the MRI, which indicated a prior cervical fusion at C4-5 and C5-6 without instrumentation and the position of the bone graft at C4-5 was out of the interbody space resulting in moderate to significant bilateral foraminal stenosis

(PX 3, p. 12). Dr. Salehi ordered a CT of the cervical spine to assess his prior fusion and an MRI of the lumbar spine to assess his low back and bilateral radicular complaints. Dr. Salehi opined that the Petitioner should hold off on physical therapy for the time being. The Petitioner was given light duty restrictions of no lifting greater than 20 pounds, no pushing or pulling greater than thirty five pounds, no repetitive bending and twisting, no overhead work, and to alternate sitting and standing every thirty-five to forty-five minutes (PX 2, p. 24).

On the October 19, 2012 follow up visit with Dr. Salehi, the Petitioner complained of pain in his lower back and (mostly) in his neck. The Petitioner stated that the pain became worse since he stopped physical therapy. The Petitioner stated that he was experiencing pain in his bilateral arms and tingling in his right hand. The Petitioner stated that the pain in his lower back radiated to both lower extremities. Dr. Salehi noted that the imaging he had ordered in the previous visit had not been performed since it had not been approved. The Petitioner was diagnosed with a cervical spondylosis status post anterior cervical discectomy and fusion. In the meantime, the Petitioner was to refrain from physical therapy, continue light duty work and take medications for pain control (PX 2, p.18).

On the November 2, 2012 follow up visit with Dr. Salehi, the Petitioner presented with the CT and MRI imaging. The Petitioner complained of severe pain in his neck radiating to his bilateral arms, and lower back pain radiating to his bilateral legs. The Petitioner also complained of headaches radiating to his neck region associated with nausea, vomiting and dizziness. The Petitioner stated that sitting and standing for prolonged periods of time worsened his pain and that he experienced whole body weakness.

The Petitioner also stated that he experienced pain more significantly in his right arm than his left, as well as numbness and tingling in his right hand (PX 2, p.14). Dr. Salehi reviewed the CT of the cervical spine, which revealed pseudoarthrosis and interbody cage displaced, and the MRI of the lumbar spine, which revealed a single-level disk disease at L4-5 manifested by slight T2 signal loss without significant height loss, left foraminal disk bulge at L4-5 causing mild foraminal stenosis. Dr. Salehi diagnosed the Petitioner with cervical spondylosis and lumbar disk degeneration. Dr. Salehi opined that the Petitioner should undergo a posterior cervical fusion at C4-6. The Petitioner agreed to the surgery recommendation. Dr. Salehi opined that the Petitioner should continue working light duty until the surgery was performed (PX 2, p.15).

On the November 30, 2012 follow-up visit, the Petitioner presented with worsening pain in neck and both arms, lower back pain down his legs, headaches, nausea and dizziness. The Petitioner stated that he becomes very tired at work and was currently awaiting surgery approval (PX 2, p.11).

On December 20, 2012, the Petitioner presented for an Independent Medical Examination with Dr. Avi J. Bernstein. Dr. Bernstein opined that the Petitioner's objective findings did not support his subjective complaints. Dr. Bernstein opined that the Petitioner suffered, at most, contusions and strains as a result of the work injury and that the Petitioner should be at maximum medical improvement. Dr. Bernstein opined that the chronic pseudoarthrosis had not been caused or aggravated as a result of the work related incident and that the Petitioner's flagrant diffuse symptoms cannot be related anatomically to the cervical spine (IME report).

On the January 11, 2013 follow up visit with Dr. Salehi, the Petitioner complained of pain down both arms and pain in lower back down both legs with tingling and that he also experienced tingling in his right hand and felt weakness in both arms and legs. Dr. Salehi noted that the Petitioner attended an IME by Dr. Bernstein. Dr. Salehi stated that he continued to recommend the posterior fusion C4-C6, and disagreed with the IME doctor's opinion, as the Petitioner was asymptomatic up until the August 6, 2012 work injury. Dr. Salehi opined that the Petitioner should work at a sedentary capacity (PX 2, pp. 6, 8).

On the February 8, 2013 follow up visit with Dr. Salehi, the Petitioner stated that he experienced pain in his neck and arms with numbness in his bilateral hands and severe pain in his lower back radiating down both legs. The Petitioner complained that the pain in his lower extremities and thighs felt like muscle aches and that he experienced weakness in his arms and legs. Dr. Salehi stated that if approval for surgery was not granted, he would send the Petitioner to an FCE to determine permanent work restrictions. The Petitioner was to continue taking medications for pain and his work restrictions remained at sedentary capacity (PX 2, p. 2).

On the February 20, 2013 follow up visit, Dr. Salehi noted that surgery had not been approved. The Petitioner complained of constant pain in his neck, lower back and increasing pain in his legs. Dr. Salehi noted that the Petitioner was experiencing muscle weakness and sciatica. The Petitioner stated that he was laid off work a week prior to this appointment and was not currently working (PX 3, p.15). The Petitioner was diagnosed with lumbar degenerative disk disease and Dr. Salehi continued to recommend surgery, a cervical fusion. The Petitioner was ordered to continue taking medication for pain and continue with sedentary work restrictions (PX 3, p. 17).

On March 5, 2013, the Petitioner sought emergency treatment due to pain at the Emergency Room at Elmhurst Memorial Hospital. The Petitioner presented with chronic pain down his neck and back (PX 5, p.1, 4). The Petitioner stated that he was taking medications but was not getting any relief (PX 5, p. 18). The Petitioner was diagnosed with acute chronic neck/back pain (PX 5, p. 23).

On the March 11, 2013 follow up visit with Dr. Salehi, the Petitioner complained of neck pain radiating down both arms and lower back pain radiating down both legs. The Petitioner stated that his arms fall asleep and he has weakness in his legs (PX 3, p.9).

On March 23, 2013, the Petitioner underwent a pseudoarthrosis at C4-5 and C5-6, lateral mass screw placement from C4 to C6, use of Osteocel allograft, use of intra operative fluoroscopy at the Center for Minimally Invasive Surgery (PX 6, p. 11).

On the March 27, 2013, post surgery follow up, the Petitioner reported nausea and vomiting, along with headaches in the back of the head, dizziness, fever and itching all over the body. However, the Petitioner stated that he no longer was having preoperative arm symptoms (PX 3, p.7). Dr. Salehi opined that symptoms were related to pain medication and should be discontinued. The Petitioner was to continue wearing the cervical collar and was given a spinal cord stimulator and instructed on its use (PX 3, p.8).

On the July 2, 2013 follow up, the Petitioner stated that his pain was significantly reduced. However, the Petitioner had complaints of some discomfort on the left side of his neck on to the left shoulder during physical therapy. The Petitioner also stated that he was experiencing tingling in his left forearm. The Petitioner stated that he was taking Tramadol & Xanax and was experiencing panic attacks when driving. The Petitioner stated that he

was experiencing lower back pain with some radiation to his legs (PX 3, p.4). The Petitioner was ordered to undergo physical therapy for C5 symptoms which were likely of muscular origin. The Petitioner was given medication for spasms and pain and could return to work with sedentary restrictions (PX 3, p.6). At Arbitration, the Petitioner testified that his pain symptoms improved approximately fifty percent.

On the July 30, 2013 follow up visit, the Petitioner stated that he was experiencing more pain in the sides of his neck with head turning. The Petitioner stated that he was attending physical therapy and Dr. Salehi opined that he should continue with additional three weeks for cervical conditioning. The Petitioner stated that the pain in his lower back sometimes radiated to his legs but described it as internal pain (PX 3, p. 1). The Petitioner was to follow up in a month and was given light duty restrictions. Dr. Salehi stated that in one month's time he would make further recommendations for the lumbar spine once he reviewed the Petitioner's imaging but the Petitioner would more likely begin a work conditioning program if there was no surgical intervention necessary for the lumbar spine (PX 3, p. 3).

CONCLUSIONS OF LAW

The Arbitrator adopts the above findings of material facts in support of the following conclusions of law.

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

The Petitioner testified credibly to the accident of August 6, 2012. This testimony was uncontroverted and un-rebutted. Further, the medical records corroborate his

testimony. There were no conflicting medical records, reports or testimony entered into evidence.

The Arbitrator finds as a matter of material fact and as a matter of law that the Petitioner has proven by a preponderance of the evidence that the Petitioner sustained an accident in the course and scope of his employment on August 6, 2012.

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

The Petitioner testified credibly that he sustained injuries to his back and neck on August 6, 2012. The Arbitrator finds that the accident of August 6, 2012, either caused or aggravated the Petitioner's pseudoarthrosis and interbody cage displacement, which necessitated the posterior cervical fusion at C4-C6. The medical evidence submitted into evidence document that the Petitioner had a pre-existing cervical fusion. The Petitioner also testified to this pre-existing condition. The medical records also document the Petitioner' s symptoms after the fall. The Arbitrator finds that the Petitioner was asymptomatic before the fall and had documented objective and subjective symptoms after the fall. The Arbitartor finds that the fall either caused or aggravated his condition of ill-being.

Even if the injury arose from Petitioner's pre-existing condition, the Act will not relieve Respondent from liability. The case law is well-settled that a work injury is compensable 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, 6 Ill 2d 296, 128 N.E. 2d 718 (1955). Further, a work injury is compensable within the meaning of the Act when it is traceable to a definite time, place,

and cause and occurs in the course of the Petitioner's employment. Mathiessen & Hageler Zinc Co. v. Industrial Board, 284 Ill 378, 120 N.E. 249 (1918). An employer is not relieved of liability under the Illinois Workers' Compensation Act because the injury arose from a preexisting condition. A.C. & S. v. Industrial Comm'n, 304 Ill.App.3d 875, 882, 710 N.E.2d 837, 842 (2000). The Respondent takes its employees as it finds them. General Refractories v. Industrial Comm'n, 255 Ill.App.3d 925, 930, 627 N.E.2d 1270, 1274 (1994). The Petitioner needs only show that some act of employment was a causative factor, not the sole or principal cause, of the resulting injury.

The Petitioner need only show that some act of employment was a causative factor, not the sole or principal cause, of the resulting injury. Teska v. Industrial Comm'n, 266 Ill.App.3d 740, 742, 640 N.E.2d 13 (1994). The claimant must show, *inter alia*, that some aspect of his employment was *a causal factor* that resulted in the complained of injury. Teska at 742. The fact that the employee had a preexisting condition, even though the same result may not have occurred had the employee been in normal health, does not preclude a finding that the employment was a causative factor. County of Cook v. Industrial Comm'n, 69 Ill.2d 10, 17, 370 N.E.2d 520, 523 (1977). Proof of the state of health of an employee prior to and down to the time of the injury, and the change immediately following the injury and continuing thereafter, is competent as tending to establish that the impaired condition was due to the injury. Kress Corp. V. Industrial Commission, 190 III. App. 3d 72, 82 (1989) p. 14. The Arbitrator finds that the workplace injury was a causative factor of Petitioner's current condition of ill-being. Based on the record, the Arbitrator, therefore, finds that the Petitioner established that his present condition of ill-being with regard to his Cervical neck and low back is causally related to his accident of August 6, 2012.

In order to obtain compensation under the Act, the Petitioner must show, by the preponderance of the evidence, that he suffered a disabling injury arising out of and in the course of his employment. Sisbro, Inc. v. Industrial Comm'n, 207 Ill.2d 193, 203, 797 N.E.2d 65, 278 Ill.Dec. 70 (2003). However, the Petitioner needs only show that some act of employment was a causative factor, not the sole or principal cause, of the resulting injury. Teska v. Industrial Comm'n, 266 Ill.App.3d 740, 742 640 N.E.2d 13 (1994).

The Illinois Workers' Compensation Act is a humane law of a remedial nature, and wherever construction is permissible, its language is to be liberally construed to effect the purpose of the Act. Shell Oil Co., v. Industrial Commission, 2 Ill. 2d 590, 119 N.E.2d 224 (1954), *citing* City of West Frankfort v. Industrial Commission, 406 Ill. 452, 94 N.E.2d 413 (1950) ; Lambert v. Industrial Commission, 411 Ill. 593, 104 N.E.2d 783 (1952). "Every injury sustained in the course of the employee's employment, which causes a loss to the employee, should be compensable." Id. at 596 , citing Petrazelli v. Propper, 409 Ill. 365, 99 N.E.2d 140 (1951); Lambert v. Industrial Commission, 411 Ill. 593, 104 N.E.2d 783 (1952).

The Arbitrator finds as a matter of fact and conclusion of law that the Petitioner's condition of ill-being is causally related to the work injury he sustained on August 6, 2012.

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

The Arbitrator adopts his previous findings for disputed issues (C) and (F). The Petitioner submitted into evidence, the following outstanding medical bills, at the Medical Fee Schedule:

Premier Physical Therapy	$9,272.36
Elmhurst Emergency Medical Services	$279.59
Elmhurst Radiologists	$79.00
MD2X, S.C.	$75.77
Franciscan St. James Hospital and Health Centers	$35,474.80
Concentra Medical Centers (IL)	$493.31
Neurological Surgery and Spine Surgery, S.C.	$19,061.82
Elmhurst Memorial Healthcare	$2,396.59
Total Outstanding Balance	**$67,133.24**

The Arbitrator concludes, after reviewing the medical records introduced into evidence, that the medical bills submitted by petitioner for payment are as a matter of fact and law reasonable and necessary under 8(a). Since the Arbitrator has concluded that the Petitioner did sustain a compensable accident, and that his present condition is casually related to that injury, the Respondent is hereby found to be liable for those bills. The Arbitrator, therefore, orders the Respondent to pay to the Petitioner and his attorney $67,133.24 for medical services as provided in Section 8 of the Act.

L. **What amount of compensation is due for temporary total disability?**

The Petitioner was authorized off of work or on work restrictions for the time period from February 15, 2013 to August 21, 2013.

The Arbitrator concludes, after considering the Petitioner's un-rebutted testimony and the medical records, that as a matter of law the Respondent is liable for the TTD, and,

orders the Respondent to pay the Petitioner and his attorney temporary total disability benefits of $253.33 a week for 26 5/7 weeks, as provided in Section 8(b) of the Act.

Temporary total disability is the temporary period following an accident during which the employee is totally incapacitated by reason of the injury and it is considered temporary in the sense that the disabling condition exists until the employee is as far restored as the injury's permanent character will permit. Mount Olive Coal Co. v. Industrial Commission, 295 Ill. 429, 129 N.E.103 (1920). In order to recover temporary total disability benefits, a claimant must prove by a preponderance of the evidence that the injuries arose out of and in the course of his employment and that the claimant had a resultant incapacity to work. Pemble v. Industrial Comm's, 181 App.3d 409, 536 N.E.2d 1349 (1989). Under Illinois law, the inability to work is found where the employee cannot work without endangering his health. Swindle v. Industrial Comm's, 126 Ill.3d 793,467 N.E.2d 1074 (1984). The dispositive test is whether the claimant's condition has stabilized, that is, whether the claimant has reached maximum medical improvement. Freeman United Coal v. Industrial Commission, 318 App.3d 170, 741 N.E.2d 144 (2000). Section (b) of the Act states that weekly compensation shall be paid as long as the total temporary incapacity lasts.

K. Is Petitioner entitled to any prospective medical care?

Based on the above discussion and pursuant to Plantation Manufacturing Co. v. Industrial Commission, 294 Ill.App.3d 705, 691 N.E.2d 13 (2d Dist. 1997), the Respondent is ordered to provide written approval of the medical treatment requested by Dr. Salehi.

M. Should penalties or fees be imposed upon Respondent?

No penalties are awarded in this matter. Respondent reasonably relied on the medical opinion of Dr. Avi Bernstein, a board certified orthpaedic surgeon.

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

Lawrence Cosek,

Petitioner,

vs. NO. 10WC 20439

Medspeed & Clearpoint,

14IWCC0755

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19b having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of medical expenses, penalties and fees, continuing disability, 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. 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.

14IWCC0755

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:
SJM/sj SEP - 8 2014
7/10/2014
44

Stephen J. Mathis

Mario Basurto

David L. Gore

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

14IWCC0755

COSEK, LAWRENCE
Employee/Petitioner

Case# **10WC020439**

MEDSPEED & CLEARPOINT
Employer/Respondent

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:

2255 LUCAS & APOSTOLOPOULOS LTD
MAXINE R GRIEF-BLESS
881 W LAKE ST
ADDISON, IL 60101

2337 INMAN & FITZGIBBONS LTD
SCOTT McCAIN
33 N DEARBORN ST SUITE 1825
CHICAGO, IL 60602

14IWCC0755

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)

LAWRENCE COSEK
Employee/Petitioner

v.

MEDSPEED & CLEARPOINT
Employer/Respondent

Case # 10 WC 20439

Consolidated cases: N/A

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **BRIAN CRONIN**, Arbitrator of the Commission, in the city of **CHICAGO**, on **JULY 10, 2013**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On the date of accident, **12/26/07**, Respondent *was* operating under and subject to the provisions of the Act.

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

On this date, Petitioner *did* 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 $**31,200.00**; the average weekly wage was $**496.84**.

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

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

Respondent shall be given a credit of $**31,893.56** for TTD, $**0.00** for TPD, $**0.00** for maintenance, and $**28,561.63** for other benefits, for a total credit of $**60,455.19**.

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

ORDER

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.

Signature of Arbitrator

December 15, 2013
Date

ICArbDec19(b)

DEC 16 2013

14IWCC0755

STATE OF ILLINOIS)
) SS
COUNTY OF COOK)

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

LAWRENCE COSEK,	)	
	)	
Petitioner,	)	
	)	No. 10 WC 20439
v.	)	
	)	Arbitrator Brian Cronin
MEDSPEED & CLEARPOINT	)	
	)	
Respondent.	)	

DECISION OF ARBITRATOR

STATEMENT OF FACTS

A. TESTIMONY OF PETITIONER

The petitioner was employed as an associate driver; he picked up and delivered medical samples throughout the Chicago area. (Tx. 27).

On December 26, 2007 the petitioner picked up medical samples from Holy Family Hospital and was driving northbound on Wolf Road; heading towards Northwest Community Hospital for another pick-up. (Tx. 31). He glanced to the left in preparation to switch lanes, and when looked forward again a man appeared in front of his vehicle and he struck him. (Tx. 32).

After the vehicle struck the man, the petitioner testified that he was calm enough to immediately pull the car over, get out of the car, and approach the individual to start checking for a pulse. (Tx. 32-33, 63). He testified that he was prepared to administer first aid and CPR. (Tx. 63). He did not faint. (Tx. 62). A bystander wanted to move the pedestrian but the petitioner advised against it. (Tx. 33). The petitioner advised the bystander to call 911 and police and fire personnel ultimately appeared at the scene. (Tx. 33). The petitioner did not seek medical treatment on the date of accident. (Tx. 64).

The petitioner did not seek medical attention until January 3, 2008, eight days after the accident on which date he was seen by Dr. McFadden from the Village Counseling Center. (P. Ex. 2). Initial treatment records from Dr. McFadden were not introduced into evidence. However, records from the Village Counseling Center document visits with Dr. McFadden on January 3, 2008, January 7, 2008, and January 14, 2008. (P. Ex. 2). The petitioner testified that he stopped seeing Dr. McFadden because he was feeling better. (Tx. 64). There is no evidence that Dr. McFadden authorized the petitioner off of work or restricted him from driving in any capacity. (P. Ex. 2).

Dr. McFadden referred the petitioner to Dr. Pawlowski, M.D., who saw the petitioner on January 9, 2008, February 6, 2008, and June 12, 2008. (P. Ex. 3). Dr. Pawlowski prescribed Xanax for anxiety (P. Ex. 3). Dr. Pawloswki did not authorize the petitioner off of work or restrict him from driving in any capacity. (P. Ex. 3).

After a brief period of time off of work that was granted by the respondent, the petitioner returned to his regular job. (Tx. 37). The respondent ultimately transitioned the petitioner into a position as a dispatcher. (Tx. 39). The petitioner drove to and from work as a dispatcher on a daily basis. (Tx. 68). He testified that he did not seek any medical care while working as a dispatcher. (Tx. 40-41). This position was eventually eliminated. (Tx. 28, 68).

The petitioner did not seek or receive any treatment in 2009. (Tx. 65). He testified that he drove a vehicle off an on in 2009. (Tx. 69).

The petitioner was admitted to the emergency room department of Central DuPage Hospital on June 27, 2009. He reported that he had fallen down 16 stairs. He was noted to have injured his ankle the previous night while driving a motorcycle. He was noted to have been out drinking the prior evening until one or two o'clock in the morning. The petitioner was diagnosed with syncope, chest wall contusion, chest wall abrasion, and pain and swelling of the left lateral malleolus. (R. Ex. 4).

The petitioner was seen by Dr. Ward on March 18, 2010. The doctor indicated that he needed to have psychiatric care and counseling for his anxiety and post-traumatic stress disorder issues. No work restrictions were placed on the petitioner and he was not restricted from driving. (P. Ex. 4).

On April 8, 2010 Dr. Ward indicated that the petitioner should continue counseling and that he needed to meet with a psychiatrist who could prescribe medications for him. (P. Ex. 4).

The petitioner returned to Village Counseling Center and treated with Dr. McFadden in April 2010. The petitioner reported that he continued to have anxiety. No restrictions were imposed. (P. Ex. 2).

Dr. Pawloski saw the petitioner at the Glenbrook Family Clinic on May 3, 2010. He assessed the petitioner with anxiety, insomnia, and a history of panic disorder. No restrictions were imposed. (P. Ex. 3).

The petitioner returned to Dr. Ward on May 18, 2010. He was instructed to see a psychiatrist for proper treatment of his anxiety/panic/possible post-traumatic stress disorder. No restrictions were imposed. (P. Ex. 4).

Dr. McFadden saw the petitioner twice in May 2010. He had ongoing complaints of anxiety. No restrictions were imposed. (P. Ex. 2).

On November 24, 2010, the petitioner was seen by Dr. Pawlowski. Anti-anxiety medication was prescribed. No restrictions were imposed. (P. Ex. 3).

On referral from Dr. McFadden, the petitioner was seen by Dr. Graves at the Village Counseling Center on February 16, 2011. Dr. Graves treated the petitioner on a regular basis through to the end of 2012. Dr. Graves didn't authorize the petitioner off of work until July 19, 2011. (P. Ex. 2). Dr. Graves testified by way of evidence deposition. (P. Ex. 8).

The petitioner testified that he drives recreationally. (Tx. 78). While treating with Dr. Graves, he flew to Southern California in May 2011 where he rented a car to drive. (Tx. 72). He also drove to a festival in Bartlett, Illinois in July of 2011 and drove to Iowa in September 2011. (Tx. 73). The petitioner also acknowledged driving to Florida in 2012. (Tx. 74). In addition, the petitioner indicated that he was hired as a truck driver in 2011 by D & D Expedite, and that he as an active CDL. (Tx. 67). The petitioner acknowledged that he has ridden a motorcycle since the date of accident, and that he has attended motorcycle club meetings once a week. (Tx. 71). The petitioner stated that he drives to and from the motorcycle meetings. (Tx. 71).

On March 14, 2011 the petitioner presented to Dr. Ward. The petitioner was instructed to follow-up with his psychiatrist to get treatment for his post-traumatic stress disorder. He was also instructed to stay off alcohol and stop smoking. No work restrictions were imposed. (P. Ex. 4).

Dr. Sharma, psychiatrist, saw the petitioner on April 13, 2011. She diagnosed post-traumatic stress disorder and prescribed medication. No work restrictions were imposed. (P. Ex. 5).

Dr. Edward Tuder examined the petitioner on November 23, 2011. He diagnosed the petitioner with post-traumatic stress disorder, panic disorder without agoraphobia, major depressive disorder, and alcohol dependence. He opined that the work accident did cause post-traumatic stress disorder, panic disorder, and major depression. He indicated that further treatment was necessary including individual counseling on a weekly basis and medication management, preferably by a psychiatrist. Dr. Tuder wrote that the petitioner had not reached maximum medical improvement, and that he was unable to work. (P. Ex. 9).

Dr. Tuder examined the petitioner a second time on July 12, 2012. He placed the petitioner at maximum medical improvement effective April 12, 2012 due to treatment resistance. With respect to work status, Dr. Tuder indicated that he did not believe that the petitioner could return to work full duty. (P. Ex. 9).

Dr. Tuder authored an addendum report dated August 8, 2012. He wrote that the petitioner was not compliant with his therapist's recommendations, and that he resists doing what is necessary in therapy to progress. He wrote that the petitioner's medication management was similarly inadequate to substantially improve the status, both by virtue of the dosage of medications prescribed and the choice of medications. He wrote that the medication he was using had been unchanged for a considerable period of time. He wrote that the petitioner resisted more aggressive medication management of his symptoms. For the above reasons, Dr.

Tuder placed the petitioner at maximum medical improvement, "since he essentially chooses to not pursue or be aggressively involved in any treatment which would impact the status quo." (P. Ex. 9).

With respect to work status, Dr. Tuder wrote that the petitioner's status was a consequence of noncompliance with treatment and resisting more aggressive treatment. He wrote that there was no reason why the petitioner could not be tried in some basic non-skilled job now, and noted that there was certainly every reason to anticipate that he would be capable of performing a basic non-skilled job in the future. (P. Ex. 9).

The petitioner testified that he wants to continue treatment with Dr. Sharma and Dr. Graves. (Tx. 60).

B. TESTIMONY OF DR. GRAVES

Dr. Graves, clinical psychologist, testified via evidence deposition on May 15, 2013. (P. Ex. 8). She began treating the petitioner on February 16, 2011 on referral from Dr. McFadden. (P. Ex. 8, at pp. 12-13).

When she first saw the petitioner he described "back to back terrible things that happened;" namely the accident of December 26, 2007 and losing his mother in 2008. (P. Ex. 8, pp. 16-17). The petitioner told Dr. Graves that his whole life had changed. (P. Ex. 8, p. 17). The petitioner reported to Dr. Graves that he was stressed, angry, unable to connect with people, unable to sleep, lacking confidence, depressed, anxious, and overwhelmed. (P. Ex. 8, p. 21).

Dr. Graves diagnosed post-traumatic stress disorder, panic disorder, and major depressive disorder. (P. Ex. 8, p. 18). In reaching the diagnosis of post-traumatic stress disorder, Dr. Graves noted that the most marked DSM-IV criteria for post-traumatic stress disorder were increased hypervgilance and startle response. (P. Ex. 8, pp. 27-28). She also noted that the petitioner had a feeling of a foreshortened life, nightmares about the accident, intrusive memories about the accident, some flashbacks about the accident, and a lack of interest in relating to other people. (P. Ex. 8, p. 28).

Dr. Graves testified that the post-traumatic stress disorder came from the accident of December 26, 2007. (P. Ex. 8, p. 19). She stated that ever since the accident the petitioner had been carrying guilt, even though he knows intellectually that it is not his fault. (P. Ex. 8, p. 20). She testified that the petitioner blames himself that there could have been something that he could have done differently. (P. Ex. 8, p. 20).

Dr. Graves also diagnosed panic disorder, indicating that the petitioner described a discreet episode lasting about 20 minutes that consisted of rapid heartbeat, sweating, numbness and tingling in hands and feet, and a feeling that he was going to have a heart attack. (P. Ex. 8, p. 29). She did acknowledge that panic disorder does occur with the petitioner's heart condition, Wolff-Parkinson's. (P. Ex. 8, p. 29).

Dr. Graves testified that there is nothing about the petitioner's life prior to the accident that she attributes to having caused or contributed to the problems the petitioner experienced after the accident. (P. Ex. 8, pp. 24, 58).

With respect to the depression and panic disorder, Dr. Graves testified that cognitive therapy is appropriate. (P. Ex. 8, p. 46). Dr. Graves testified that the preferred treatment plan for the petitioner going forward is EMDR (eye movement desensitization and reprocessing) for the post-traumatic stress disorder. (P. Ex. 8, p. 26). This treatment involves inducing rapid eye movements, enabling a patient to process troubling memories and making them neutral so a patient is no longer distraught. (P. Ex. 8, p. 40).

Dr. Graves testified that due to the petitioner's heart condition, Wolff-Parkinson-White, clearance from a cardiologist is required to move forward with EMDR. (P. Ex. 8, pp. 42-45). She also testified that the petitioner needed to be examined by a psychiatrist to get his medication appropriately managed before moving forward with EMDR. (P. Ex. 8, pp. 42-45).

Dr. Graves testified that the petitioner was unable to work at the current time. (P. Ex. 8, p. 47).

C. TESTIMONY OF DR. DAVID HARTMAN

Dr. Hartman, clinical and forensic psychologist and neuropsychologist, testified via evidence deposition on May 16, 2013. (R. Ex. 1).

Dr. Hartman evaluated the petitioner on March 26, 2013. (R. Ex. 1, p. 6). The petitioner described himself to Dr. Hartman as a former alcoholic and drug addict, indicating that he had experienced issues with drug abuse since he was a teenager. (R. Ex. 1, pp. 9-10). A family history of drug abuse, alcoholism, and depression was reported. (R. Ex. 1, pp. 9-10). The petitioner advised Dr. Hartman that he had been sober for 2 ½ half years. (R. Ex. 1, pp. 9-10). The petitioner reported a history of three different children by different women, and a variety of jobs which Dr. Hartman noted was suggestive of an itinerant work history. (R. Ex. 1, pp. 9-10). The petitioner indicated that he had a history of sustaining a gunshot wound. (R. Ex. 1, pp. 9-10). The petitioner indicated that he felt as if he were deteriorating and getting worse over time. (R. Ex. 1, pp. 9-10).

Dr. Hartman assessed the validity of the petitioner's symptom presentation and his motivation/effort through objective testing, noting that self-reported symptoms alone are extremely inaccurate with respect to making a diagnosis. (R. Ex. 1, pp. 12-15). Dr. Hartman testified that post-traumatic stress disorder is easy to fake. (R. Ex. 1, p. 10).

The first symptom validity test Dr. Hartman administered was a word memory test. (R. Ex. 1, p. 16). Dr. Hartman indicated that this test is so easy that even patients coming off of severe brain injuries typically do pretty well on it. (R. Ex. 1, p. 16). He indicated that the only patients who fail this test are patients who are confined to a nursing home or patients who are hallucinating. (R. Ex. 1, pp. 16-17). Dr. Hartman testified that mentally retarded children do very well on this test. (R. Ex. 1, p.17).

Dr. Hartmann testified that the petitioner did only about two thirds as well as 8-year-old mentally retarded children. (R. Ex. 1, p.17). Dr. Hartman indicated that the test results from the word memory test indicated to him that the petitioner was attempting to show him that his memory was worse than extremely young mentally disabled children; and worse than adults in their seventies confined to a nursing home due to dementia. (R. Ex. 1, p.17). Dr. Hartman opined that the test results were completely outside of any realistic presentation. (R. Ex. 1, p.17).

The second test administered to assess the validity of the petitioner's symptoms is called the computer assessment of response bias. (R. Ex. 1, p.17). The petitioner's rate of accuracy was very significantly below what he would expect in people with severe brain injuries or deteriorating neurological diseases. (R. Ex. 1, pp.17-18). Dr. Hartman testified that no patient outside of a nursing home would do this poorly. (R. Ex. 1, p.18).

A third test to check the validity of the petitioner's response patterns is the structured inventory of malingering symptomatology (SIMS). (R. Ex. 1, p.18). This is a multiple-choice test. (R. Ex. 1, p.18). This test revealed that the petitioner was attempting to endorse symptoms because they sounded serious rather than because they actually exist. (R. Ex. 1, pp.18-19).

The five areas assessed by the SIMS test included complaints related to neurologic impairment, emotional anxiety and depressive symptoms, complaints related to psychotic symptoms, and complaints related to memory. (R. Ex. 1, p.19). These were all above the cutoffs for non-credible for response admissions. (R. Ex. 1, p.19). The test as a whole was above the cutoff for being generally non-credible and generally exaggerated set of symptoms that were admitted. (R. Ex. 1, p.19). From this test, Dr. Hartman concluded that the petitioner was willing to admit to a lot of symptoms, whether or not anyone could realistically have them, if they sounded serious enough. (R. Ex. 1, p.19).

Also utilized by Dr. Hartmann was the modified somatic perception questionnaire, which looks at symptoms of muscle tension and other kinds of psychophysiological issues that could be a problem with pain. (R. Ex. 1, pp.19-20). The petitioner was well above the test cut off for unrealistic presentation. (R. Ex. 1, p.20).

Lastly, Dr. Hartman indicated that he utilized the most current version of the Minnesota Multiphasic Personality Inventory. (R. Ex. 1, p.20). Dr. Hartman testified that the validity scales on this test were so extreme as to invalidate the test for clinical interpretation. (R. Ex. 1, p.20). The petitioner admitted to a pattern of responses that were most similar to individuals who are, per research and publication, shown to be magnifying their symptoms in the context of litigation and potential secondary gain. (R. Ex. 1, p.20).

With respect to diagnosis, Dr. Hartmann testified that based upon the objective results; there was consistent evidence for a malingering approach to symptom presentation which is a voluntary and non-credible simulation of symptoms for some kind of secondary gain. (R. Ex. 1, p.26). He noted that all of the tests that looked at symptom validity were extreme and not realistic for any claim that the petitioner may have or any combination of disorders that he may have in his history. (R. Ex. 1, p.26).

Dr. Hartmann testified that the petitioner does not qualify for the diagnosis of post-traumatic stress disorder. (R. Ex. 1, p.28). He indicated that one of the more obvious reasons that the petitioner does not fit this diagnosis is that the petitioner continues to drive. (R. Ex. 1, p. 28). That is, he noted that that post-traumatic stress disorder is related to severe anxiety responses that occur to events similar to or related to or can be generalized from what you are exposed to that caused you the initial trauma. (R. Ex. 1, p.29). He noted that the petitioner was claiming driving induced posttraumatic stress disorder, but continued to drive. (R. Ex. 1, p.29). He also noted that the petitioner continued to ride a motorcycle. (R. Ex. 1, p.20). Dr. Hartman testified that both of these activities placed the petitioner in situations that are similar to and even more potentially stimulating or dangerous from a risk perspective than the actual driving behavior in the context of this case. (R. Ex. 1, pp. 29-30). He concluded that someone who can drive and ride a motorcycle doesn't fit posttraumatic stress disorder incurred while driving a vehicle. (R. Ex. 1, p.30).

Dr. Hartman testified that the second reason the petitioner did not fit the diagnosis of post-traumatic stress disorder is because the DSM-IV requires there to be some formal rule out of whether a person is malingering posttraumatic stress disorder. (R. Ex. 1, p.30). He indicated that it is known in the literature that posttraumatic stress disorder is very easy to memorize symptoms for. (R. Ex. 1, p. 30). He noted that without doing any assessment for exaggeration or malingering, you are not fulfilling what the DSM-IV requires, which is to assure yourself that there is no attempt to memorize the list or otherwise utilize the symptoms for some sort of secondary gain. (R. Ex. 1, p.30).

Dr. Hartman opined that the providers in this case did not utilize any objective pathology to look at whether the petitioner had a credible response pattern, and therefore were not looking at the requirements of the DSM-IV, which do not fit someone being able to drive and ride a motorcycle while claiming vehicular induced posttraumatic stress disorder. (R. Ex. 1, pp. 30-31, 53-54). Dr. Hartman again noted that it didn't make sense diagnostically to give the petitioner a diagnosis of post-traumatic stress disorder. (R. Ex. 1, p.31).

Dr. Hartman testified that the petitioner probably had some temporary period of upset after the accident, which he noted is normal and expected in a situation like this. (R. Ex. 1, p.32). However, he opined that the petitioner now has entirely a problem that is the result of chronic conditions that are deteriorating and are not related to this incident except insofar as there is an opportunistic attempt to use this incident to peg all of his problems to. (R. Ex. 1, p.32). Dr. Hartman wrote opined that the petitioner reached maximum medical improvement at the point that he began driving after the incident. (R. Ex. 1, p.33).

CONCLUSIONS OF LAW

The Arbitrator adopts the above findings of material fact in support of the following conclusions of law:

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

In Pathfinder Company v. Indus. Comm'n, 62 Ill.2d 556 (1976), the Illinois Supreme Court determined that to prove an accident within the meaning of the Illinois Workers' Compensation Act, the petitioner was required to prove sudden, severe emotional shock.

It is undisputed that on December 26, 2007, the petitioner struck and killed a pedestrian during the course and scope of his employment.

The petitioner testified that shortly after the accident he experienced nightmares, had trouble sleeping and had to take a brief period off work, which was granted by the respondent.

The petitioner further testified that sometime in January 2008 he returned to work at his regular job but was unfocused, was having difficulty concentrating and would become anxious as a result of driving his truck. The petitioner claimed that he had a lot of panic attacks.

Following the accident, the petitioner sought medical treatment for his anxiety with Dr. McFadden whom he first saw on January 3, 2008. Although Dr. McFadden's initial treatment records were not introduced into evidence, the records from the Village Counseling Center refer to the petitioner's visits to Dr. McFadden on January 3, January 7 and January 14, 2008 (P. Ex. 2). Dr. McFadden subsequently referred the petitioner to Dr. Pawlowski, who first saw him on January 9, 2008. Dr. Pawlowski's diagnosis on that date was "insomnia, anxiety, depression." He further indicated "I believe this is secondary to the MVA." Paxil and Xanax were prescribed. (P. Ex.3). The petitioner followed up with Dr. Pawlowski on February 6, 2008 and June 12, 2008. (P. Ex. 3).

In the instant case, very shortly after the accident in which he struck and killed a pedestrian, the Petitioner began experiencing nightmares and anxiety. He had to take a brief period off work before he was able to return to work following the accident. Furthermore, the petitioner sought medical treatment within eight days of the accident and was diagnosed with insomnia, anxiety and depression secondary to the motor vehicle accident.

Accordingly, the arbitrator finds the petitioner sustained a compensable accident under the Act meeting the Pathfinder requirements as he suffered a sudden, severe emotional shock that was traceable to a definite time and place and there was a clear causal relationship between the December 26, 2007, event and his psychological injury of insomnia, anxiety and depression.

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

The petitioner testified that at time of the subject accident, he immediately stopped at the scene to render aid to the victim. Upon realizing the victim's condition, the petitioner asked a bystander to call 911. The petitioner then telephoned his supervisor at Medspeed, "Jack". The petitioner was then taken to the police station by investigating police personnel, where he was later picked up by his Medspeed supervisor, "Jack", and driven back to Medspeed so that the petitioner could get his own car to go home. Clearly, Medspeed had timely notice, on the date of injury, of the petitioner's accident.

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

The Arbitrator finds that the petitioner failed to prove that his current condition of ill-being is causally related to the injury.

First, the records from Dr. Graves and the petitioner's own testimony indicate that petitioner engaged in recreational driving in California in 2011, a road trip to a festival in July 2011, a road trip when he drove to and from Iowa in September 2011, a road trip when he drove to and from Florida in 2012, and weekly motorcycle club meetings to which he drove. (P. Ex 2, and Tx. pp. 71-74).

Second, the records from Central DuPage Hospital dated June 27, 2009 reflect that the petitioner fell down 16 steps at home after a late night out during which he was drinking and riding a motorcycle. The chart note indicates that with regard to his psychiatric examination, his mood and affect were normal. (R. Ex. 4).

Third, no medical provider/professional ever restricted the petitioner from driving, and he was not authorized off of work until July 19, 2011, which was more than three years after the accident occurred. (P. Ex. 2).

The Arbitrator adopts Dr. Hartman's opinion that that someone who continues to drive a car and ride a motorcycle does not fit the diagnosis of a post-traumatic stress disorder incurred while driving a vehicle. (R. Ex. 1, p. 30) The Arbitrator finds Dr. Hartman's reasoning, as quoted below, to be particularly persuasive:

"Again, the reason why he doesn't fit the diagnosis, I think one of the more obvious reasons is that posttraumatic stress disorder is - - when it is a credible diagnosis is related to severe anxiety responses that are - - that occur to events similar to or related to or can be generalized from what you were exposed to that caused you the initial trauma. So, for example, if you were in a war and you were traumatized by gunshots, you might then be extremely agitated by hearing a car backfire in your neighborhood. Even though that was not a gunshot, it was close enough to the original stimulation, which caused your trauma. Now, Mr. Cosek is claiming PTSD related to a driving accident, but he continues to drive. He continues to ride a motorcycle. Both of those put him in situations which should be similar to or perhaps even more potentially stimulating or dangerous from a risk perspective than his actual driving behavior in

the context of this claim. So really somebody who can - - who can drive and ride a motorcycle doesn't fit posttraumatic stress disorder incurred while driving a vehicle. That just doesn't make any sense for the disorder... " (R. Ex. 1, pp. 29-30)

Moreover, the Arbitrator notes that Dr. Hartman is the only medical provider who assessed the validity of the petitioner's symptom presentation and his motivation/effort through objective testing. The Arbitrator notes that the DSM-IV requires there to be some formal rule out of whether a person is malingering post-traumatic stress disorder (R. Ex. 1, p. 30), and finds that none of the providers in this case fulfilled the DSM-IV requirement to assess for exaggeration or malingering through utilization of objective pathology to look at whether the petitioner had a credible response pattern. (R. Ex. 1, pp. 30-31).

The Arbitrator further finds that the petitioner's results on the word memory test (R. Ex. 1, p. 17), the computer assessment of response bias (R. Ex. 1, pp. 17-18), the structured inventory of malingering symptomatology (SIMS) (R. Ex. 1, pp. 18-19), and the modified somatic perception questionnaire (R. Ex. 1, pp. 19-20), are supportive of and confirm the accuracy of Dr. Hartman's opinion that there is consistent evidence for a malingering approach to symptom presentation which is a voluntary and non-credible simulation of symptoms for some kind of secondary gain. (R. Ex. 1, p.26).

Although the Arbitrator finds that Petitioner has failed to prove that he suffers from PTSD and that same is causally related to the accident of December 26, 2007, the Arbitrator does concur with Dr. Hartman's opinion stating that "It's probably more likely than not, that Mr. Cosek had some temporary period of upset after the accident. That would be normal and expected in situations like that." (R. Ex.1, p. 32).

Therefore, the Arbitrator finds that as a result of the accident of December 26, 2007, the petitioner sustained a sudden, severe emotional shock resulting in psychological injury that consisted of insomnia, depression and anxiety as per Dr. Pawlowski's diagnosis on January 9, 2008. (P. Ex.3).

At the petitioner's follow-up visit to Dr. Pawlowski on February 6, 2008, the doctor noted that the petitioner was presenting with "significant improvement overall." The prescription for Xanax that was originally issued at the time of the initial visit on January 9, 2008 was continued with instructions to take mainly at night on a PRN basis. (P. Ex. 3).

The petitioner's last visit to Dr. Pawlowski in 2008 took place on June 12, 2008, at which time the doctor ordered a refill of Xanax and noted that if the petitioner failed to improve, he "may consider evaluation by a psychiatrist for posttraumatic stress disorder." (P. Ex.3).

The petitioner did not follow up for a psychiatric evaluation in 2008 and furthermore, he sought no treatment for any psychological condition in 2009.

On June 27, 2009, the petitioner was seen at Central DuPage Hospital for injuries sustained when he fell down 16 steps at home after a late night out during which he was drinking

and riding a motorcycle. The chart note indicates that with regard to his psychiatric examination, his mood and affect were normal. (R. Ex. 4).

Based on the foregoing, the Arbitrator finds that the petitioner sustained a sudden, severe emotional shock resulting in psychological injury, which resolved as of June 12, 2008.

The petitioner failed to seek any medical treatment for any alleged psychological injury from the time of the June 12, 2008 visit to Dr. Pawlowski until March 18, 2010 when he saw Dr. Ward, which is a gap of over one year and nine months. In the meantime, his mother died, he continued to drive motor vehicles and motorcycles and was not taken off work by any medical professional until July 19, 2011, which was more than three years after the accident occurred. This sequence of events coupled with Dr. Hartman's opinions establish that the petitioner's current condition of ill-being was not caused by the traumatic event of December 26, 2007.

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

The Arbitrator finds that the petitioner sustained an accident that arose out of and in the course of his employment. The Arbitrator also finds that the petitioner's condition of ill-being that was causally related to the accident of December 26, 2007 had resolved as of June 12, 2008, and only the related medical services rendered to petitioner during the aforesaid dates were reasonable and necessary.

L. What amount of compensation is due for temporary total disability?

The Arbitrator finds that the petitioner sustained an accident that arose out of and in the course of his employment by the respondent. The Arbitrator also finds that the petitioner's condition of ill-being that was causally related to the accident of December 26, 2007 had resolved as of June 12, 2008. Therefore, the Arbitrator finds that the petitioner is not entitled to any temporary total disability benefits after June 12, 2008.

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

The Arbitrator finds penalties and fees should not be imposed upon the respondent and further finds that the respondent factually had a good and just cause to dispute this claim and did not act unreasonably in doing so. The Arbitrator specifically finds that the employer had a reasonable and good faith challenge to liability based on the issues of accident and medical causation.

N. **Is the respondent entitled due any credit?** 14IWCC0755

The parties stipulated that, prior to trial, the respondent paid **$28,561.63** in medical expenses. The respondent is not liable for any medical charges incurred subsequent to June 12, 2008, and the credit owed respondent is to be calculated accordingly.

The parties stipulated that, prior to trial, the respondent paid **$31,893.56** in TTD benefits. The respondent is not liable for payment of any temporary total disability benefits subsequent to June 12, 2008, and the credit owed respondent is to be calculated accordingly.

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 down	☐ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Brenda Harrell,
Petitioner,

vs.

No. 97 WC 08178
(consol. with 95 WC 37971—not appealed)

Witte Hardware,
Respondent.

14IWCC0756

DECISION AND OPINION ON REVIEW

Petition for Review having been timely filed by Respondent and notice given to all parties, the Commission, after considering the issues of accident, notice, medical expenses, notice, causal connection, temporary total disability, and permanent partial disability, and being advised of the facts and law, modifies the November 13, 2013 Decision of Arbitrator McCarthy 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 No. 95 WC 037971, which was consolidated with this case for hearing at arbitration, has not been appealed by either party.

After considering the entire record, the Commission affirms and adopts the Arbitrator's findings with respect to all issues except for the award for permanent partial disability. The Commission acknowledges the difficulties involved in apportioning disability especially in those cases where, as here, the Petitioner has a pre-existing degenerative condition and alleges that two work accidents from two separate and distinct employers caused her permanent disability. The Commission notes that Petitioner's own treating physicians disagree on the role each work accident played in Petitioner's disability.

Petitioner suffered her first work accident on April 26, 1995, while working for an employer other than Respondent and caring for disabled adults. She testified that she heard her low back snap and felt immediate pain while attempting to lift a heavy patient from the floor to the bed. Petitioner sought emergency room treatment and followed up with her primary care physician, Dr. Stephens, who prescribed physical therapy, noted that her CT scan showed no disc herniation, and returned her to work on May 7, 1995. When Petitioner complained of worsening symptoms following her return to work, Dr. Stephens referred her to an orthopedist, Dr. Nashed, who diagnosed her with a muscle strain and possible disc herniation and recommended additional physical therapy. In August 1995, Petitioner advised both doctors that her condition had improved

dramatically and that she was ready to return to work at a new job as packer for Respondent. Petitioner filed a workers' compensation claim for her April 26, 1995 injury under No. 95 WC 034971.

That claim was consolidated and tried with the instant case, No. 97 WC 008178, in which Petitioner alleged that she suffered a second work accident on October 26, 1995 while lifting boxes and pushing a cart in her new job as packer for Respondent. She denied that a specific incident occurred, but testified to an onset of symptoms on that date. Petitioner testified that her prior back pain recurred after she had been performing her regular job duties for Respondent for a couple of months. She testified that the pain was the same as she suffered following her first accident, but was more severe, and she sought treatment again from Dr. Stephens, who provided conservative care.

On January 10, 1996, Petitioner began treating with Dr. Hanaway, a neurologist who had been recommended by a family friend. Petitioner reported pain in her left low back, buttock, and left leg down to her calf. Dr. Hanaway reviewed Petitioner's April 27, 1995 CT scan and noted a prominent protruding disc at L4-5. He noted that Petitioner's December 9, 1995 MRI showed a central herniated disc at L5-S1. Petitioner admitted to Dr. Hanaway that she went to work for Respondent with pain. Her April injury continued to cause her pain that continuously waxed and waned.

Dr. Hanaway referred Petitioner to a neurosurgeon, Dr. Cole, for a surgical opinion. Dr. Cole evaluated Petitioner on May 23, 1996, noting that her CT scan showed no herniation, but only a slight bulge. Dr. Cole recommended that Petitioner not undergo surgery for her back complaints. Dr. Hanaway then referred Petitioner to another neurosurgeon, Dr. Bailey, for a second opinion, and Dr. Bailey agreed with Dr. Cole that Petitioner was not a surgical candidate at that time. Dr. Hanaway noted that other St. Louis surgeons would be unlikely to recommend a surgery for Petitioner in the face of Dr. Cole's and Dr. Bailey's opinions, so he referred Petitioner to an out-of-state surgeon, Dr. Pinto at the Minnesota Spine Center, for another surgical opinion.

Dr. Pinto evaluated Petitioner on September 10, 1996. Petitioner reported a history of only one work accident, her April 26, 1995 lifting injury. Dr. Pinto reviewed Petitioner's CT scan which he believed showed hypertrophic change in her facet joints at L5-S1 and her MRI which he felt showed disc degeneration and a possible annular tear at that same level. Dr. Pinto performed a discogram, which confirmed the annular tear, and he performed a fusion at L5-S1 on December 14, 1996. Because of the distance to Minnesota, Petitioner followed up with Drs. Hanaway and Stephens. Dr. Pinto performed a second surgery to remove the hardware he had implanted on December 5, 1997. He testified by deposition that Petitioner's fusion was solid at that time, and he removed screws that had loosened since the implant. Dr. Pinto noted that Petitioner did have a complete annular tear at L5-S1, as well as stenosis resulting from arthritis.

Petitioner continued to experience back complaints, and pain specialist, Dr. Gahn, implanted a spinal cord stimulator in 2000 and removed it in 2005. Petitioner testified at hearing that she continued to utilize stimulators for pain relief through the date of hearing.

Arbitrator McCarthy found that Petitioner suffered a back strain as a result of her April 1995 accident, lifting a disabled adult in the care center, and awarded 5% loss of use of the person as a whole for that accident. The No. 95 WC 034971 award was not appealed by either party.

Arbitrator McCarthy found that Petitioner's April 1995 back strain resolved in August 1995, prior to the occurrence of her second accident. The Arbitrator noted that, although Petitioner's condition following the April accident resolved after only conservative treatment, her condition deteriorated after the second accident to the point where physical therapy did not provide complete relief. He found Petitioner's October accident causally related to her surgeries and condition of ill-being at the time of hearing.

Several doctors provided causation opinions supporting the Arbitrator's finding of causal connection. Dr. Hanaway opined that Petitioner's April 26, 1995 accident caused disc protrusions at L4-5 and L5-S1, but her repetitive work duties on October 26, 1995 aggravated her condition and necessitated her fusion surgery. Dr. Pinto testified at deposition that Petitioner only informed him of one work accident, the April 1995 lifting incident, which he believed played a significant role in causing her symptoms. When presented with a hypothetical question, Dr. Pinto opined that the October 1995 incident aggravated Petitioner's previous condition and played a more significant role than her April injury in causing her need for surgery. Dr. Stephens opined that Petitioner's surgery was causally related to her April accident, but admitted on cross-examination that the April 1995 injury had resolved prior to October 1995 and that it was possible that Petitioner's work for Respondent aggravated her condition. The Commission finds that Petitioner's October 1995 accident did aggravate her prior lumbar condition and contribute to her current condition of ill-being, but disagrees with the Arbitrator's finding of permanent total disability resulting from that injury.

Arbitrator McCarthy found Petitioner "obviously unemployable" as a result of her October 1995 accident. The Arbitrator noted that the only vocational evidence admitted in the hearing was that Petitioner was 43 years old when she reached MMI and that she had worked two years caring for disabled adults and two months as a packer for Respondent. No evidence was offered as to her education, work history, job skills, or attempts to find work after her condition had stabilized. Petitioner clearly failed to prove that she qualified for permanent total disability benefits under the "odd lot" theory. Neither did she qualify under the statutory permanent total disability provision of Section 8(e)18 of the Act.

Arbitrator McCarthy relied upon Dr. Hanaway's opinion that "there's no kind of light duty job this patient could do five days a week, eight hours a day that would be a benefit to her or her employer," but Dr. Hanaway's opinion was based upon his last examination of Petitioner five years before the hearing.

Respondent's Section 12 examiner, Dr. Mirkin, found that Petitioner could not work without restrictions against squatting, bending or lifting more than 15 pounds. Dr. Mirkin opined that Petitioner was probably capable of performing very light or sedentary work, but his opinion was seven years old at the time of hearing. Section 12 examiner, Dr. Delheimer, testified that Petitioner reached MMI in August 1995 when she returned to work full duty. Records from after

14IWCC0756

the October 1995 accident show that Petitioner's low back pain after her second accident radiated to the right, whereas her previous complaints were left sided.

Petitioner's primary care physician, Dr. Stephens, opined that Petitioner might be able to perform a sitting job, although he did not know how long she would be able to remain in the sitting position. Dr. Stephens noted that Petitioner had other serious health conditions, including an abdominal wall hernia and scleroderma, that would prevent her from returning to work of any kind. This opinion was provided in 1999, 14 years before the arbitration hearing.

Petitioner provided no contemporaneous medical records or doctor's opinion indicating that Petitioner's condition had remained the same or had worsened from the time of the medical opinions regarding Petitioner's employability to the time of hearing. The Commission finds that, in the absence of opinions from vocational experts or contemporaneous medical evaluations regarding Petitioner's restrictions and whether a stable labor market exists for Petitioner, Arbitrator McCarthy's award of permanent total disability is unsupported by the record. The primary question before the Commission relates to the nature and extent of the permanent disability caused by Petitioner's October 1995 accident.

Petitioner testified that the boxes she lifted while working for Respondent were not large and the cart was not difficult to push. She opined that her symptoms were the same as when she suffered her April 1995 lifting accident, but worse. Prior to hearing, she underwent two surgeries with Dr. Pinto and had a spinal cord stimulator implant for five years before the wires began to break and the implant was removed in 2005. Dr. Hanaway could offer no other treatment options and suggested that Petitioner file for disability benefits, which she did. She testified that her pain has continued to worsen and that she continues to treat with Percocet and a spinal cord stimulator. Despite that treatment, she always has pain and hurts from the shoulder blade down.

The Commission finds that Petitioner did prove that she sustained an accident that arose out of and in the course of her employment with Respondent in October 1995 and that the accident aggravated her pre-existing condition stemming from her April 1995 injury. She failed to prove that this second accident rendered her permanently and totally disabled, but did prove that the second accident resulted in a significant increase in symptoms. The Commission finds that Petitioner suffered a loss of use of 20% of the person as a whole under Section 8(d)2 of the Act as a result of her October 1995 accident.

All else is affirmed and adopted.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed on November 13, 2013 is hereby modified. Petitioner has failed to prove permanent total disability.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $110.90 per week for the period of 100 weeks as provided in Section 8(d)2 of the Act for the reason that the injuries sustained caused 20% loss of use of the person as a whole.

14IWCC0756

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay Petitioner temporary total disability benefits of $166.67 per week for 125-6/7 weeks commencing October 30, 1995 through March 4, 1998, as provided in Section 8(b) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent's Motion to Exhaust is 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 injuries.

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 $40,000.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: SEP 0 8, 2014

Daniel R. Donohoo

Charles J. DeVriendt

o-07/23/14
drd/dak
68

DISSENT

I respectfully dissent from the majority opinion. I would have found that Petitioner did not sustain her burden of proving she suffered an accident on October 26, 1995. Therefore, I would have reversed the Decision of the Arbitrator and denied compensation. This case involved two separate alleged accidents purporting to injure the same part of the body, the lumbar spine. Even though the two accidents were alleged to have occurred while Petitioner was working for different employers, the cases were consolidated and arbitrated together.

The first accident occurred on April 26, 1995. Petitioner was working as a caregiver and suffered an injury to her low back while lifting a heavy patient. Petitioner treated for that condition conservatively and returned to work on May 7, 1995. On May 16, 1995, Petitioner returned to her primary care physician, Dr. Stephens, complaining of a recurrence of back pain. She began a regimen of physical therapy. She was returned to light duty on June 28, 1995. She continued in physical therapy and after 22 physical therapy sessions she was released to full duty "as she can" on August 24, 1995 in a less physically demanding job as a packer with another employer.

Petitioner did not note any specific traumatic accident but noted an onset of symptoms on October 26, 1995. Petitioner testified the pain was the same type as she experienced on April 26, 1995 but was worse. On October 30, 1995, Dr. Stephens noted a recurrence of low back symptoms, took her off work, and resumed physical therapy. Dr. Stephens referred Petitioner to Dr. Hanaway, a neurologist. He referred Petitioner to Dr. Cole, a neurosurgeon for a consultation. Dr. Cole opined that Petitioner was not a surgical candidate. Dr. Hanaway then referred her to another neurosurgeon, Dr. Bailey, for a second opinion. He concurred with Dr. Cole that surgery was not indicated. At that time Dr. Hanaway noted that considering the opinions of Drs. Cole and Bailey it was unlikely that any neurosurgeon in St. Louis would operate on Petitioner so he referred her to Dr. Pinto in Minnesota.

On Petitioner's initial visit to Dr. Pinto on September 10, 1996, he noted only the April 26, 1995 accident. There was no mention of any work-related accident or activities while working for the second employer. Dr. Pinto performed two-level spinal surgery on December 14, 1996. He then performed a second surgery on December 5, 1997 to extract screws that had become loose. In deposition, Dr. Pinto testified that the April 26, 1995 accident played a significant role in Petitioner developing symptoms. He noted that a CT from April 27, 1995 showed a tear at L4-5. Similarly, in deposition, Dr. Hanaway testified that the April 26, 1995 accident caused disc protrusions at L4-5 and L5-S1. Finally, at arbitration Petitioner testified she still had pain when she began to work for the second employer.

In my opinion Petitioner did not sustain her burden of proving a second accident. She had persistent symptoms when she returned to work for the second employer. Dr. Hanaway referred her symptoms as recurrent. Petitioner did not even mention a second accident when giving her history to her surgeon, Dr. Pinto. Simply put Petitioner's condition did not resolve after the first accident. Whatever portion of her current condition of ill-being that is work-related would be attributable to the first accident. Her work activities with the second employer would have constituted nothing more than a manifestation of symptoms of her underlying condition.

For the reasons specified above, I respectfully dissent.

Ruth W. White

Ruth W. White

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION
CORRECTED

HARRELL, BRENDA
Employee/Petitioner

Case# **97WC008178**
95WC034971

WITTE HARDWARE
Employer/Respondent

14IWCC0756

On 11/13/2013, 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:

2453 CALLIS PAPA HALE & SZEWCZYK
LARRY CALVO
1517 20TH ST
GRANITE CITY, IL 62040

1872 SPIEGEL & CAHILL PC
CHRISTINA BAWCUM
15 SPINNING WHEEL RD SUITE 107
HINSDALE, IL 60521

1337 KNELL & KELLY PC
PATRICK J JENNETEN
504 FAYETTE ST
PEORIA, IL 61603

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
CORRECTED ARBITRATION DECISION

Brenda Harrell
Employee/Petitioner

v.

Witte Hardware
Employer/Respondent

Case # 97 WC 8178

Consolidated cases: 95 WC 34971

14IWCC0756

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **D. Douglas McCarthy**, Arbitrator of the Commission, in the city of **Urbana**, 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 **Motion to Exhaust**

FINDINGS

On **October 26, 1995**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$13,000.00**; the average weekly wage was **$250.00**.

On the date of accident, Petitioner was **40** years of age, *married* with **0** dependent children.

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

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

Respondent shall be given a credit of **$0.00** 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 is entitled to Temporary Total Disability benefits from October 30, 1995 through March 4, 1998, a period of 125 6/7 weeks, at a rate of $166.67 per week.

Petitioner is entitled to Permanent and Total Disability benefits of $250.00, commencing March 5, 1998 and continuing for life, as provided in Section 8 (f) of the Act.

Respondent's Motion To Exhaust 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. Dylan McCarthy
Signature of Arbitrator

Nov 6, 2013
Date

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

BRENDA HARRELL,	)	
	)	
Petitioner,	)	
	)	
vs.	)	97 WC 8178
	)	
WITTE HARDWARE,	)	
	)	14IWCC0756
Respondent.	)	

CORRECTED ARBITRATION DECISION

STATEMENT OF FACTS

Petitioner, Brenda Harrell, filed an Application for Adjustment of Claim at the Illinois Workers' Compensation Commission alleging that she sustained a work related accident on October 26, 1995. On that date, Petitioner was employed by Witte Hardware as a Packer. Petitioner has also filed an Application for Adjustment of Claim alleging a work accident of April 26, 1995, which is captioned as 95 WC 34971. On that date of accident, Petitioner was employed by Braun's Terrace. Both claims involve alleged injuries to the Petitioner's lower back. By agreement, the cases were heard in consolidation. The Arbitrator will use one identical set of factual findings on each claim with separate conclusions of law.

Petitioner began working at Braun's Terrace in August of 1993 as a Care Giver. As a Care Giver, Petitioner was required to supervise 16 disabled adults. She worked the night shift, and was the only employee on staff during the night. On April 26, 1995, Petitioner was working at Braun's Terrace and was completing paperwork when she heard a thump. She discovered that a 450 pound patient had fallen and was wedged between the wall and the bed. Petitioner picked the 450 pound patient up by herself and put the patient back on the bed. When she picked up the patient, she heard a snap in her back which was accompanied by pain.

Petitioner then completed her shift, and when her shift was over she went straight to Edward A. Utlaut Memorial Hospital Emergency Room due to back pain. She informed the hospital personnel regarding her work accident, and complained of low back pain. Petitioner was diagnosed with low back pain, was given a prescription for Tylenol #3, and an off work slip. (PX 5)

Petitioner presented the off work slip to her employer, however, they requested that she been seen by a different doctor. Therefore, Petitioner presented to her primary care physician, Dr. Stephens. On April 27, 1995, Petitioner informed Dr. Stephens that while working at the

nursing home, she picked up a patient, and strained her low back. She complained of lower back pain with left leg radiation. Her exam revealed a positive straight leg raising test on the left, which Dr. Stephens said was indicative of nerve impingement. (PX 3 at 7) The assessment was (1) acute left sacroillitius and (2) possible disc herniation or impingement. It was recommended that she undergo a CT scan of L3-S1. (Witte, 1)

On April 27, 1995, Petitioner underwent a CT of the lumbar spine. The radiologist did not find evidence of a disc herniation and identified mild facet arthropathy at the level of L5-S1. (PX 5)

On May 2, 1995, Petitioner returned to Dr. Stephens. She reported that her back was doing much better. A work release was given for her to return to work on May 7. (Witte, 1)

On May 16, 1995, Petitioner returned to Dr. Stephens due to a recurrence in back pain. She advised the doctor that she had been back to work for six days. She reported that her job involves bending, stooping, and lifting, and that her symptoms had progressively gotten worse. An injection was performed and she was authorized off of work.

On May 24, 1995, Petitioner began physical therapy at the request of Dr. Stephens. At her initial evaluation, she complained of pain in the lower back radiating to the left buttock. She had 22 physical therapy sessions between then and August 18, 1995. On that date she reported no tenderness to the lumbar spine or sacroiliac joints. She was found to have a normal range of lumbar motion with normal strength and no deficits in sensation. Her therapist concluded that she had met all of her therapy goals, showing marked improvement. (PX 5)

Dr. Stephens eventually referred Petitioner to Dr. Nashed, an orthopedist on the Utalat Hospital staff. On June 5, 1995, Petitioner presented to Dr. Nashed. She complained of pain from the left side of the lower back, going down the left buttock. Dr. Nashed noted that the Petitioner's pain had not resolved despite physical therapy and that the CT scan showed no disc herniation. On exam, Dr. Nashed noted that the Petitioner's pain did not travel down her leg and that her straight leg raising test was negative for radiculopathy. The impression was muscular strain of the lower back, possible disc herniation. Additional physical therapy was recommended, as well as continuation of Lodine and Soma. (PX 5)

On June 28, 1995, Petitioner informed Dr. Nashed that her pain had improved. Petitioner felt that it was not possible for her to return to her pre-injury degree of work but wanted to start with light duty. It was noted that her job as a nursing home attendant requires taking care of patients, making 18 beds, cooking, and pushing and pulling carts. Dr. Nashed found that this activity is extremely strenuous on her back, and agreed that she should not be doing that amount of strenuous activity so soon after injury. He did not want her to lift more than 20 to 30 pounds, and recommended no excessive bending, pushing or pulling. Petitioner stated that she may be able to find a job which would not require much strenuous activity, and Dr. Nashed agreed with that option in terms of keeping her from becoming reinjured. (Witte, 2)

On July 10, 1995, Petitioner reported improvement of her symptoms to Dr. Nashed, reported occasional pain from her lower back down to her left heel. He released Petitioner to return to work "as possible" and recommended that she return on an as needed basis. (Witte, 3) Petitioner returned to Dr. Nashed on July 24, 1995, and complained of severe pain in her lower back after some recent therapy. He took her off therapy until her symptoms resolved. (Witte, 4)

On July 26, 1995, Petitioner underwent an IME with Dr. William Sedgwick of Orthopedic Surgery & Sports Medicine at the request of Braun's Terrace. Dr. Sedgwick felt that Petitioner sustained a sprain to her lower back superimposed on underlying arthritic changes of the facet joints in the lumbosacral area. He felt that she could be further evaluated with an MR scan of the lumbar and thoracic area. He recommended work restrictions of no excessive repetitive forward bending or twisting or excessive heavy lifting from a compromised position at the waist (less than 30-40 pounds lifting, pushing or pulling). Dr. Sedgwick also felt that a work hardening program may be indicated. (Brauns, 6)

On August 14, 1995, Petitioner informed the physical therapist that she still had a lot of stiffness. She felt that she would likely have pain on the job, but wanted to return to work anyway. (PX 5)

On August 18, 1995, Petitioner informed Dr. Stephens that her back was doing wonderful, and that she was about to be released from Dr. Nashed and PT. (Braun's, 12) On August 21, 1995, Dr. Nashed noted that the Petitioner's back pain had dramatically improved, and released Petitioner to return to work for full duty "as she can." (PX 5) Petitioner testified that she continued to experience pain at this visit but asked for the release.

On August 24, 1995, Petitioner advised Dr. Stephens that she needed a work release as she had found a new job at a hardware store. (Braun's, 12). On August 27, 1995, Petitioner began working for Witte Hardware as a Packer. At arbitration, she testified that her job duties as a Packer involved picking out different items identified on a list and putting them in a cart. She did not have to lift big or heavy boxes. In addition, the cart was not heavy and it had a handle on it. She denied that her employment for Braun's Terrace required "heavy" lifting. However, on October 30, 1995, when she was seen by Dr. Stephens for a reoccurrence of her pain, she said that her job required pushing a cart and lifting heavy boxes. (PX 3 at 17) She also reported to her physical therapist on the same day that she did a lot of heavy lifting at work, and that the boxes she had to lift had increased in size. She said that after a few days of lifting for ten hours, she developed severe pain in the lower back which was intractable. (PX 6)

Dr. Stephens took the petitioner off work and referred her for therapy. (PX 3 at 17) She was seen for fifteen visits through December 5, 1995, and the therapist reported that she had partially met her goals. (PX 6) On December 8, 1995, she saw Dr. Stephens with complaints of pain in the left lower back, hip and leg. The doctor ordered an MRI which was done on

December 11, and decided she needed a second opinion. She referred the Petitioner to Dr. Hanaway, a neurologist. (PX 3 at 20,21)

On January 10, 1996, Petitioner saw Dr. Hanaway. She told him about her accident of April 26 while lifting a patient. She said that it caused a sudden onset of lower back and left leg pain which improved with treatment. She said that she returned to work on August 27, 1995, and felt good until having a reoccurrence of pain on October 26 without a specific episode. Dr. Hanaway testified that she said her pain was located in the left lower back, buttock and left posterior sciatic pain to the left calf, and came on in the course of her days work. (PX 1 at 5,6)

Dr. Hanaway reviewed the CT of April 27, 1995, and found that it revealed a prominent and protruding disc at L4-5 filling foramina at L5-S1. He also found that there was significant posterior protrusion of the disk seen on the reconstruction series. The MRI done on December 9, 1995, revealed a central herniated disk seen on the sagittal runs that was pushing against the dura. The axial runs were vague so it was impossible for the doctor to make any diagnosis. His exam was consistent with disc pressure on a nerve, and he diagnosed a herniated lumbar disk at L5-S1 with a lumbar radiculopathy down the left leg. It was recommended that she see a neurosurgeon. He also recommended a lumbar myelogram and EMG. (Id at 8,9)

Pursuant to Dr. Hanaway's referral, Petitioner presented to Dr. Cole for an evaluation. On May 23, 1996, Dr. Cole noted that the Petitioner's MR/CT study failed to demonstrate evidence for a disk herniation. The only abnormality seen was a slight bulge with diminished signal intensity of the intervertebral disc. Dr. Cole did not recommend surgical intervention, though he was surprised that the finding was negative given her symptoms. (Witte, 14) Dr. Hanaway then referred Petitioner to Dr. Bailey. Dr. Bailey also recommended against surgical intervention.

Dr. Hanaway again examined the Petitioner on July 31, 1996. He concluded that she had clear cut sciatica, and referred her to Dr. Pinto at the Minnesota Spine Center. (PX 1 at 14) Dr. Hanaway had continued her off work through the course of his treatment.

Petitioner saw Dr. Pinto, an orthopedic surgeon, on September 10, 1996. She provided Dr. Pinto with a history of her accident in April lifting a patient. He testified that he was not made aware of her subsequent job at Witte Hardware until providing his testimony on February 11, 1998. (PX 2 at 23) Petitioner underwent a lumbar discogram, which Dr. Pinto said confirmed a complete tear of her disc at L5-S1. (Id at 11) On December 14, 1996, Dr. Pinto performed a posterolateral fusion at L5-S1, autogenous iliac crest bone graft (harvest from right iliac crest), lumbar laminectory L5, bilateral recess decompression L5-S1 and foraminal decompression at L5-S1 and foraminal decompression at L5-S1 bilaterally. (PX 7) He testified that she did well initially, but after a few months began to develop pain. He determined that a surgical screw had loosened, causing her pain, and had the hardware removed on December 5, 1997. He testified that her fusion was solid. (Id at 15-17)

Since then the Petitioner remained under the care of Dr. Hanaway until his retirement in September 2008. She also treated with a pain specialist, Dr. Gahn. She had a pain stimulator from 2000 through 2005, and it was removed in 2005. On May 15, 2006, Dr. Gahn released the Petitioner. Dr. Hanaway also tried a TENS unit, which was unsuccessful, and various pain medications which provided some relief. When he last examined her, Dr. Hanaway noted bilateral lumbar tenderness and spasm. She had a decreased range of motion and a positive straight leg raising test on the left. Her reflexes were absent. He concluded that she was permanently and totally disabled. (PX 4 at 21)

Respondent Witte had the Petitioner examined pursuant to Section 12 by Dr. Mirkin, an orthopedic surgeon, on October 11, 2006. He concluded that the Petitioner could only work with considerable restrictions. He said she could not do a job where she would have to squat, bend, stoop or lift over fifteen pounds. He concluded that a job would have to be very light or sedentary for her to do it. (Witte 15 at 13)

Petitioner testified that she has been on Social Security Disability since 1995. She has constant pain from her shoulders down to her feet. She takes Percocet and uses an external pain stimulator. She has numbness in her legs and is able to walk less than 100 feet.

A number of the Petitioner's treating and examining physicians testified on the issue of causation. Dr. Hanaway testified on two occasions; the first coming without participation by Witte Hardware in October 1997, and the second, with all parties present in September 2010. On both occasions, Dr. Hanaway testified that the accident of April 26, 1995 caused disc protrusions at L4-5 and L5-SI. (PX 1 at 10, 18; PX 4 at 25) Also on both occasions, he said that the Petitioner's work duties on October 26, 1995 aggravated her condition to the point where she needed surgery. (PX 1 at 25; PX 4 at 26,74)

Dr. Pinto, her surgeon, provided similar testimony. He said that the April accident played a significant role in the development of her symptoms and, further, that the CT scan which he reviewed of April 27, 1995 showed a tear in the disc at L5-S1. (PX 2 at 8,18) Later, after he had been provided with records from Drs. Stephens and Hanaway, along with the physical therapy notes of August 1995, he testified that the injury at the hardware store aggravated the previous condition and "... played a more significant role toward the need for surgical treatment." (ID at 25, 26)

Dr Delheimer testified that the Petitioner suffered a soft tissue injury with underlying degenerative disc disease in April 1995. He said that the treatment records showed improvement, and that by August 21, 1995, she was at maximum medical improvement. Based upon his review of the diagnostic reports of April, he said that she did not have a herniated disc. He did not review the actual films. (Brauns 26 at 10)

Dr. Mirkin also opined that the Petitioner did not have a disc condition warranting surgical intervention. He also based his opinion on the test reports instead of the actual films.

(Witte 15 at 26) He said that the accident in April resulted in a strain which accounted for her back pain. (Id at 11,12) He also acknowledged that if she did have radiological evidence of a disc herniation and/or a positive discogram, then " ...some people would say that's an indication for doing aggressive surgery..." (Id at 44) He said that there was no evidence of nerve compression so surgery was not indicated. (Id at 42) Finally, he opined that the Petitioner's present condition of ill being was the result of her surgery and the complications that followed. (Id at 13)

Dr. Stephens also testified on causation. She said first that the Petitioner's surgery was the result of her original injury of April. She said that the work at Witte did not represent a new injury. (PX 3 at 25, 26) Later, on cross-examination by Braun's attorney, she said that the acute episode of April seemed to have resolved and that it was "possible" that her work at Witte could have aggravated her condition. (Id at 42)

CONCLUSIONS OF LAW

With regards to issue (C), Did an accident occur that arose out of and in the course of Petitioner's employment with Respondent?, the Arbitrator concludes as follows:

Petitioner testified that her back "locked up" on October 26, 1995, while working at Witte Hardware. On that date, she was performing her usual and customary job duties as a Packer, which involved pulling items and placing them in a cart. The cart would then be pushed to a conveyor belt. Based upon the Petitioner's testimony, and the medical records, the Arbitrator finds that Petitioner sustained a compensable accident.

With regards to issue (E), Was timely notice of the accident given to Respondent?, the Arbitrator concludes as follows:

Petitioner testified that on the date of accident, she informed her supervisor regarding her injury. The Arbitrator finds Petitioner to be a credible historian, and that notice was proper.

With regards to issue (F), Is Petitioner's current condition of ill-being causally related to the injury?, the Arbitrator concludes as follows:

The Petitioner sustained an accidental injury on April 26, 1995 while lifting a patient for Braun's Terrace. The Arbitrator finds Drs. Hanaway and Pinto persuasive in opining that the accident resulted in a disc injury. First of all, they reviewed the actual diagnostic films. Secondly, the Petitioner's symptoms of radicular leg pain found in the treatment records beginning with Dr. Stephens' the day after the accident are consistent with such an injury.

The Petitioner, however, did improve with conservative care. By August 18, 1995, her therapist said that she had no radiating leg pain. Dr. Nashed said that she had made a dramatic improvement and returned her to full duty work. Dr. Stephens also returned to full duty work, noting that her exam was normal and her symptoms resolved as of August 24.

She then went to work for Witte Hardware on August 27 as a Packer. Though she testified at her hearing held in September 2013 that her job did not involve any heavy lifting, the histories that she provided to her treating providers at the time tell a different story. The Arbitrator believes those histories, referred to in the fact statement, are more reflective of how she actually performed her job than her later testimony.

She performed her job from August 27 until October 26 without any record of medical care for her lower back. Then, after lifting boxes which were heavier than normal for several days, her symptoms returned.

This time the physical therapy did not provide complete relief. She was taken off work by Dr. Stephens, sent to Dr. Hanaway and eventually to Dr. Pinto for surgery. She developed surgical complications including a loose screw which necessitated removal of her hardware. She later developed complications from the subcutaneous nerve stimulator, necessitating its removal. She has never really recovered.

Even if the Arbitrator were to accept Dr. Mirkin's theory that surgical complications have caused her condition of ill being, it would not relieve the Respondent Witte of its liability. The surgery, as Dr. Mirkin acknowledged, would have been a treatment option if she had evidence of a damaged disc. He suggested a discogram. Dr. Pinto had one performed and it showed a herniation at L5-S1. The surgery was performed because the Petitioner's symptoms, which returned after her work at Witte, did not improve with conservative treatment.

Based upon the above evidence, the Arbitrator finds the accident of October 26, 1995 causally related to the Petitioner's surgical treatments and her condition of ill being.

With regards to issue (K), What temporary benefits are in dispute?, the Arbitrator concludes as follows:

On September 30, 1995, Petitioner was seen by Dr. Stephens and taken off work. (PX 3 at 17) Dr. Stephens saw her again on November 6, 1995. At that time the doctor noted that the Petitioner had been laid off by her employer. She prescribed more treatment and kept the Petitioner off work for at least two to three more weeks. (Id at 18) Those restrictions did not change, and Dr. Hanaway continued them after he took over treatment on January 10, 1996. The Petitioner did not reach a point of maximum medical improvement until after Dr. Pinto removed her surgical hardware on December 5, 2007. He testified by deposition shortly after that procedure, and estimated that it would take the Petitioner at least three months to recover from that surgery.

Based upon the above evidence, the Arbitrator finds the Petitioner temporarily totally disabled from October 30, 1995 through March 4, 1998, a period of 125 6/7 weeks.

With regards to issue (L), What is the nature and extent of the injury?, the Arbitrator concludes as follows:

The only evidence offered concerning the Petitioner's vocational abilities was that she was forty-three years old when she reached MMI, and that she had two years work as a caregiver and two months as a packer at a hardware store. No evidence was offered concerning her education, past relevant work and skills or attempts to find work after her condition had stabilized. Accordingly, the only way for the Petitioner to establish total disability under Section 8 (f) would be for her to show she was obviously unemployable because of her injuries.

Dr. Hanaway testified in detail about the Petitioner's failed attempts to obtain relief from her lower back and leg symptoms. (PX 4 at 12-18) She tried a dorsal column stimulator for about five years, and it did not provide any lasting relief. She also has not improved through the use of a TENS unit or various medications, including Percocet, Vicodin and OxyContin. (Id at 14-15) Dr. Hanaway's exam findings when he last saw the Petitioner in September 2008 are set forth in the findings of fact. He opined "...there's no kind of light duty job this patient could do five days a week, eight hours a day that would be a benefit to her or her employer." (Id at 21)

Dr. Mirkin, on October 11, 2006, found her active range of motion to be 20% of normal. She could not squat or rise from that position. She had decreased tendon reflexes and pain with straight leg raising. He said that she could not work without considerable restrictions, as set forth in the fact findings. (Witte 15 at 12-14)

No other medical evidence was offered concerning the Petitioner's functional abilities. Given the evidence presented, the Arbitrator finds the Petitioner obviously unemployable due to her medical condition and awards permanent and total disability benefits under Section 8 (f) of the Act.

With regards to issue (O), Respondent Witte's Motion to Exhaust, the Arbitrator concludes as follows:

Based upon the Arbitrator's findings in the companion case holding the employer Braun's Terrace not liable for the injuries sustained in this claim, the Respondent's motion to exhaust is 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 Choose reason	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☐ Modify Choose direction	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Peggy J. Ogden,
Petitioner,

vs.

NO: 11 WC 16111

14IWCC0757

State of Illinois/
Secretary of State,
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, permanent partial disability, and medical expenses and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed August 29, 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 Respondent shall have credit for all amounts paid, if any, to or on behalf of Petitioner on account of said accidental injury.

DATED: SEP 0 8 2014

Daniel R. Donohoo

Charles J. DeVriendt

Ruth W. White

o-08/27/14
drd/wj
68

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

OGDEN, PEGGY J
Employee/Petitioner

Case# **11WC016111**

14IWCC0757

ST OF IL/SECRETARY OF STATE
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:

4440 LAW OFFICE OF STEVEN W PERBIX
PO BOX 708
DECATUR, IL 62525

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

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

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

AUG 29 2013

KIMBERLY B. JANAS Secretary
Illinois Workers' Compensation Commission

STATE OF ILLINOIS)
)
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

PEGGY J. OGDEN,
Employee/Petitioner

Case # 11 WC 016111

v.

STATE OF ILLINOIS,SECRETARY OF STATE,
Employer/Respondent

PEORIA
14IWCC0757

An *Application for Adjustment 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 **06/21/2013**. After reviewing all of the evidence presented, the arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

B. ☐ Was there an employee-employer relationship?

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

D. ☐ What was the date of the accident?

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

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

G. ☐ What were the petitioner's earnings?

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

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

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

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

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

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

N. ☐ Is the respondent due any credit?

O. ☐ Other _____

FINDINGS **14IWCC0757**

- On **07/26/2010** , the respondent **State of Illinois,Secretary of State** *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 $ **46,910.24** ; the average weekly wage was $ **902.12** .
- At the time of injury, the petitioner was **46** years of age, *single* with **1** child under 18.
- Necessary medical services *have not* been provided by the respondent.
- To date, $ **0.00** has been paid by the respondent for TTD and/or maintenance benefits.

ORDER

- The respondent shall pay the petitioner temporary total disability benefits of $ **601.41**/week for **5 and 6/7** weeks, from **08/21/12** through **10/01/12** ,which is the period of temporary total disability for which compensation is payable. State Employee Retirement System paid the petitioner for two (2) days, so the respondent is entitled to credit for those 2 days under **8 (j).**
- The respondent shall pay the petitioner the sum of $ **541.27**/week for a further period of 22.90 weeks, as provided in Section **8 (e) (9) and 8 (e) (10)** of the Act, because the injuries sustained caused 25.6 **percent minus 20.6 percent prior credit. or 5 percent of the right hand and 20 percent minus 15 percent prior credit or 5 percent of the right arm**.
- The respondent shall pay the petitioner compensation that has accrued from **07/26/10** through **06/21/13**, and shall pay the remainder of the award, if any, in weekly payments.
- The respondent shall pay the further sum of $ **15,414.00** for necessary medical services, as provided in **Section 8(a) of the Act. Medical bills subject to Fee Schedule reductions in Section 8.2 and credit to respondent under Section 8(j) for group insurance payments to the medical providers**
- The respondent shall pay $ **0.00** in penalties, as provided in Section 19(k) of the Act.
- The respondent shall pay $ **0.00** in penalties, as provided in Section 19(l) of the Act.
- The respondent shall pay $ **0.00** in attorneys' fees, as provided in Section 16 of the Act.

Medical bills subject to Fee Schedule in Section 8.2 and credit to respondent under Section 8 (j) for medical bills.

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

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

AUG 29 2013

FACTS

In support of the Arbitrator's Decision relating to issues C, Accident, F, Causal Connection J, reasonableness and necessity of Medical bills, K, Temporary Total Disability, L, Nature and Extent of the injury and N, Credit the Arbitrator finds the following facts:

At the arbitration hearing, the petitioner, Peggy J. Ogden, testified herself. In her testimony, she indicated that she is right hand dominant and that she is five feet, two inches tall. She testified that she is employed at the Secretary of State, driver's license facility in Havana, Illinois as a Public Service Representative. She also testified that she has worked for the Secretary of State since May, 1985 and for the Havana driver's license facility since January 16, 1998. Her days and hours of employment at the Havana facility are and have been since 1998 Tuesdays, Wednesdays, Thursdays, Fridays, and Saturdays, totaling 37.5 hours per week.

According to the petitioner, she worked about 31 to 32 hours per week at the work station depicted in three (3) photographs that were exhibits in Dr. Ronald R. Romanelli's November 2, 2011 evidence deposition from 1998 until that station was modified in September, 2010. (Pet. Ex. #1, deposition exhibits 6A, 6B, and 6C). At that station, she would use the keyboard depicted in the photographs to enter data for titles, registrations, and forms, as well as a mouse. She indicated that she would sit in the chair depicted in two of the photographs (6B and 6C) with the chair raised up and then reach forward with her hands and arms to the keyboard on a repeated basis, or that she would stand and reach up and forward with her hands and arms to the keyboard to enter data for the various forms to allow those forms to be printed on an older style Okidata printer initially and then a laser printer thereafter, about 6 hours per day. Her work duties also included administering driving tests to the public about 4 to 5 hours per week, which involves taking motorists on driving test and writing with a pen with her right hand while observing the motorists, but that task did not cause her any symptoms or problems in her right hand or right elbow. She further testified that she also works on inventory and taking driver's license photographs of motorists, but those tasks take about an hour per week. She often logs on and off her work station as well as any other computer she uses at the facility, and she uses a mouse as well as a keyboard at each computer station.

In 2006, the petitioner filed a work injury claim for right carpal tunnel and right cubital tunnel conditions in IWCC claim number 06 WC05485, for which she received prior settlements of 20.6 percent loss of use of the right hand and 15 percent loss of use of the right arm. Dr. Romanelli performed right carpal tunnel and cubital tunnel surgery on the petitioner in 2006 and she returned to work for the respondent doing the same job on the same work station after being released to return to work from that surgery in 2006. Following that surgery, she testified she was not experiencing any symptoms or problems in either her right hand/wrist or right arm/elbow until the spring of 2010, at which time she claims that the work on the work station depicted in the photographs from 2006 till 2010 caused her injury.

In the spring of 2010, the petitioner began to notice pain in the top part of her right elbow. She testified that she had not had these problems until the spring of 2010 following her surgery in 2006. She initially saw Dr. Bleyer, who ultimately referred her to Dr. Trudeau. Dr. Trudeau performed an EMG on July 26, 2010. Thereafter, she eventually sought treatment from her prior surgeon in August, 2010, Dr. Romanelli, as recommended by Dr. Trudeau in his EMG report of July 26, 2010. She testified that none of her medical bills had been paid by worker's compensation insurance to the best of her knowledge, but these medical bills had been paid in part at least by her group health insurance through her employer along with all other medical bills she attributes to this claim to Dr. Neumeister.

The petitioner was sent for an IME in Peoria and after the IME doctor and Dr. Romanelli disagreed about her claim, she sought a second opinion from Dr. Michael Neumeister in March, 2011, who recommended

therapy and then surgery later that year, but she did not get surgery done until August 21, 2012 because there was a shortage of employees working at her facility at that time because those employees were off for surgery and because she did not have available personal time off until then. She was off work from the date of the surgery until October 1, 2012 even though the surgeon had excused off work longer and she returned to work on October 2, 2012. During her time off, she received no TTD benefits, but did after a waiting period receive two (2) days of pay from the State Employment Retirement System.

The petitioner testified that she is a bowler, having bowled consistently all her life since age 9 in leagues one day per week, with only time off from that activity in high school and then while recuperating from her surgeries in 2006 and 2012 plus a reduction in bowling activity in 2010 through 2012 before her surgery in 2012. According to her testimony, bowling has never caused her any problems to her right elbow, right arm, or right wrist or hand.

After the modification to her work station on September 14, 2010, but prior to her surgery by Dr. Neumeister in 2012, the petitioner said she noticed a diminution of her right upper extremity symptoms, and after the surgery, she is not having any further problems or symptoms in her right elbow, right hand or right wrist.

On cross examination, the petitioner testified that she thought Dr. Neumeister diagnosed her with right radial tunnel and right carpal tunnel syndrome. When she was asked about lateral epicondylitis as as diagnosis of her right elbow condition, she admitted she did not know all the medical terminology, although she was able to testify that the surgery to her elbow in 2012 involved an incision made to the top of her elbow, as compared to her 2006 right elbow surgery that was made at the bottom of the elbow.

According to the records, the petitioner saw Dr. Eric Bleyer on July 12, 2010. She then saw Dr. Edward Trudeau for an evaluation on July 26, 2010 when an EMG nerve conduction study was done. The petitioner gave the doctor a detailed history according to his records, which is summarized in part as follows at Petitioner's Exhibit 1, deposition Exhibit 4 at pages 27 and 28:

The patient who is right-handed has severe discomfort in the right upper extremity...and has had these difficulties related to her work as a public service representative with the Secretary of State's Office in the Havana driver's license facility...[I]n the course of repetitive work...she will have to have her arms elevated, her workstation unfortunately is not ergonomically modified, though a wrist rest was put in, but still it is a high counter, and she has to have a high chair because of her height and has to raise her arms up to constantly be using the upper extremities in the course of the work duties. She describes using the computer and various other activities related to repetitive motion work duties....The patient notes in her pain questionnaire, "pain in the right elbow...pain shooting up arm when picking up objects or putting down on surface..." The patient is very specific and descriptive about her difficulties radiating up and down both upper extremities.

Dr. Trudeau's interpretation of the EMG study was moderately severe interosseous neuropathy in the right proximal forearm (PINS)/radial tunnel syndrome, and mild to moderately severe median neuropathy at the right wrist (carpal tunnel syndrome). He further indicated that the petitioner may have lateral epicondylitis at the right elbow. He commented at length in his records about the ergonomic setup of the workstation as described to him by petitioner. (Pet. Ex. #1, deposition Ex. #4 at pps. 29-32).

The petitioner next consulted with Dr. Ronald Romanelli on a referral from Dr. Bleyer on August 11, 2010. Dr. Romanelli, a board certified orthopedic surgeon, had previously performed a right carpal tunnel release and right cubital tunnel release on the petitioner in 2006. (Pet. Ex. #1, p.7). At his deposition he testified that the petitioner gave him a history of recurrent pain and discomfort in her right elbow into the lateral aspect of the elbow, with pain radiating into the forearm from repeated keyboard and mouse usage at work. He also reviewed Dr. Trudeau's EMG report. He tested the posterior interosseous nerve, which was positive, and he diagnosed her with posterior interosseous nerve entrapment (PINS), some lateral epicondylitis, as well as the

prior ulnar nerve transposition and carpal tunnel release, and he noted a recurrent carpal tunnel finding in Dr. Trudeau's EMG report. (Pet. Ex. #1, pps 10-11 and deposition exhibit #4).

Dr. Romanelli recommended a modification of petitioner's workstation and rendered an opinion that the workstation as described to him by the petitioner and as depicted in photographs deposition exhibits 6A, 6B and 6C, as well as the work activities described in the employer's job description (deposition exhibit #7) and those activities posed in the hypothetical question from petitioner's attorney from 2005 through 2010, contributed to the entrapment of the nerves. (Pet. Ex. #1, pps. 11-19). More specifically, he testified how complete extension of the arms from reaching forward would put more pressure on her nerves than when the arms are at 45 to 90 degrees. (Pet. Ex. #1, pps. 12 and 19). He said he has heard this history from other employees at license bureaus. (Pet. Ex. #1, p. 24). He also opined that the job position, the typing, as well as the repetitive use was "compatible with the clinical symptoms and condition" for which she was being treated. (Pet. Ex. #1, p. 18). On cross examination, he testified that the anatomy, namely a thicker transverse ligament affects the development of PINS. (Pet. Ex. #1, p. 34).

Dr. Romanelli prescribed the modified work station, anti-inflammatory medications and wrist brace following his initial visit with the petitioner and saw her again September 10, 2010. His diagnosis did not change. The petitioner called with some additional complaints a few days later. He testified that the petitioner's arm was being overused, contributing to his ultimate recommendation for surgical nerve releases, as the petitioner's anatomy was being exacerbated by the repetitive conditions including her anatomy related to her prior surgeries of the right elbow and wrist. (Pet. Ex. #1, pps. 19-21). He did not believe her bowling activity was a causative factor. (Pet. Ex. #1, pps. 44-45).

On January 5, 2011, the respondent had the petitioner examined pursuant to Section 12 by Dr. James R. Williams, a board certified orthopedic and hand surgeon who in addition to his practice performed 20 to 24 Section 12 examinations in 2011. (Resp. Ex. #1, pps. 20-21). In his IME report and his later deposition testimony, he diagnosed the petitioner with right elbow lateral epicondylitis and possible recurrence of right carpal tunnel syndrome. He found no evidence of posterior interosseous nerve entrapment himself on examination or otherwise. Further, his opinion was that her work as described to him by her, as described in the same job description from respondent as shown to Dr. Romanelli at his deposition, and as depicted in photographs 6A, 6B, and 6C used at Dr. Romanelli's deposition, did not in any way cause her conditions of ill being he diagnosed her with, as the work duties did not involve vibration or any continuous repetitive work. (Resp. Ex. 1, including deposition exhibit #2). Other than a possible cortisone injection, Dr. Williams' treatment recommendations included an MRI perhaps and a counter force brace. He interpreted her EMG results in 2010 as better than her 2007 EMG results as further support of his opinion as to causal connection. Regarding bowling, he opined that an individual would have to bowl at least "several" times per week for it to result in lateral epicondylitis. (Resp. Ex. #1, p. 17).

After seeing Dr. Williams, the petitioner saw Dr. Michael Neumeister, a board certified surgeon in plastic surgery, on a referral by Dr. Bleyer on March 2, 2011. (Pet. Ex. #2, deposition Ex. #3 at p. 14). The history noted by Dr. Neumeister in that initial visit was less detailed than noted by her other doctors or Dr. Williams, consisting essentially of work as a "a typist" 8 hours per day, 5 days per week since 1985. He evaluated her for numbness and tingling in her hand, and pain that radiated down the extensor musculature from the elbow. (Pet. Ex. #2, pps. 8-9). His diagnosis was that she had lateral epicondylitis, radial tunnel, and significant carpal tunnel. (Pet. Ex. #2, p. 12). He initially recommended splints and therapy, and did not see the petitioner again thereafter until August 13, 2012. (Pet. Ex. #2, p. 12 and deposition Ex. #3).

On August 21, 2012, Dr. Neumeister performed a right radial tunnel release and tight carpal tunnel release after seeing the petitioner on August 13, 2012 based on the failure of conservative treatment measures. (Pet. Ex. #2, deposition Ex. #3). As part of his deposition testimony, he described a congenital condition over the nerve in the petitioner's radial tunnel that required ligation and cutting. (Pet. Ex. #2, pps. 26-30). He opined that the activities such as she described at work caused her symptoms in her right elbow and carpal tunnel. (Pet. Ex. #2,

pps. 29-30). He released her from care with a return to work as of October 2, 2012 although he saw her October 12, 2012 apparently; he testified that the petitioner was restricted to no use of the right hand/one handed duty or no work at all following her surgery till he released her to return to work. (Pet. Ex. #2, pps. 17-19).

The petitioner submitted medical bills into evidence at the hearing as follows:

Dr. Edward Trudeau, M.D. 07/26/2010 , $3,652.00 (Pet. Ex. #3)

Memorial Medical Center, 07/26/2010, $1,389.00 (Pet. Ex. #4)

Orthopaedic Center of Illinois/Dr. Romanelli, 08/11/2010, 09/10/2010, 10/22/2010,01/28/2011, $369.00 (Pet. Ex. #1, deposition Ex. #8)

SIU Healthcare/Dr. Neumeister 03/02/2011, 08/13/2012, 08/21/2012, 08/27/2012, 09/04/2012, $9725.00 (Pet. Ex. #2, deposition Ex. #4)

The total of the bills listed above is $15,415.00, and group insurance has paid portions of the bill(s)..

The Arbitrator finds that the job tasks described by the petitioner were a significant causative factor in the right elbow lateral epicondylitis and radial tunnel and right recurring carpal tunnel conditions based on the testimony of the witnesses, by a preponderance of the evidence. Despite the testimony of Dr. Williams and the differences in his opinions from those of the treating physicians, the evidence presented by the petitioner was sufficient to prove causal connection.

The Arbitrator finds that the EMG test date of July 26, 2010 is the appropriate accident date when the petitioner's injuries would have manifested themselves as diagnosed that date.

Regarding Temporary Total Disability, the petitioner is entitled to 5 6/7 weeks at a rate of $601.41 per week. The petitioner did receive two days of pay from the State Employee Retirement System, for which the respondent is entitled to credit subject to the indemnification provisions of the Act.

The Arbitrator finds that the medical expenses in petitioner's exhibits 1, 2, 3 and 4 are reasonable and necessary expenses and orders respondent to pay them, subject to the Medical Fee Schedule in Section 8.2 of the Act, with credit to respondent for bills paid by group health insurance as provided in Section 8 (j) of the Act and the respondent's obligation to petitioner for indemnification for said group insurance payments under the same section 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

Joseph Murphy,
Petitioner,

vs. NO: 06 WC 55273

Meta Tec,
Respondent.

14IWCC0758

DECISION AND OPINION ON REVIEW

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

The Commission notes that the Arbitrator's Order contains the following boilerplate language: "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." As the Commission has determined that Petitioner has not met his burden of proof to establish the essential elements of his claim, the Commission declines the remand the case to the Arbitrator for further proceedings and removes the above referenced paragraph in the Arbitrator's November 8, 2013 Order.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed November 8, 2013, is hereby affirmed and adopted.

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

14IWCC0758

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: SEP 0 8, 2014

Daniel R. Donohoo

Charles J. DeVriendt

Ruth W. White

o-08/27/14
drd/wj
68

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

MURPHY, JOSEPH
Employee/Petitioner

Case# **06WC055273**

META TEC
Employer/Respondent

14IWCC0758

On 11/8/2013, 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 0.08% 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:

4707 LAW OFFICE OF CHRIS DOSCOTCH
CASEY MATLOCK
2708 N KNOXVILLE AVE
PEORIA, IL 61604

2674 BRADY CONNOLLY & MASUDA PC
JULIA B McCARTHY
705 E LINCOLN SUITE 313
NORMAL, IL 61761

STATE OF ILLINOIS)
)SS.
COUNTY OF PEORIA)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

JOSEPH MURPHY ,
Employee/Petitioner

v.

META TEC ,
Employer/Responden

Case # 06 WC 55273

Consolidated cases: NONE .

14IWCC0758

An *Application for Adjustment 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 **July 10, 2013.** After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

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

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

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

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

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

G. [ ] What were Petitioner's earnings?

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

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

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

K. [x] Is Petitioner entitled to any prospective medical care?

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

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

N. [x] Is Respondent due any credit?

O. [ ] Other: _____

FINDINGS

On the date of accident, **December 4, 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 alleged accident *not* 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 **$54,119.52**; the average weekly wage was **$1,040.76**.

On the date of accident, Petitioner was **52** years of age, *married* with **no** dependent children.

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

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

Respondent shall be given a credit of $ **39,578.07** for TTD, $ **0.00** for TPD, $ **0.00** for maintenance, and $ **0.00** for other benefits, for a total credit of $ **39,578.07**.

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

ORDER

The Arbitrator finds that Petitioner failed to prove that he sustained an accidental injury that arose out of and in the course of his employment by Respondent on **December 4, 2006.**

The Arbitrator further finds that the condition of ill-being complained of is not causally related to the alleged accidental injury of **December 4, 2006.**

As no award of compensation or medical expenses exists in this matter, all claims made for credit by Respondent for such payments are hereby denied.

All claims for compensation made by Petitioner in this matter are thus hereby denied.

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

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

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

Signature of Arbitrator JOANN M. FRATIANNI

November 4, 2013
Date

ICArbDec19(b)

NOV - 8 2013

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

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

Petitioner testified that he injured himself on December 4, 2006 when he fell off a roof at work while shoveling snow. Petitioner testified he does not have any specific recollection of an accident on December 4, 2006.

Mr. Rick Hock was called to testify by Petitioner. Mr. Hock testified he is a co-employee of Petitioner. Mr. Hock testified he never saw Petitioner fall from the roof on that date. Mr. Hock further testified that Petitioner returned to work a few days later, walked to his desk, and logged into his computer using his password to check his e-mails.

Mr. Dave Suffern testified on behalf of Respondent. Mr. Suffern is the owner and CEO of Respondent. Mr. Suffern testified that Petitioner claimed he hung from the gutter and then fell from the roof. Mr. Suffern then went up to the roof to investigate, and found no indication of any type of damage or deformity to the gutter that would reflect an individual hanging from it.

Introduced into evidence were the emergency room records of OSF Medical Center dated December 4, 2006. These records do not indicate any physical findings of trauma to support a fall, specifically there was no evidence of any abrasions or trauma to the face or head. (Px2)

The medical records of Dr. Mattia reflect that doctor's uncertainty if the reported symptoms were organic due to inconsistencies during his examination. Dr. Mattia questioned the validity of any neurological deficit and found it curious that Petitioner reported he drove around town without a problem, remembered where he was going, and was not disrupted by jerks or tremors. (Px8)

Petitioner saw Dr. Obolsky. This examination was at the request of Respondent. Dr. Obolsky testified by evidence deposition (Rx1) that he examined Petitioner and made a detailed review of all medical records of treatment up to the date of his evaluation, or August 13, 2007. He completed his report on December 3, 2007. Dr. Obolsky testified he is board certified in forensic psychiatry, addiction and general medicine. Dr. Obolsky also reviewed reports of examinations by Dr. McManus, a neuropsychologist, and Dr. Itkin, a neurologist.

Dr. Obolsky testified he based his opinion on no physical markings or abrasions in the initial emergency room visit, no radiographic evidence to support a fall, of Petitioner's reported behavior on the date of the alleged fall of lying in the snow for an hour, then crawling to get help, followed by exhibiting eyes closed and grimacing to painful stimulus, which he felt was not consistent with an acute brain injury. Dr. Obolsky relied on the description of Mr. Hock of cognitive functioning ability following the alleged accident, which was inconsistent with Petitioner's subsequent cognitive functioning, and his fluctuating level of consciousness and behavior that was incompatible with objective medical evidence. Dr. Obolsky also noted that two days after the alleged fall, Petitioner exhibited no neurological symptoms such as gait problems or tremors, which he felt eliminated a causal linkage between the accident and the complained of neurological symptoms. Short term memory was noted to be intact two days after the alleged fall, contradicting Petitioner's complaints of short term memory loss.

Dr. Obolsky also noted that Petitioner's complaints to Dr. Alsorogi two days after the accident over difficulty with long-term memory in the context of an intact MMSE test cannot be scientifically explained by acute traumatic brain injury, and complaints of short-term memory deficit exhibited during Dr. Itkin's examination was also inconsistent with surveillance showing him driving. The MRI dated December 7, 2006 was described as being normal, and December 4, 2006 and January 30, 2007 brain CT scans were also described as being normal.

Dr. Obolsky felt that the expected course of symptom development and progression in cases of acute mild brain injury is for gradual symptom improvement and resolution, rather than fluctuating or worsening of symptoms with time. Dr. Obolsky noted that Dr. Mordhorst found only mild inefficiencies in information and attention processing and word finding six weeks after this alleged fall, and as such would eliminate any causative link between the alleged fall of December 4, 2006 and the cognitive complaints offered subsequent to that evaluation.

Dr. Obolsky noted in conclusion that the medical evidence did not support but refuted the presence of emotional and cognitive complaints caused by this alleged accident and felt he was malingering and did not require any further care or treatment.

Mr. Roger Wilkinson testified by evidence deposition (Rx2) in this matter. Mr. Wilkinson is the Mayor of Sparland. Mr. Wilkinson testified Petitioner has been employed as the water superintendent for the Village of Sparland for 16 years, and continued working in that department as of the date of the evidence deposition, or September 22, 2009. As part of Petitioner's job duties, he is required to drive a car or vehicle.

Based upon the above, the Arbitrator finds that Petitioner failed to prove that he sustained an accidental injury that arose out of and in the course of his employment with Respondent on December 4, 2006. This finding is based on the lack of corroborating evidence from other employees and medical providers.

Based further upon the above, the Arbitrator also finds that Petitioner failed to prove that the condition of ill-being alleged was caused by an injury at work for Respondent.

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

See findings of this Arbitrator in "C" and "F" above.

Based upon said findings, all claims made by Petitioner for medical expenses in this matter are hereby denied.

K. Is Petitioner entitled to any prospective medical care?

See findings of this Arbitrator in "C" and "F" above.

Based upon said findings, the Arbitrator further finds that all claims made by Petitioner for certain prospective medical care and treatment for this alleged injury are hereby denied.

N. Is Respondent due any credit?

See findings of this Arbitrator in "C" and "F" above.

As no awards of compensation or medical expenses are being made in this matter, all claims made by Respondent for credit are hereby denied.

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

Robert E. Todd,

Petitioner,

14IWCC0759

vs.

NO: 10 WC 09733

City of Springfield, Dept. of Public Works,

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, causal connection, prospective medical expenses, 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 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.

14IWCC0759

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: SEP 0 9 2014

David L. Gore

Stephen Mathis

Mario Basurto

DLG/gaf
O: 8/28/14
45

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

TODD, ROBERT E
Employee/Petitioner

Case# **10WC009733**

14IWCC0759

CITY OF SPRINGFIELD DEPT OF PUBLIC WORKS
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:

2046 BERG & ROBESON PC
STEVE W BERG
1217 S 6TH ST PO BOX 2485
SPRINGFIELD, IL 62705

0490 SORLING NORTHUP
GARY BROWN
1 N OLD CAPITOL PLZ SUITE 200
SPRINGFIELD, IL 62701

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)

14IWCC0759

ROBERT E. TODD
Employee/Petitioner

Case # 10 WC 9733

v.

CITY OF SPRINGFIELD DEPT. OF PUBLIC WORKS
Employer/Respondent

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Brandon J. Zanotti**, Arbitrator of the Commission, in the city of **Urbana**, on **October 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

14IWCC0759

FINDINGS

On the date of accident, **12/22/2009**, 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. (See Memorandum of Decision of Arbitrator, finding that Petitioner's right shoulder condition is causally related to the accident, but that all other problems claimed are not causally related to the accident).

In the year preceding the injury, Petitioner earned **$71,104.28**; the average weekly wage was **$1,367.39**.

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

Respondent shall be given a credit of **$55,794.85** for TTD, **$0** for TPD, **$35,790.63** for maintenance, and **$0** for other benefits, for a total credit of **$91,585.48**.

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

ORDER

Respondent shall pay for any outstanding medical invoices contained in Petitioner's Exhibit 2 that pertain to treatment received for Petitioner's right shoulder condition, pursuant to Section 8(a) of the Act and subject to the medical fee schedule, Section 8.2 of the Act. Prospective medical treatment is denied.

Respondent shall pay Petitioner temporary total disability benefits of $911.59 per week for 66 1/7 weeks, commencing November 24, 2010 through February 29, 2012, as provided in Section 8(b) of the Act, and subject to a credit of $55,794.85 (see above).

Respondent shall pay Petitioner maintenance benefits of $911.59 per week for 42 3/7 weeks, commencing March 1, 2012 through December 22, 2012, as provided in Section 8(a) of the Act, and subject to a credit of $35,790.63 (see above).

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

12/13/2013
Date

ICArbDec19(b)

DEC 20 2013

STATE OF ILLINOIS)
)SS
COUNTY OF CHAMPAIGN)

14IWCC0759

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

ROBERT E. TODD
Employee/Petitioner

v. Case # 10 WC 9733

CITY OF SPRINGFIELD DEPT. OF PUBLIC WORKS
Employer/Respondent

MEMORANDUM OF DECISION OF ARBITRATOR

FINDINGS OF FACT

Petitioner, Robert Todd, was employed by Respondent, the City of Springfield Department of Public Works (also known as City Water Light and Power, or CWLP), on the stipulated date of accident, December 22, 2009. Mr. Todd had been employed as a carpenter with Respondent since 1997.

On December 22, 2009, Petitioner testified that he and another employee were setting concrete forms to build a retaining wall. Another person was carrying the forms forward; Petitioner was walking backwards with the forms. Petitioner testified that the conditions were muddy and slippery and that he slipped and fell over backwards, landing on his back. When he got up, he slipped again. Petitioner testified that following that fall he had considerable pain in his neck, right shoulder and back. He continued to work.

Petitioner had suffered a prior injury to his right shoulder on December 19, 2007. He was trying to lift a concrete form. As a result of that accident Petitioner suffered a superior labral tear and full thickness tear of the interior and mid-portion of the supraspinatus. Petitioner underwent surgery for his right shoulder by Dr. Tomasz Borowiecki on May 21, 2008. Surgery consisted of a subacromial decompression, mini open Mumford procedure and a mini open rotator cuff repair. Following the accident of December 19, 2007, Petitioner was placed on permanent restrictions by Dr. Borowiecki of no lifting over 40 pounds, no overhead lifting and no repetitive motion/awkward positions, at least, in part, due to his right shoulder condition and a combination of his conditions resulting from the aforesaid injuries. (Respondent's Exhibit (RX) 13).

On July 28, 2003, Petitioner had suffered an accident while employed with Respondent. Petitioner filed an Application for Adjustment of Claim for that injury. (See Case Number 04 WC 5788). The case was tried and a decision was rendered by Arbitrator Jeffrey Tobin on November 2, 2009. Arbitrator Tobin awarded permanent partial disability benefits to the extent of 50% loss of use to the person as a whole under Section 8(d)2 of the Illinois Workers' Compensation Act, 820 ILCS 305/1 *et seq.* (hereafter the "Act"). Arbitrator Tobin found that Petitioner credibly testified to a number of problems with his left shoulder and arm, and that he had to forego activity such as golf, bow hunting, baseball, and activities with his grandchildren because of the injury in question. Petitioner had ongoing pain in his neck which limited his function and activities. Petitioner further

testified in that case that he had constant ongoing pain in his low back and continued to have symptoms that limited his activities. Petitioner also testified that he experienced symptoms in his left lower extremity, including his leg giving out and difficulty in sitting, standing and walking. He also noticed foot drop in his left foot. The Arbitrator takes judicial notice of the decision in Case Number 04 WC 5788. It is also noted that said case was affirmed by the Commission in Case Number 10 IWCC 475.

Petitioner began treating with Dr. David Fletcher following the accident at issue (*i.e.*, the accident of December 22, 2009). Dr. Fletcher noted that at the time of this accident, Petitioner was working under permanent restrictions resulting from a prior accident. (PX 27, p. 9).

Dr. Fletcher testified that on November 23, 2009, approximately one month prior to the accident in this case, Petitioner had multiple issues and his plan was to get some closure to his work injury of 2003. Dr. Fletcher testified that Petitioner had several ongoing problems at that time but that he was stable and he was not recommending any aggressive surgical intervention. The doctor was encouraging case closure with permanent work restrictions. (PX 27, pp. 9-10).

Dr. Fletcher first treated Petitioner subsequent to the present case on January 11, 2010. Dr. Fletcher testified that the only information he had regarding this accident was the history given to him by Petitioner, and that he had never seen any accident reports, investigation reports, or a Form 45. (PX 27, p. 11).

Petitioner gave Dr. Fletcher a history on that date (January 11, 2010) that Petitioner and a co-worker were carrying concrete, he slipped in the mud on his back, and fell trying to get back up. The record also notes that Petitioner's neck area had constant pain, his shoulder blade felt sharp and he stated that since the accident, his low back had eased. (PX 27, pp. 11-12).

Dr. Fletcher reviewed a pain drawing that was completed by Petitioner on January 11, 2010. It was Dr. Fletcher's interpretation that the symptoms consisted of lumbar radiculopathy, not so much in the way of surgical radiculopathy, and bilateral shoulder pain. (PX 27, pp. 13-14). Dr. Fletcher recommended physical therapy at that time. (PX 27, p. 15). Dr. Fletcher testified that there was a "little bit" worsening of the examination compared to how Petitioner was in November 2009, after the doctor was trying to emphasize that Petitioner was at maximum medical improvement (MMI). (PX 27, p. 16). It was Dr. Fletcher's opinion that the December 22, 2009 injury was an aggravation of a pre-existing condition. (PX 27, pp. 20-21).

Dr. Fletcher then saw Petitioner several months later in June 2010 to address problems Petitioner was having with his right shoulder. (PX 27, p. 23). Dr. Fletcher then referred Petitioner to Dr. Borowiecki. (PX 27, p. 24). Dr. Fletcher testified that he treated Petitioner for his cervical spine, lumbar spine, lower extremity problems and his shoulder during the time he was being treated by Dr. Borowiecki. (PX 27, p. 25). Dr. Fletcher last saw Petitioner in June 2011. (PX 27, p. 26). At that time, Dr. Fletcher did not know of any neurological deficit in Petitioner which he felt would require aggressive intervention. (PX 27, p. 26).

Dr. Fletcher testified that Petitioner was suffering from depression. (PX 27, pp. 30, 32). Dr. Fletcher noted that Petitioner had features of DSM IV depression throughout the care he had given him from 2008 forward, which pre-dates the accident at issue. (PX 27, p. 32). Dr. Fletcher discussed Petitioner's depression as it related to a functional capacity evaluation (FCE) report conducted by Memorial Industrial Rehab after which Petitioner was given permanent restrictions of lifting 50 pounds occasionally, 25 pounds frequently, overhead lifting of 10 pounds occasionally, no constant ladder climbing and 5 pounds frequent overhead work. (PX 27, pp. 33-34). The FCE in question (conducted on May 5, 2011) placed Petitioner at the medium physical demand

level. (PX 8, p. 3). It was Dr. Fletcher's opinion that Petitioner was unable to perform a normal scope of his job activities as a carpenter, but that he was not totally and permanently disabled. The doctor felt that Petitioner had work capacity as outlined in the FCE restrictions. (PX 27, p. 34).

Dr. Fletcher testified that during his examination of Petitioner on November 22, 2009, approximately one month prior to the accident at issue, Petitioner's lumbar radiculopathy was stable and the cervical radiculopathy was stable. Subsequent to Petitioner's accident on December 22, 2009, Dr. Fletcher again examined Petitioner and his office note reflects that there was no substantial change in his condition other than an increase of subjective complaints. (PX 27, pp. 38-39). Dr. Fletcher also testified that he did not have in his possession for the purposes of testifying a pain diagram pre-dating the accident of December 22, 2009. (PX 27, p. 40).

Dr. Fletcher testified regarding the MRI report ordered by Petitioner's primary care physician, Dr. Robert Juranek, and that he had not had an opportunity to review the MRI film to verify its findings. (PX 27, pp. 40-41).

Dr. Fletcher testified regarding Petitioner's low back injury following December 22, 2009, in that there were no other physicians treating Petitioner for his low back condition. (PX 27, pp. 46-48).

Following Petitioner's accident on December 22, 2009, Petitioner sought treatment for his right shoulder complaints with Dr. Borowiecki on August 5, 2010. Dr. Borowiecki conducted an examination. His impression was that Petitioner has suffered a recurrent impingement type symptom and possibly a re-tear of the rotator cuff. Dr. Borowiecki ordered an MRI and reviewed the findings. As he had suspected, Petitioner had re-torn his rotator cuff secondary to his injury of December 22, 2009. Dr. Borowiecki restricted Petitioner from work effective November 24, 2010. (PX 6).

On November 24, 2010, Dr. Borowiecki performed surgery consisting of a right shoulder arthroscopy, arthroscopic debridement of degenerative labral tearing followed by an arthroscopic subacromial decompression and bursectomy and mini open rotator cuff repair, as well as a biceps tenodesis utilizing two 5 mm anchors. Dr. Borowiecki prescribed physical therapy on November 30, 2010. (PX 6).

Petitioner then began a course of physical therapy at Midwest Rehab on December 9, 2010. Petitioner continued physical therapy at Midwest Rehab until April 7, 2011. In a treatment note dated March 31, 2011, Jessica Blackburn, the physical therapist, noted that Petitioner's shoulder range had improved, and that he was gradually advancing strengthening. He noticed that his shoulder felt much more limber following the therapeutic sessions, and motions throughout the day had eased. Petitioner had noted that his goals were to return to work at that time in a light duty capacity. (PX 7).

Petitioner continued to receive temporary total disability (TTD) benefits from Respondent. In response to correspondence by Petitioner's attorney, Petitioner was informed through his attorney that in response to their inquiries as to whether or not light duty was available for Petitioner, that Respondent replied that light duty was not available and that the case appeared ready for resolution. Respondent then sought a settlement demand. (PX 9).

Under date of March 7, 2012, Respondent's attorney received a letter from Steve Berg, Petitioner's attorney, inquiring as to whether work was available for Petitioner within his restrictions. Mr. Berg also stated that Respondent had sent a letter dated February 14, 2012 to Mr. Todd indicating that his TTD benefits would

be terminated as of March 1, 2012. Petitioner then stated that because Respondent did not have any work available for him, that he should be receiving maintenance benefits, and further that if Respondent was intent on trying to not make work available to Petitioner within his permanent restrictions, then he would request vocational rehabilitation efforts be initiated to see if there was some type of work Petitioner could perform given his current extensive restrictions at that time. (PX 11).

Dr. Juranek referred Petitioner to Dr. Paul Smucker of the Orthopedic Center of Illinois. Dr. Smucker conducted a physical examination of Petitioner on October 10, 2012, and found that Petitioner was in no acute distress, ambulated around the office without a limp, and that he stood erect. Visual inspection revealed no gross lumbosacral deformity, and hip ranging was free and painless bilaterally. Manual motor testing revealed 5/5 lower extremity strength, and reflexes were symmetric. Dr. Smucker ordered an EMG. It was Dr. Smucker's impression that Petitioner suffered from lumbar degenerative disc disease and radiculopathy. On March 1, 2013, Dr. Smucker continued to recommend an EMG, stating that Petitioner may be a candidate for a lumbar epidural steroid injection and additional physical therapy. He indicated that none were being pursued until they get some resolution with the workers' compensation issues which Petitioner was pursuing with his attorney. It appears that Petitioner was last seen by Dr. Smucker on October 7, 2013. At that time, Dr. Smucker recommended that Petitioner continue with his permanent restrictions that were already in place. (PX 15).

Petitioner testified that prior to his accident of December 22, 2009, he was treating with Dr. Fletcher for low back problems. Petitioner testified that there has not been a physician at any time recommending low back surgery.

Petitioner testified that prior to the accident of December 22, 2009, he had suffered from depression and had ongoing depression since his previous work-related accident of June 28, 2003, for which he received compensation for depression. He testified that since that accident, he has continued to be treated for depression. He testified that he has gotten worse since this accident. Petitioner testified that while undergoing the FCE on May 5, 2011, he hurt his left foot. He did not seek treatment from a foot specialist or anyone else for treatment to his left foot.

Petitioner testified at trial that if he cannot return to work for Respondent, that he does not want to work for any other employer. Petitioner testified that he felt like he could do something for Respondent. Petitioner was asked whether or not as a union member he had checked with the union whether there were any job postings. He confirmed that he had not.

Dr. Gunnar Andersson performed an examination at the request of Respondent pursuant to Section 12 of the Act on April 22, 2010. Dr. Andersson is board certified in orthopedic surgery in Sweden for life, and was certified in the United States in 1990 and 2001. He is currently up for re-certification at the current time. (RX 12, pp. 15-16). Dr. Andersson no longer performs surgery, as he lost the vision in his left eye. (RX 12, p. 5). He was provided medical records from Dr. Fletcher, Dr. Pencek and Dr. Juranek. (RX 12, p. 6).

Dr. Andersson testified that Petitioner told him that he had pain in the neck and lower back, and that his worst pain was in the neck. Dr. Andersson further testified that there was radiation of pain into the shoulders and numbness into the hands, and radiation into the left buttocks, thigh and calf. Petitioner also indicated that he had left side thigh and calf numbness. Dr. Andersson conducted a physical examination. He found that Petitioner walked normally, had normal posture, and was perhaps leaning his neck slightly forward. Petitioner had no tenderness and the doctor found range of motion of both the lower and upper back was near normal. Straight leg raising and Spurling's testing were both noted as negative. Upper extremity and lower extremity

reflexes were normal. There were motor or sensory changes in either the upper or lower extremities. Petitioner had normal hip motions. He had no positive and no organic physical signs. (RX 12, pp. 8-10).

Dr. Andersson also reviewed x-rays. He found that Petitioner had a fusion of the third and the fifth vertebrae in the neck with degenerative changes above and below the fusion area. Dr. Andersson testified that Petitioner had a long history of lower back problems, but not as severe as his neck problems. Dr. Andersson testified that about a month before the accident, Petitioner had seen Dr. Fletcher complaining about back and neck pain, which Dr. Fletcher described as stable. After the accident Petitioner again saw Dr. Fletcher. In his report, Dr. Fletcher stated that there was no significant change in Petitioner's condition compared to when he had seen him one month before the accident of December 22, 2009. Dr. Andersson conducted an examination approximately four months after the accident. (RX 12, pp. 10-11).

It was Dr. Andersson's opinion that Petitioner may have aggravated his pre-existing degenerative condition of the neck and shoulder, although a more likely diagnosis was lumbar and cervical strains. Dr. Andersson further stated in his report that Petitioner's most current symptomology is not related to the December 22, 2009 accident but rather to his pre-existing condition, which in all likelihood was not aggravated and if so, only temporarily, since by January 2010 his condition was back to the same condition as in November 2009. Dr. Andersson further opined that there was no need for treatment related to the December 22, 2009 accident, from which Petitioner had recovered. (RX 12, Dep. Exh. 2).

It was Dr. Andersson's opinion that Petitioner was capable of returning to the type of job he had before December 22, 2009, within the restrictions of lifting 40 pounds occasionally and limiting work above the shoulders. It was Dr. Andersson's understanding that those restrictions were permanent. Finally, it was Dr. Andersson's opinion that as of April 22, 2010, the date of his examination, Petitioner was at MMI. (RX 12, Dep. Exh. 2).

At Petitioner's request, on March 7, 2012, Respondent initiated vocational rehabilitation. (See PX 11). Respondent retained the services of the Triune Health Group to provide vocational rehabilitation services. Ms. Liala Slaise, MS, CRC, LPC, was assigned to assist Petitioner in finding suitable employment. (RX 15).

Ms. Slaise prepared an initial vocational report under date of March 30, 2012. She reviewed the medical records of Dr. Fletcher, Dr. Andersson, Dr. Borowiecki and the FCE dated May 5, 2011. Ms. Slaise scheduled a vocational assessment on March 28, 2012 at Mr. Berg's office, which was completed as scheduled. Petitioner and Mr. Berg were present and participated. Petitioner told Ms. Slaise that he had an interest in returning to work with Respondent. (RX 15).

Ms. Slaise testified that Mr. Berg contacted her on April 11, 2012, and informed her that Petitioner believed that he still had a job with Respondent and that he wanted to make sure all avenues were exhausted to be certain before he proceeded with vocational services. (See also RX 15). Ms. Slaise testified that she wanted to ensure that there were indeed no options to return to work with Respondent, and contacted Respondent's adjuster, who referred her the file. Ms. Slaise advised her of Petitioner's concerns and asked if there were any opportunities for Petitioner returning to work for Respondent. Ms. Slaise then testified that she was advised to place her file on "hold" status by Respondent while Respondent looked into the matter.

Ms. Slaise testified that she was told to re-open the file on October 8, 2012, at the direction of Respondent. Ms. Slaise was informed by Respondent that she was to proceed with assisting Petitioner to find alternate employment, as there was no work available from Respondent. Ms. Slaise scheduled a meeting at

Petitioner's attorney's office on November 16, 2012. Attorney Berg and Petitioner communicated that Petitioner was still medically treating and was not yet released to work.

Ms. Slaise testified that it was her impression that at that time, Petitioner was unsure if he could return to work as he was still treating with a doctor (Dr. Juranek), but agreed to let her proceed with job seeking skills training, which was preliminary work (*e.g.*, drafting a résumé, establishing interviewing skills, etc.). The process began on November 16, 2012. (RX 15).

During the meeting of November 16, 2012, Ms. Slaise asked Petitioner if he had looked for work. Petitioner responded that he believed that there was work available to him through Respondent. He again expressed interest in returning to Respondent's employment at that time. (RX 15).

Apparently, Petitioner had returned for treatment with his primary care physician, Dr. Juranek. A disability claims slip contained in Dr. Juranek's records appears to be dated February 8, 2013, which states that Petitioner should not lift greater than 25 pounds frequently or 50 pounds regularly. These appear to be permanent restrictions imposed by Dr. Juranek. Dr. Juranek felt that Petitioner could never resume work without restrictions. (PX 14, last two pages in exhibit).

Ms. Slaise asked Petitioner if he had looked for work. Petitioner answered that he believed he could work, and that work was still available for him with Respondent. He expressed interest in returning to work with Respondent on multiple occasions. Ms. Slaise testified that she still proceeded after their meeting with job seeking skill training, knowing that Petitioner desired to be returning to work with Respondent. Ms. Slaise stated that she had scheduled another meeting with Petitioner on November 30, 2012. She was contacted by Petitioner and informed that he had been directed not to attend the meeting because he was still under a doctor's care. (RX 15). At that point Ms. Slaise testified that she put her file on "hold" status again.

Subsequent to trial, the parties stipulated that the issue as to the amount of Petitioner's average weekly wage was no longer in dispute. Accordingly, the Arbitrator notes that Petitioner's average weekly wage is $1,367.39.

CONCLUSIONS OF LAW

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

Respondent is taking the position that Petitioner's lumbar condition is not related to the stipulated work accident. As set forth in the Findings of Fact section above, Petitioner first injured his low back on July 28, 2003, in which he filed an Application for Adjustment of Claim in Case Number 04 WC 5788. In that case, the arbitrator found that Petitioner had ongoing pain in his low back, and continued to have symptoms that limited his activities. It was also found that Petitioner experienced symptoms in his left lower extremity, including the leg giving out and difficulty sitting and walking. Dr. Fletcher, Petitioner's treating rehabilitation physician, was of the opinion that the present December 22, 2009 accident was an aggravation of the pre-existing injury. (PX 27, pp. 20-21).

Dr. Andersson performed an examination at the request of Respondent pursuant to Section 12 of the Act on April 22, 2010. It was Dr. Andersson's opinion that Petitioner may have aggravated his pre-existing degenerative condition, although a more likely diagnosis was lumbar and cervical strains. It was Dr. Andersson's opinion that Petitioner's most current symptomology is not related to the December 22, 2009

accident, but rather to his pre-existing condition, which in all likelihood was not aggravated, and if so, only temporarily, since by January 2010, his condition was back to the same condition seen in November 2009.

Based on the foregoing, the Arbitrator finds that Petitioner's current low back (or lumbar) and cervical conditions are not causally related to this accident. Based on a lack of credible evidence, the Arbitrator also finds that Petitioner's claimed ankle injury and alleged increased depression are not causally related to the work accident of December 2009. The Arbitrator finds that the right shoulder injury is, however, related to this accident.

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

As stated *supra*, Petitioner's current lumbar, cervical and ankle conditions are not causally related to the accident at issue. However, Petitioner's right shoulder condition is related to the accident at issue. The medical treatment Petitioner received for his right shoulder is found to be reasonable and necessary. Respondent shall pay for any currently unpaid medical invoices contained in Petitioner's Exhibit 2 involving Petitioner's right shoulder, subject to the medical fee schedule, Section 8.2 of the Act.

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

Petitioner is seeking an authorization for recommended medical treatment. It is not clear from the record in this case as to type of recommended medical treatment that Petitioner is requesting. While Petitioner underwent rehabilitation treatment for a number of years from Dr. Fletcher, that doctor has not medically treated Petitioner since June 2011. Dr. Borowiecki performed right shoulder surgery on Petitioner on November 24, 2010, consisting of a right shoulder arthroscopy, arthroscopic debridement of degenerative labral tearing followed by an arthroscopic subacromial decompression and bursectomy and mini open rotator cuff repair, as well as a biceps tenodesis utilizing two 5mm anchors. Following physical therapy and follow-up treatment with Dr. Borowiecki, that physician discharged Petitioner from his care on February 14, 2012. At that time, Dr. Borowiecki filled out a work form indicating his recommendation for a repeat FCE to determine Petitioner's ability to return to work.

Petitioner underwent an FCE. Petitioner demonstrated maximum effort and was cooperative throughout the evaluation. After reviewing the FCE, medical records charts, documentations, job description and other physician notes, Petitioner was not cleared for unrestricted work. He still has permanent restrictions in place by the surgeon of occasional lifting of 50 pounds, frequent lifting of 25 pounds, 10 pounds of occasional overhead lifting, no constant ladder climbing and 5 pounds frequent overhead lifting. There is no recommended medical treatment prescribed by Dr. Borowiecki at this time.

Petitioner has treated on a regular basis with his primary care physician, Dr. Juranek. However, Dr. Juranek does not outline any prescribed or prospective medical treatment at this time. It appears that Petitioner is not under active medical treatment which would be specific enough to order any prescribed medical tests or course of treatment. Therefore, based on the foregoing, Petitioner's request for prospective medical care is denied.

Issue (L): What temporary benefits are in dispute? (TTD; Maintenance)

Petitioner claims to be entitled to TTD/maintenance benefits from November 23, 2010 through October 17, 2013 (the date of hearing). Respondent is claiming credit for payment of TTD and maintenance benefits. (RX 20). Respondent's Exhibit 20 is a payment history of the TTD/maintenance payments made by Respondent to Petitioner.

Respondent paid Petitioner TTD benefits for the period of November 24, 2010 through February 29, 2012, in the total amount of $55,794.85, for which Respondent shall be given credit. Respondent paid maintenance benefits for the period of March 1, 2012 through December 22, 2012, in the amount of $35,790.63, for which Respondent shall also be given credit. (See RX 20).

There remains at issue unpaid TTD/maintenance periods from December 23, 2012 through October 17, 2013. The corresponding amount of TTD/maintenance benefits at issue is during the period of time that Respondent was attempting to provide vocational rehabilitation services in order to return Petitioner to a job within his permanent restrictions.

At Respondent's request, on March 7, 2012, Respondent initiated vocational rehabilitation. Respondent retained the services of Triune Health Group to provide vocational rehabilitation services, and Ms. Liala Slaise, MS, CRC, LC, was assigned to assist Petitioner in finding suitable employment. It is clear from the credible testimony of Ms. Slaise, as well as the testimony of Petitioner, that Petitioner would only return to work if he could find a suitable position with Respondent.

Ms. Slaise performed a labor survey and identified a number of suitable positions within Petitioner's permanent restrictions. Pursuant to the FCE, Petitioner could return to medium level work with lifting restrictions of 50 pounds occasionally and 25 pounds frequently. In her interviews with Petitioner, Petitioner told Ms. Slaise he felt work was available for him with Respondent, and that he wanted to return to work with only Respondent. As noted above, the Arbitrator finds the testimony of Ms. Slaise to be credible. Ms. Slaise was a credible witness at trial, and testified in an open and forthcoming fashion and endeavored to be giving the full truth during her testimony.

Petitioner testified at trial that he only wanted to return to work if he could return to work Respondent. Consequently, vocational rehabilitation efforts were suspended for a number of months, at which time Respondent made efforts to find a position for Petitioner. Respondent was unable to find a position for Petitioner within his restrictions at that time, and Petitioner continued to receive maintenance benefits during this period. Petitioner then took the position that he was unable to return to work in that his primary physician, Dr. Juranek, said he could not work. It is not clear from Dr. Juranek's off duty slip that Petitioner could not work in a light duty position. In fact he so stated. Dr. Borowiecki returned Petitioner to light duty work with permanent restrictions.

Petitioner has not proven entitlement to any maintenance or TTD benefits for this period of un-cooperation, March 18, 2012 through October 17, 2013. Therefore, Petitioner's claim for TTD/maintenance benefits for the period of March 18, 2012 through October 17, 2013 is denied.

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Edward Henschel,

Petitioner,

14IWCC0760

vs.

NO: 13 WC 12591

Nordstrom's,

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

FINDINGS OF FACTS AND CONCLUSIONS OF LAW

- Petitioner had started working for Respondent around the end of March 2009. On the date of accident Petitioner worked as a stock person. As a stock person, Petitioner processed shoes which involved lifting and transporting boxes that contained shoe boxes, stickering of shoes, and the transportation of merchandise, shipping and receiving. Petitioner testified lifting was 70-100% of his work day. Petitioner testified he lifted from 5 pound

boxes to full totes of boxes weighing 50 pounds or so. Petitioner lifted the totes from behind him on the plastic pallets to the workbench he used to break down and process. On the date of accident, January 31, 2012, Petitioner testified that he was lifting a heavy clear tote from a flatbed cart to put on a shelf. The totes are used for inventory and they weigh about 75 pounds. Petitioner testified that as he lifted he felt a slight tingling or like a slight pain sensation in his lower back. Petitioner finished his workday and went home for the evening. Petitioner testified that the following morning getting up, it was hard to move, get out of bed and walk; he just went to work. Petitioner stated it just continued to be very sore in his lower back and it seemed really stiff and just like a sharp pain. Petitioner continued working the following days and on February 6, 2012 Petitioner saw his family doctor, Dr. Bathala, who prescribed Flexaril. Petitioner returned to the doctor February 21, 2012 and at that time Petitioner reported to the doctor that his back pain was getting worse. The doctor prescribed Naprosyn and sent Petitioner for an MRI which was done March 7, 2012.

- Petitioner testified that he then received an e-mail from Lisa Orr, the workers' compensation coordinator for Respondent at corporate headquarters in Seattle. Petitioner testified that Ms. Orr directed him for further treatment with Dr. Anis Mekhail at Parkview Orthopedics. Petitioner attended therapy there on ten occasions between March 21 and April 9, 2012. Petitioner returned to Dr. Mekhail April 12, 2012 and he then explained to the doctor what he noticed about himself. Petitioner was examined and the doctor released him to full duty, him a home therapy exercise program and advised him to return in four weeks. Petitioner again saw Dr. Mekhail May 14, 2012 and he again advised the doctor of what he was noticing and the doctor examined him and released him to full duty and advised him to return as needed.

- On November 26, 2012, at Respondent's request, Petitioner was examined by Dr. Komanduri. Petitioner testified that after that examination, he did return to see Dr. Mekhail on February 25, 2013. Petitioner was still working full duty at that time. Petitioner had then advised the doctor of what he was noticing when he was working and told the doctor about the pain in his low back going down to his right buttock. Petitioner was sent by the doctor to Dr. Bayron, a pain doctor, who Petitioner saw March 18, 2013. Dr. Bayron prescribed Mobic and an epidural steroid injection (ESI) for Petitioner's lower back. Petitioner had an ESI to the right side of his low back from Dr. Bayron on April 5, 2013. Petitioner testified that the following day he was terminated from Respondent due to attendance issues.

- Petitioner testified that he found work 3-4 weeks later at Home Depot and was still working there. Petitioner returned to see Dr. Mekhail on July 29, 2013 and the doctor examined Petitioner and recommended an updated MRI. Petitioner stated that he wished to have that, but he did not yet have the MRI because it had not been authorized.

- Petitioner testified that currently, as he sat at hearing, he was trying to get in the right position. He stated that there is slight numbness and like a soreness around the right buttock, right side. Petitioner stated that with his activities at Home Depot, it varies from light soreness and tingling in the right lower back through his right buttock and sometimes like a tingling and numbness through his right leg into his foot. Petitioner testified he had not been examined by any doctors that told him that he should not have the updated MRI.

- On cross examination, Petitioner agreed that he was currently employed at Home Depot (hired at the end of April 2013). His job title there is inventory control (IC). He testified that his responsibilities are to see that the locations in the warehouse are systematically and physically the same. He stated that meant observing and looking at if there is the right amount of quantity physically in locations and systematically in those locations and if not fixing that systematically. Petitioner testified 'fixing it systematically' does mean that sometimes he has to move product from one area of the warehouse to another. Petitioner stated that he used a Crown forklift for that; using the forklift to move a pallet. Petitioner testified that he did not physically position a pallet once it was off the forklift. Petitioner does have to unload product from the pallets. Petitioner testified that the only things he physically moves off pallets are small, under 10-pound boxes that are too little to be on the pallets. Petitioner stated that he works 40 hours per week for Home Depot. Petitioner testified that he does not always use the forklift; sometimes it is just walking or mostly using the computer just to research the product that is in the areas. He stated they also have other co-workers that move it all, other than Petitioner.

- Petitioner testified that on January 31, 2012 while working at Respondent he felt the pain in his back when picking up and he reported it between 10:00 and 11:00am. Petitioner stated that his typical work hours at Respondent were 6:00am to 2:00 or 2:30pm. Petitioner agreed that he did not go to the emergency room that day or the next day. Petitioner indicated that since January 31, 2012 he had no reason not to be truthful with the medical providers and he had no reason to withhold symptoms he may have been experiencing. Petitioner agreed he had gone to therapy. He believed he stopped going to therapy April 12, 2012 and he had not received any additional physical therapy since then. Petitioner recalled having the MRI in March 2012. Petitioner recalled being seen by Dr, Komanduri about November 26, 2012. Petitioner testified that prior to seeing Dr. Komanduri he had no additional accident or incident that had caused him additional back pain. Petitioner testified he had no reason to not be truthful with Dr. Komanduri.

The Commission notes that Petitioner argued that a causal connection exists between the accident and the current condition of Petitioner's ill-being. Petitioner argued Respondent hand-picked Dr. Mekhail who found the MRI findings explained Petitioner's symptoms; Respondent's §12 IME noted the disc bulge and some impingement and stated it was consistent with the job

activity described. Petitioner argued both the treating doctor and IME doctor have causally related Petitioner's ill-being to the accident January 31, 2012 and Respondent offered no evidence of an intervening accident or a pre-existing condition and no doctor opined anything other than the accident caused Petitioner's condition of ill-being. Petitioner argued the chain of events demonstrates his prior good health, accident, and subsequent injury resulted in disability sufficient to prove causal connection. Petitioner requests the Commission find CC existed between the accident and the current condition of ill-being.

The Commission notes that Respondent argued that the decision of the Arbitrator should be affirmed; the decision was well reasoned and based on a thorough understanding of the evidence. Respondent stated the Arbitrator had an opportunity to evaluate credibility and observed there had been a work injury and that Petitioner's condition of his lumbar spine was partially causally related to the work injury. Respondent stated the additional MRI sought since being discharged at MMI would be duplicative and would only reveal new developments and problems of the lumbar spine since the discharge date. Respondent stated Petitioner has not presented a reason to overturn any aspect of the Arbitrator's decision. Respondent stated the award as written contemplates a lumbar spine injury that is causally connected to the claimed work injury of January 31, 2012. Respondent stated at the time of arbitration Petitioner's condition of ill-being was credibly said to be only partially related to the incident and Petitioner had already been discharged from care at MMI on May 14, 2012. Respondent stated Petitioner's opportunity to prove his case and prove a worsening of the condition after being discharged from care at MMI, as related to the work incident in question, was at arbitration and that Petitioner has not presented the Commission with a basis to overturn any aspect of the Arbitrator's decision.

Petitioner had started working for Respondent around the end of March 2009. On the date of accident Petitioner worked as a stock person. As a stock person, Petitioner processed shoes which involved lifting and transporting boxes that contained shoe boxes, stickering of shoes, and the transportation of merchandise, shipping and receiving. Petitioner testified lifting was 70-100% of his work day. Petitioner testified he lifted from 5 pound boxes to full totes of boxes weighing 50 pounds or so. Petitioner lifted the totes from behind him on the plastic pallets to the workbench he used to break down and process merchandise. On the date of accident, January 31, 2012, Petitioner testified that he was lifting a heavy clear tote from a flatbed cart to put on a shelf. The totes are used for inventory and they weigh about 75 pounds. Petitioner testified that as he lifted he felt a slight tingling, a slight pain sensation in his lower back. Petitioner finished his workday and went home for the evening. Petitioner testified that the following morning getting up, it was hard to move, get out of bed and walk; he just went to work. Petitioner stated it just continued to be very sore in his lower back and it seemed really stiff and just like a sharp pain. Petitioner continued working the following days and on February 6, 2012 Petitioner saw his family doctor, Dr. Bathala, who prescribed Flexaril. Petitioner returned to the doctor February 21, 2012 and at that time Petitioner reported to the doctor that his back pain was getting worse. The doctor prescribed Naprosyn and sent Petitioner for an MRI which was done March 7, 2012. Petitioner then received an e-mail from Lisa Orr, the workers' compensation coordinator for Respondent at corporate headquarters in Seattle. Petitioner testified that Ms. Orr directed him for

further treatment with Dr. Anis Mekhail at Parkview Orthopedics. Petitioner attended therapy there on ten occasions between March 21 and April 9, 2012. Petitioner returned to Dr. Mekhail April 12, 2012 and he then explained to the doctor what he noticed about himself. Petitioner was examined and the doctor released him to full duty, him a home therapy exercise program and advised him to return in four weeks. Petitioner again saw Dr. Mekhail May 14, 2012 and he again advised the doctor of what he was noticing and the doctor examined him and released him to full duty and advised him to return as needed. On November 26, 2012, at Respondent's request, Petitioner was examined by Dr. Komanduri. Petitioner testified that after that examination, he did return to see Dr. Mekhail on February 25, 2013. Petitioner was still working full duty at that time. Petitioner had then advised the doctor of what he was noticing when he was working and told the doctor about the pain in his low back going down to his right buttock. Petitioner was sent by the doctor to Dr. Bayron, a pain doctor, who Petitioner saw March 18, 2013. Dr. Bayron prescribed Mobic and an epidural steroid injection (ESI) for Petitioner's lower back. Petitioner had an ESI to the right side of his low back from Dr. Bayron on April 5, 2013. Petitioner testified that the following day he was terminated from Respondent due to attendance issues. Petitioner testified that he found work 3-4 weeks later at Home Depot and was still working there. Petitioner returned to see Dr. Mekhail on July 29, 2013 and the doctor examined Petitioner and recommended an updated MRI. Petitioner stated that he wished to have that, but he did not yet have the MRI because it had not been authorized. Petitioner testified that currently, as he sat at hearing, he was trying to get in the right position. He stated that there is slight numbness and like a soreness around the right buttock, right side. Petitioner stated that with his activities at Home Depot, it varies from light soreness and tingling in the right lower back through his right buttock and sometimes like a tingling and numbness through his right leg into his foot. Petitioner testified he had not been examined by any doctors that told him that he should not have the updated MRI.

The Commission finds that Petitioner's testimony is unrebutted. Petitioner's testimony of ongoing symptoms is supported in the records. Dr. Mekhail's May 2012, record finding Petitioner to be at MMI and releasing him to regular duty did note that Petitioner was still symptomatic after therapy and ESI. There was then a break in treatment until February 25, 2013. Respondent's November 2012 §12 IME had recommended further care with therapy and ESI. Petitioner did return to Dr. Mekhail on July 29, 2013 who recommended the updated MRI before further treatment (therapy and ESI). While there was somewhat of a break in treatment, the records, including the IME, indicated Petitioner having ongoing symptoms. There is no indication in either the treating records or the records of Respondent's examiner, that Petitioner's current complaints are not causally related to the January 31, 2012 accident. Furthermore, both Drs. Mekhail and Komanduri indicate that further medical care is needed. Clearly, as Dr. Mekhail indicated, an MRI may be in order before pursuing further medical care. There is one flag with Dr. Bathala (PCP), for an unrelated problem from December 4, 2012 - complaint of joint pain; left elbow. No injury. Constant pain; morning stiffness; worse with activities; Petitioner clearly presented for unrelated treatment to the elbow, that visit being about 6 months from Dr. Mekhail finding Petitioner at maximum medical improvement (MMI), but Petitioner denied back pain. That clearly does raise question as to whether or not Petitioner has truly been

symptomatic since January 31, 2012 or if his condition ebbed and flowed with some flare-ups periodically from everyday activities or other intervening aggravations.

The Commission finds that there are clearly indications of ongoing symptoms to support an ongoing causal connection despite the treater finding of MMI in May 2012. At the time of Dr. Mekhail's MMI finding he recognized and documented that Petitioner still had ongoing symptoms and may need further future care and that he may be more prone to injuring his back due to the herniation. The break in treatment of so many months does raise the question of whether Petitioner was just dealing with it or had minimal symptoms in the intervening period that were aggravated by something else during the intervening period. Petitioner's primary care physician clearly noted no back pain in December 2012. However, on March 18, 2013, Dr. Bayron noted that Petitioner had complaints of low back pain radiating to right buttock as well as numbness and tingling radiating right leg to ankle. His records indicated that Petitioner's pain started in January 2012 at work lifting heavy boxes; that therapy had helped some and that Petitioner had no ESI in past. Petitioner then was on Mobic and working full time and Dr. Bayron noted that Petitioner had a positive right straight leg raise. Dr. Bayron noted the MRI results and then indicated that Petitioner was a candidate for ESI. Petitioner then saw Dr. Mekhail in July 2013 who suggested a new MRI before any further treatment. There was also a note of Dr. Bathala that the patient said he was moving some stock around on February 20, 2012 and may have moved the wrong way and hurt his lower back again. thus supporting the doctors noting that Petitioner was at higher risk for injury with the bad disc and supporting the possibility of other aggravations along the way causing further symptoms.

The Commission finds that there was testimony of ongoing symptoms and medical records to support an ongoing causal connection. While there are a number of questions raised with the break in treatment, the apparent further development of later symptoms and findings, and the apparent ebb and flow of symptoms, to support the Arbitrator's findings; the opinions of Dr. Mekhail and Dr. Komanduri very clearly stated that Petitioner's condition of ill-being was due to the un-operated herniated lumbar disc that had not stabilized and that Petitioner's symptoms had indeed worsened as the doctors had predicted. Petitioner now does works for Home Depot and per his unrebutted testimony he does not have to lift as much, as mostly he uses a forklift to move inventory, but again his disc problem does make him more at risk for reinjury which may not require as much lifting to aggravate. The Commission finds that there is a clearly a preponderance of evidence of causal connection to Petitioner's current condition of ill-being and need for the currently recommended updated MRI and potential additional treatment from the January 2012 injury. While there is no specific medical opinion by any doctor that Petitioner's current condition is causally related, there is an unbroken causal chain evidenced in the unrebutted testimony and medical records. The evidence and testimony finds Petitioner met the burden of proving a causal connection to his current condition of ill-being and need for further medical testing and potential treatment. The Commission finds the decision of the Arbitrator as contrary to the weight of the evidence, and herein, reverses/modifies the decision to find Petitioner's current condition of ill-being to be causally related to the accident of January 31, 2013 and further modifies the decision, and herein, orders Respondent to authorize and pay for

14IWCC0760

the recommended MRI to determine if further treatment is needed to resolve or treat Petitioner's current condition of ill-being.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent authorize and pay for medical expenses related to the proposed MRI to determine if further treatment is still needed, 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.

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $5,000.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: SEP 0 9 2014
o-7/10/14
DLG/jsf

David L. Gore

Stephen Mathis

Mario Basurto

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

HENSCHEL, EDWARD
Employee/Petitioner

Case# **13WC012591**

14IWCC0760

NORDSTROM'S
Employer/Respondent

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:

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

5001 GAIDO & FINTZEN
JUSTIN KAUTER
30 N LASALLE ST SUITE 3010
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)

14IWCC0760

ILLINOIS WORKERS' COMPENSATION COMMISSION

19(b) ARBITRATION DECISION

EDWARD HENSCHEL
Employee/Petitioner

Case #13 WC 12591

v.

NORDSTROM'S
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 December 3, 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 January 31, 2012, the respondent was operating under and subject to the provisions of the Act.
- On this date, an employee-employer relationship existed between the petitioner and respondent.
- On this date, the petitioner sustained injuries that arose out of and in the course of employment.
- Timely notice of this accident was given to the respondent.
- In the year preceding the injury, the petitioner earned $26,000.00; the average weekly wage was $500.00.
- At the time of injury, the petitioner was 24 years of age and single with no children under 18.
- The respondent reserved their right to assert any entitlements to Section 8(j) credits.

ORDER:

- The petitioner's request for a second MRI is denied.
- In no instance shall this award be a bar to subsequent hearing and determination of an additional amount of temporary total disability, medical benefits, or compensation for a permanent disability, if any.

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

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

Robert E. Williams
Signature of Arbitrator

December 31, 2013
Date

DEC 31 2013

FINDINGS OF FACTS:

On January 31, 2012, the petitioner, a stock person, felt low back pain while lifting a tote. The petitioner complained of sharp back pain to Dr. Bathala of Primary Healthcare Associates Family Practice on February 6 and 22, 2012, and was prescribed medication. An MRI on March 7th revealed degenerative changes greatest at L4-5, where there was a diffuse disc bulge and a right central and right lateral recess disc protrusion abutting the exiting nerve roots causing mild to moderate bilateral neural foraminal stenosis. Dr. Anis Mekhail at Parkview Orthopedics saw the petitioner on March 15th and prescribed physical therapy for his assessment of axial back pain. The petitioner had ten physical therapy sessions from March 21st through April 9th. On April 12th, the petitioner reported back pain with intermittent right leg pain but an 80% improvement. Dr. Mekhail released the petitioner to full duty. On May 14th, Dr. Mekhail noted continued complaints of low back pain with intermittent numbness down his right leg. The doctor noted that the petitioner was at maximum medical improvement.

Dr. Mukand Komanduri evaluated the petitioner at the request of respondent on November 26, 2012, and opined that the petitioner's condition may intermittently worsen. He recommended conservative care and epidural injections. Dr. Bayran administered lumbar transforaminal epidural steroid injections on the right at L4-5 and L5-S1 on April 5, 2013. The petitioner's employment was terminated on April 6th. He found employment at a Home Depot three weeks later performing inventory control. On July 29th, the petitioner reported a gradual reoccurrence of his symptoms to Dr. Mekhail, who requested a second MRI. The petitioner currently complains of low back pain radiating to his right leg with occasional numbness and tingling.

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 low back is partially causally related to the work injury.

FINDING REGARDING PROSPECTIVE MEDICAL:

The petitioner failed to prove that the MRI recommended by Dr. Mekhail is reasonable medical care necessary to relieve the effects of the work injury. An MRI was performed on March 7, 2012, and revealed the petitioner's degenerative changes, disc protrusion and neural foraminal stenosis at L4-5. The petitioner received conservative care and was discharged at maximum medical improvement on May 14, 2012. A second MRI would only reveal any new developments or problems in his lumbar spine since his discharge on May 14, 2012. The petitioner's request for a second MRI is 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	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☐ Modify	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Dawn McGee,

Petitioner,

14IWCC0761

vs.

NO: 12 WC 38857

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

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

14IWCC0761

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 09 2014

DLG/gaf
O: 8/28/14
45

David L. Gore

Stephen Mathis

Mario Basurto

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

McGEE, DAWN
Employee/Petitioner

Case# **12WC038857**

14IWCC0761

JACKSONVILLE DEVELOPMENTAL CENTER
Employer/Respondent

On 4/8/2014, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.05% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

2333 WOODRUFF JOHNSON & PALERMO
JAY JOHNSON
4234 MERIDIAN PKWY SUITE 134
AURORA, IL 60504

1745 DEPT OF HUMAN SERVICES
BUREAU OF RISK MANAGEMENT
PO BOX 19208
SPRINGFIELD, IL 62794-9208

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

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

APR 8 2014

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

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)

14IWCC0761

Dawn McGee
Employee/Petitioner

Case # 12 WC 38857

v.

Consolidated cases: n/a

Jacksonville Developmental 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 Springfield, on February 18, 2014. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

14IWCC0761

FINDINGS

On the date of accident, March 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.

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

In the year preceding the injury, Petitioner earned $40,496.04; the average weekly wage was $778.77.

On the date of accident, Petitioner was 40 years of age, married with 2 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 $20,841.91 for TTD, $0.00 for TPD, $0.00 for maintenance, and $0.00 for other benefits, for a total credit of $20,841.91.

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

ORDER

Respondent shall pay reasonable and necessary medical services as identified in Petitioner's Exhibits 8, 9, 10 and 11 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 prospective medical treatment including, but not limited to, knee surgery as recommended by Dr. Brett Wolters.

Respondent shall pay Petitioner temporary total disability benefits of $519.18 per week for 44 5/7 weeks commencing January 24, 2013, through December 3, 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)

March 31, 2014
Date

APR 8 - 2014

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 March 19, 2012. According to the Application, Petitioner was injured at work and sustained injuries to the neck, head, left hand, right knee and body. This case was tried in a 19(b) proceeding and Petitioner sought an order for payment of temporary total disability benefits and medical as well as prospective medical treatment. Respondent disputed liability on the basis of accident and causal relationship.

Petitioner worked for Respondent as a housekeeper and, on March 19, 2012, she was assaulted by a mentally retarded resident of the facility. For no apparent reason, this individual struck Petitioner in the neck and kicked her several times in the right upper shin and knee area. Petitioner sustained a number of soft tissue injuries as a result of the accident; however, most of the injuries totally resolved shortly after the accident. The primary injury was to Petitioner's right knee.

Petitioner testified that she had a prior right knee problem when she was a child and described the condition as being "knock-kneed" and that she wore orthopedic shoes. When treated for these prior right knee symptoms as a child, no surgery was either recommended or performed. Petitioner also stated that she received some physical therapy in 2006 for right knee symptoms which included popping but, again, no surgery was either recommended or performed.

Following the accident of March 19, 2012, Petitioner was seen at Midwest Occupational Health Associates that same day by Dr. Robert Gordon. The initial diagnoses were neck contusion, left hand trauma/crush injury, left elbow contusion and right knee/shin contusion. Dr. Gordon recommended application of cold packs and prescribed medication. Petitioner continued to be treated by Dr. Gordon primarily for right knee pain. When Dr. Gordon saw Petitioner on April 21, 2012, he noted that she had lost approximately 21 pounds and had been working out and walking. Because of her continued right knee complaints, Dr. Gordon ordered a CT scan. When Dr. Gordon saw Petitioner on April 23, 2012, he noted that the CT scan revealed Grade II chondromalacia of the patellofemoral and tibialfemoral joints. When Dr. Gordon saw Petitioner on May 3, 2012, he recommended that she be seen by an orthopedic specialist (Petitioner's Exhibit 2).

Petitioner was referred to Dr. Brett Wolters, an orthopedic surgeon, associated with Springfield Clinic. Petitioner was initially seen by Dr. Wolters' Physician's Assistant on May 8, 2012. Petitioner informed the Physician's Assistant of the work-related accident of March 19, 2012, and the medical treatment she received thereafter. The Physician's Assistant examined Petitioner and gave her an injection. Dr. Wolters subsequently saw Petitioner on June 22, 2012 and, at that time, Dr. Wolters examined Petitioner and reviewed the CT scan. He opined that Petitioner had patellofemoral chondromalacia and patellofemoral syndrome of the right knee. He recommended arthroscopic surgery (Petitioner's Exhibit 3).

Dr. Wolters performed arthroscopic surgery on October 15, 2012, and the procedure consisted of a patellar chondroplasty (Petitioner's Exhibit 13). Petitioner saw Dr. Wolters on October 23,

2012, and she complained about some grinding behind her knee cap and knee pain. Dr. Wolters ordered physical therapy but noted that if she did not improve he would seek authorization for a right knee arthrotomy DeNovo Articular Cartilage Allograft Transplant (Petitioner's Exhibit 3).

In the fall of 2012, Jacksonville Developmental Center closed and Petitioner got a job with another state agency, Kid Care. She started working at Kid Care in December, 2012.

Petitioner's right knee condition did not improve to any significant degree and, on January 24, 2013, Dr. Wolters performed a DeNovo Articular Allograft Transplant. This is a cartilage transplant procedure. Following this second knee surgery, Dr. Wolters ordered physical therapy and authorized Petitioner to be off work (Petitioner's Exhibit 4).

Petitioner testified that following the second knee surgery she initially had some improvement of her right knee symptoms. Unfortunately, the right knee pain returned and the knee began to catch and pop.

At the direction of Respondent, Petitioner was examined by Dr. Timothy Farley, an orthopedic surgeon, on May 20, 2013. In connection with his examination of Petitioner, Dr. Farley reviewed medical records provided to him by Respondent. Dr. Farley opined that Petitioner had right knee patellar chondromalacia. In regard to causality, Dr. Farley opined that there was not a causal relationship between the condition and the accident of March 19, 2012. This opinion was based on his noting that the medical records for treatment Petitioner received shortly after the accident did not indicate that Petitioner had any swelling or bruising about the knee that would indicate sufficient trauma to cause a chondral injury (Respondent's Exhibit 1; Deposition Exhibit 2).

Petitioner continued to be seen by Dr. Wolters; however, Petitioner's right knee condition did not improve. When Dr. Wolters saw Petitioner on August 27, 2013, Petitioner still complained of popping/grinding in the knee and pain that increased with activity. Dr. Wolters opined that there was a possibility of delamination of the cartilage. He recommended another arthroscopic surgery, chondroplasty and evaluation of the cartilage (Petitioner's Exhibit 5).

Petitioner testified that she received temporary total disability benefits through October 31, 2013. At that time, Respondent terminated payment of benefit based on Dr. Farley's Section 12 examination.

Petitioner was seen by Dr. Wolters on December 4, 2013 and Dr. Wolters released her to return to work without restrictions. Petitioner testified that Dr. Wolters released her to return to work because she could no longer afford to be off work. Petitioner stated that at work she has performed filing and computer work and is able to sit down for good portion of the workday. Squatting and stooping increase her knee symptoms and she does get various co-workers to assist her on a regular basis. Petitioner testified that she did participate in a 5K walk for charity in June, 2012, which caused an increase in her knee symptoms; however, she denied sustaining any type of reinjury to the knee. Petitioner does want to proceed with the surgery recommended by Dr. Wolters.

Dr. Farley was deposed on December 3, 2013, and his deposition testimony was received into evidence at trial. Dr. Farley's testimony was consistent with his medical report and he reaffirmed his opinion that there was not a causal relationship between Petitioner's right knee condition and the accident of March 19, 2012. On cross-examination, Dr. Farley agreed that there was no prior treatment recommendation regarding the right knee and that a kick to the knee can cause chondral damage (Respondent's Exhibit 1).

Dr. Wolters was deposed on January 17, 2014, and his deposition testimony was received into evidence at trial. In regard to causality, Dr. Wolters testified that the accident may have caused, aggravated or accelerated the condition in the knee that caused the need for surgery. He also stated that the lack of bruising or swelling in the knee did not mean that there was not a chondral injury. He testified that he usually does not see bruising in chondral injuries and sometimes observes swelling, but not always. He also stated that Petitioner's participation in a 5K walk did not caused her to sustain any new injury (Petitioner's Exhibit 1).

Conclusions of Law

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

The Arbitrator concludes that Petitioner sustained an accidental injury arising out of and in the course of her employment for Respondent on March 19, 2012.

In support of this conclusion the Arbitrator notes the following:

Petitioner testified that she was assaulted by a mentally ill patient who struck Petitioner in the neck and kicked her several times in the right upper shin and knee area. This testimony was unrebutted.

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 March 19, 2012.

In support of this conclusion the Arbitrator notes the following:

Petitioner was kicked in the upper right shin and knee area several times and sought medical treatment immediately thereafter. While Petitioner had some prior right knee symptoms as a child and received physical therapy in 2006, no surgical procedures were either recommended or performed.

Petitioner's treating physician, Dr. Wolters, opined that the accident of March 19, 2012, could have caused or aggravated the condition of ill-being in the right knee. Respondent's examining physician, Dr. Farley, opined that there was not a causal relationship based primarily on the lack of bruising and swelling of the knee shortly after the accident.

Dr. Farley agreed that a kick to the knee could cause chondral damage. Dr. Wolters testified that he did not usually see bruising in chondral injuries and sometimes, but not always, observed swelling.

The Arbitrator finds the opinions of Petitioner's treating physician, Dr. Wolters, to be more persuasive than those of Respondent's Section 12 examiner, Dr. Farley.

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

The Arbitrator concludes that all of the medical services were reasonable and necessary and that Respondent is liable for payment of the medical bills incurred therewith.

Respondent shall pay reasonable and necessary medical services as identified in Petitioner's Exhibits 8, 9, 10 and 11, as provided in Sections 8(a) and 8.2 of the Act, subject to the fee schedule. Respondent shall be given a credit of amounts paid for medical benefits that have been paid, and Respondent shall hold Petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act.

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

The Arbitrator concludes Petitioner is entitled to prospective medical treatment including, but not limited to, the knee surgery recommended by Dr. Wolters.

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 44 5/7 weeks commencing January 24, 2013, through December 3, 2013.

In support of this conclusion the Arbitrator notes the following:

Petitioner's treating physician, Dr. Wolters, authorized Petitioner to be off work during this period of time.

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

Steve Lindsey,

Petitioner,

14IWCC0762

vs.

NO: 11 WC 24522

State of Illinois, IYC Harrisburg,

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, 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 October 23, 2013 is hereby affirmed and adopted.

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

DATED: SEP 0 9 2014

David L. Gore

Stephen Mathis

Mario Basurto

DLG/gaf
O: 8/28/14
45

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

LINDSEY, STEVE
Employee/Petitioner

Case# **11WC024522**

14IWCC0762

SOI/IYC HARRISBURG
Employer/Respondent

On 10/23/2013, 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:

0969 THOMAS C RICH PC
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FAIRVIEW HTS, IL 62208

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

0558 ASSISTANT ATTORNEY GENERAL
AARON L WRIGHT
601 S UNIVERSITY AVE SUITE 102
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0498 STATE OF ILLINOIS
ATTORNEY GENERAL
100 W RANDOLPH ST
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CHICAGO, IL 60601-3227

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

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

OCT 23 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

14IWCC0762

Steve Lindsey
Employee/Petitioner

v.

SOI/IYC Harrisburg
Employer/Respondent

Case # 11 WC 24522

Consolidated cases: N/A

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Gerald Granada**, Arbitrator of the Commission, in the city of **Herrin**, on **8/15/13**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

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On **6/17/2011**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$67,008**; the average weekly wage was **$1,288.62**.

On the date of accident, Petitioner was **60** years of age, *married* with **0** dependent children.

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

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

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

Respondent is entitled to a credit of **any medical benefits paid through its group carrier** under Section 8(j) of the Act.

ORDER

Because Petitioner failed to meet his burden of proof on the issue of accident, this claim 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

10/18/13
Date

OCT 23 2013

FINDINGS OF FACT

This is a claim for benefits in which the Petitioner is alleging that he sustained injuries to both of his hands and arms as a result of repetitive trauma. The issues in dispute at trial were accident, notice, causation, liability for medical expenses, and TTD. The parties stipulated that the Petitioner was working for the Respondent on June 17, 2011 and was 60 years old at the time. Despite the issues in dispute, the Respondent agreed to the periods of TTD alleged and has indicated that it has paid all TTD.

Petitioner testified that he works as a Juvenile Justice Specialist at the Illinois Youth Center-Harrisburg and at the time of his trial had worked there since July 1995. He described his job duties while working in the Respondent's Drug Unit as well as his job duties in the In-Take Unit. During direct examination there was a considerable amount of testimony about his job duties on the drug unit. His testimony was at times he would turn keys upwards of 250 to 300 times a day. He would also use his hands for pulling keys and pulling doors. Petitioner also provided a written job description that he prepared. In his written job description he describes having to perform key turning "from 40-80 times a shift to upwards of 200 times a shift." He testified that he does not use Folger Adams keys during the day. His testimony on direct and then on cross examination was folger adams keys were used eight to ten years before the date of his trial. He also testified he performed shakedowns of the youth but these were only done on a monthly basis. In addition to his duties in the Drug Unit, Petitioner also worked directly with youth in the Intake Unit, where he described having to work all day with the youth, often times without any assistance. In this unit, Petitioner described having to interact with the youth during their various activities, including providing instruction, providing spots for weight-lifting and demonstrating certain activities. Additionally, Petitioner would have to prepare hand-written reports, which he explained would take up to 2 hours.

Petitioner testified his alleged injuries began in recent years when he was working on the Drug Unit. On the recommendation of his attorney, Petitioner went to see Dr. Paletta. Petitioner prepared a hand-written, detailed job description in which he describes "an average day." (PX 8) In this hand-written job description, he details the various times he has to use a key, and concludes his written description by indicating "the average 172 repetitive key turns and door pulls," to describe the amount of times he has to turn keys and pull doors. (PX 8) Although there was no testimony as to when the Petitioner's job description was prepared, it appears that this report was prepared prior to the Petitioner seeing Dr. Paletta. Petitioner testified that he did not know his injury was work related until after seeing Dr. Paletta

On June 17, 2011, Petitioner first saw Dr. Paletta on referral from his attorney. The initial history taken by Dr. Paletta states: "[h]e noted the onset of these symptoms back as early as 2002. However, it has really been in the last three years that he has noted an increase in the symptoms." (PX 3). Dr. Paletta further indicated, "I cannot really elicit any objective signs of carpal tunnel on exam today." (PX 3) There is very little mention of his actual job duties contained within his initial note. Dr. Paletta diagnosed Mr. Lindsay with "persistent bilateral carpal tunnel and cubital tunnel syndrome, right greater than left." Dr. Paletta recommended Petitioner undergo an EMG, which Petitioner sought from Dr. Phillips.

On June 17, 2011, Petitioner underwent an EMG by Dr. Phillips. (PX 4) The report prepared by Dr. Phillips that day indicates "there is relatively moderate demyelinative sensory motor median neuropathy across the right carpal tunnel and mild medial sensory neuropathy across the left carpal tunnel. The right ulnar motor conduction velocity falls at the lower limits of normal and the left is in the lower ranges of normal." (PX 4)

On July 7, 2011, Dr. Paletta prepared a report entitled "EMG and Nerve Conduction Study Results." (PX 3) In this report, Dr. Paletta indicates the following in the "Impression" section of said report: "1. Moderately severe

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carpal tunnel syndrome, right greater than left. 2. Cubital tunnel syndrome with mild ulnar nerve electrophysiologic changes." (PX 3) On October 1, 2011, Dr. Paletta conducted surgery addressing Petitioner's right-sided cubital tunnel and carpal tunnel. On November 22, 2011, Dr. Paletta conducted surgery to address Petitioner's left-sided cubital tunnel and carpal tunnel. Dr. Paletta indicated that Petitioner had an excellent outcome following these procedures. Dr. Paletta subsequently testified via evidence deposition that he believed Petitioner's carpal and cubital tunnel syndrome was related to Petitioner's job activities as described by the Petitioner. Dr. Paletta did confirm during his testimony that the Petitioner's Tinel and Phalen tests were negative. He also admitted that he did not know the frequency of Petitioner's job activities.

On October 2, 2012, Petitioner underwent a section 12 exam by Dr. Anthony Sudekum. (RX 4) Dr. Sudekum also testified via evidence deposition on September 13, 2012. (RX 5) He had a detailed analysis of the job description as well as, other documents from the State of Illinois regarding the job duties of the Petitioner. He also examined the Petitioner individually. Dr. Sudekum opined the Petitioners condition was not caused by his job duties. Dr. Sudekum attributed Petitioner's carpal tunnel syndrome to his co-morbid factors, including obesity, age, hypertension and his outside activities of bicycling and golf. Dr. Sudekum did not believe Petitioner had cubital tunnel syndrome based on the negative EMG findings from Dr. Phillips. He believed Dr. Paletta's conclusions regarding the EMG findings were a "gross misstatement" of Dr. Phillips' findings.

CONCLUSIONS OF LAW

The Arbitrator finds that the Petitioner has failed to meet his burden of proof on the issue of accident. This finding is based primarily on the lack of credibility underlying Petitioner's claim. Petitioner's testimony that he did not know his conditions were work related until he saw Dr. Paletta on referral from his attorney, are disingenuous given that the records seem to indicate the following series of events: Petitioner had been complaining of carpal tunnel symptoms for years prior to his alleged accident date; instead of seeking medical attention from his own medical provider, Petitioner was directed by his attorney to see Dr. Paletta; before seeing Dr. Paletta, Petitioner prepared a detailed, hand-written job description indicating the number of times he would turn a key or pull a door at work; Dr. Paletta issued a report on June 17, 2011 providing the diagnosis of carpal and cubital tunnel syndromes and indicated they are work-related. Additionally, Petitioner's written job description fails to mention all the time Petitioner spends with the youth as per his own testimony. Based on the evidence as a whole, the Petitioner's job duties are varied in nature and do not require constant, repetitive and prolonged use of his hands as evidenced by Petitioner's own description of spending time to interact with the youth. The Arbitrator finds even more troubling, the question of credibility on Dr. Paletta's part. Petitioner's claim is built on Dr. Paletta's findings and diagnoses. Dr. Paletta's initial report makes reference to his own inability to elicit signs of carpal tunnel syndrome on that day. Dr. Paletta then orders an EMG, despite the negative physical testing. The EMG report is negative for cubital tunnel and shows only very mild carpal tunnel findings. At this point, to support his diagnoses, Dr. Paletta misstated the findings of the EMG report prepared by Dr. Phillips by indicating Petitioner had moderately severe carpal tunnel and also had evidence of cubital tunnel syndrome. Dr. Paletta's credibility was further eroded during his cross-examination by Respondent's counsel, in which many of these questionable points were brought to light. For these reasons, the Arbitrator finds credible the opinions of Dr. Sudekum given the questionable evidence provided by both the Petitioner and Dr. Paletta.

Accordingly, this claim is denied and all other issues are rendered moot.

STATE OF ILLINOIS)
) SS.
COUNTY OF JEFFERSON)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

William Unthank,

Petitioner,

14IWCC0763

vs.

NO: 07 WC 02961

David Stanley Consultants,

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, 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.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed January 23, 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.

14IWCC0763

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $16,900.00. 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: SEP 0 9 2014

David L. Gore

Stephen Mathis

Mario Basurto

DLG/gaf
O: 8/28/14
45

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

UNTHANK, WILLIAM
Employee/Petitioner

Case# **07WC002961**

DAVID STANLEY CONSULTANTS
Employer/Respondent

14IWCC0763

On 1/23/2014, 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:

5236 CULLEY FEIST KUPPART & TAYLOR
KREIG B TAYLOR
617 E CHURCH ST SUITE 1
HARRISBURG, IL 62946

2250 LAW OFFICE OF STEPHEN H LARSON
BRUCE J MAGNUSON
940 W PORT PLZ SUITE 208
ST LOUIS, MO 63146

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

14IWCC0763

William Unthank
Employee/Petitioner

v.

David Stanley Consultants
Employer/Respondent

Case # 07 WC 02961

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 Mt. Vernon, on November 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 _____

14IWCC0763

FINDINGS

On June 12, 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, in part, causally related to the accident.

In the year preceding the injury, Petitioner earned $25,590.24; the average weekly wage was $492.12.

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 $76,302.03 for TTD, $0.00 for TPD, $0.00 for maintenance, and $5,314.86 for other benefits (PPD payment), for a total credit of $81,616.89.

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

ORDER

Respondent shall pay reasonable and necessary medical services as identified in Petitioner's Exhibit 29 for medical services provided to Petitioner from June 12, 2006, through December 6, 2010, but not thereafter, as provided in Sections 8(a) and 8.2 of the Act subject to the fee schedule.

Respondent shall pay Petitioner temporary total disability benefits of $328.08 per week for 232 5/7 weeks, commencing June 13, 2006, through January 4, 2007, and January 10, 2007, through December 6, 2010, as provided by Section 8(b) of the Act.

Respondent shall pay Petitioner permanent partial disability benefits of $295.27 per week for 75 weeks because the injuries sustained caused the 15% loss of use of the body as a whole as provided in Section 8(d) 2 of 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
ICArbDec p. 2

January 17, 2014
Date

JAN 23 2014

radiation into the right buttocks and leg. On clinical examination, most of the findings were normal with the exception of the presence of right-sided muscular spasm in the right upper lumbar region to the ilium. Dr. Kovalsky opined that Petitioner had healing transverse process fractures and could not return to work. He recommended physical therapy with a transition to work hardening and that it would take three to four months for the symptoms to resolve (Respondent's Exhibit 2).

Petitioner began physical therapy on October 5, 2006. Petitioner continued to treat with Dr. Ewell. When Dr. Ewell saw Petitioner on November 14, 2006, he noted that Petitioner ceased physical therapy because of the pain. He then referred Petitioner to Dr. Kee Park, a neurosurgeon (Petitioner's Exhibit 1).

Dr. Park evaluated Petitioner on December 13, 2006, and Petitioner continued to complain of low back pain with radiation into the right leg. Dr. Park's findings on clinical examination were benign and Dr. Park found no evidence of disc herniation or nerve root compression. Because of Petitioner's complaints, he authorized Petitioner to remain off work until he reviewed the MRI. Dr. Park subsequently reviewed the MRI and, in his office record of January 3, 2007, he noted that the MRI was essentially normal. He authorized Petitioner to return to work at full duty (Petitioner's Exhibit 23).

Petitioner was seen by Dr. Ewell on January 10, 2007, and Dr. Ewell recommended that Petitioner have work hardening. Petitioner participated in work hardening at Harrisburg Medical Center between January 15, and February 7, 2007 (Petitioner's Exhibit 16). When seen by Dr. Ewell on February 13, 2007, Petitioner informed him that work hardening was not helping. Dr. Ewell referred Petitioner to Dr. Gurpeet Padda, a pain management doctor (Petitioner's Exhibit 2).

Dr. Padda saw Petitioner on March 1, 2007, and, at that time, he administered injections in the facet joints at three levels. Dr. Padda's record stated that Petitioner experienced an immediate reduction of his symptoms; however, at trial, Petitioner testified that the injections made the pain worse.

Petitioner was seen by Dr. Ewell on March 13, 2007, and he advised Dr. Ewell that the treatment provided by Dr. Padda did not help him at all. Dr. Ewell then referred Petitioner to Dr. Kirk Price, a physician associated with the Neck and Back Pain Clinic. Dr. Price treated Petitioner on six occasions in March, 2007 (Petitioner's Exhibit 21). Petitioner continued to be seen by Dr. Ewell throughout the remainder of 2007. Dr. Ewell continued to authorize Petitioner to remain off work.

At the direction of the Respondent, Dr. Kovalsky examined Petitioner again on May 7, 2008. In connection with his examination, Dr. Kovalsky reviewed Petitioner's medical records and noted that the MRI performed in July, 2006, was normal. Dr. Kovalsky's findings on clinical examination were normal; however, he recommended Petitioner have a CT scan performed to make certain that the transverse process fractures had healed. He restricted Petitioner to light duty work with a 30 pound lifting restriction and no repetitive bending, lifting or twisting (Respondent's Exhibit 2).

Petitioner continued to be treated by Dr. Ewell in 2008. Dr. Ewell ordered another CT and MRI scan which were performed on November 10 and November 11, 2008, respectively. The studies did reveal some minimal disc bulging without neural compression and the old healed transverse process fractures but no acute findings (Respondent's Exhibit 8).

At the direction of the Respondent, Petitioner was examined again by Dr. Kovalsky on January 21, 2009. Dr. Kovalsky reviewed the CT and MRI scans that had just been performed in November, 2008, and stated that they were both unremarkable. He opined that Petitioner's injuries had healed; however, because Petitioner had not worked for a significant period of time he recommended Petitioner undergo a three month period of work conditioning/hardening. Dr. Kovalsky anticipated that Petitioner would then be at MMI and able to return to work full duty (Respondent's Exhibit 2).

Petitioner started a program of work hardening at Farrell Hospital on May 4, 2009. Petitioner attended work hardening four times, canceled two appointments and was a no-show for two appointments (Petitioner's Exhibit 20). On June 19, 2009, the physical therapist at Farrell informed the Petitioner that he was expected to give his full effort and, at that time, the Petitioner informed him that the doctor had made a mistake in ordering work hardening and that the facility was "working for comp." Petitioner ended his participation in work hardening at that time (Petitioner's Exhibit 19).

Petitioner continued to be seen by Dr. Ewell from May through June, 2009. Dr. Ewell's findings and conclusions remained essentially the same.

At the direction of the Respondent, Dr. Kovalsky examined Petitioner on September 23, 2009. Dr. Kovalsky reviewed additional medical records regarding Petitioner's treatment. Again, Dr. Kovalsky's findings on clinical examination were normal and he also observed that Petitioner was exaggerating his symptoms. He recommended that Petitioner have a functional capacity evaluation (FCE) performed. Dr. Kovalsky subsequently reviewed the FCE that was performed on October 2, 2009, but he questioned its validity on the basis that it was obtained at the request of Petitioner's attorney and it may not have been thorough enough (Respondent's Exhibit 2).

Dr. Kovalsky subsequently prepared another report also dated September 23, 2009, regarding his review of surveillance videos of Petitioner that were obtained on June 9 and June 10, 2009. Dr. Kovalsky noted that the video of June 9, 2009, showed Petitioner performing power washing of a building, climbing ladders, bending and lifting. Dr. Kovalsky noted that Petitioner did not exhibit any signs of being in distress while performing these activities. Dr. Kovalsky again concluded that Petitioner was exaggerating his symptoms and that the work limitations imposed by the FCE were not valid (Respondent's Exhibit 2).

Petitioner had another FCE performed on March 31, 2010. While the FCE report stated that Petitioner was limited to lifting and carrying of 40 and 35 pounds, respectively, the individual who administered the FCE also questioned the reliability and accuracy of the FCE findings because of the variable levels of effort exhibited by the Petitioner during the testing procedure (Petitioner's Exhibit 22).

At the direction of the Respondent, Dr. Kovalsky examined Petitioner again on September 22, 2010, and, after reviewing the report of the FCE of March 31, 2010, he prepared his final report of November 18, 2010. Dr. Kovalsky again described a normal clinical examination of Petitioner, that there were positive Waddell's signs and that Petitioner's complaints of pain were out of proportion with the findings. He opined that Petitioner was at MMI, no further treatment was indicated and that Petitioner could return to work without restrictions (Respondent's Exhibit 2). Based on this report, Petitioner terminated payment of TTD benefits effective December 6, 2010, at which time a copy of the report was tendered to Petitioner's counsel.

Petitioner has continued to treat with Dr. Ewell from 2010 through the most recent visit of August 28, 2013. Dr. Ewell has continued to prescribe medication and authorize Petitioner to remain off work.

Dr. Kovalsky was deposed on October 18, 2011, and his deposition testimony was received into evidence at trial. Dr. Kovalsky's deposition testimony was consistent with his medical reports and he reaffirmed his opinion that as of his examination of September 22, 2010, Petitioner was at MMI, did not require further medical treatment and could return to work without restrictions (Respondent's Exhibit 1).

At the direction of his attorney, Petitioner was examined by Dr. David Volarich, on June 8, 2011. Dr. Volarich is an osteopathic physician with a specialty in nuclear medicine and performs medical examination/evaluations. Dr. Volarich opined that, as a result of the accident of June 12, 2006, that Petitioner sustained a lumbar right leg radicular syndrome and transverse process fractures at L2, L3 and L4.

Dr. Volarich was deposed on July 5, 2012, and his deposition testimony was received into evidence at trial. Dr. Volarich opined that Petitioner could return to work but with restrictions of no bending, twisting, lifting, pushing, pulling, carrying, climbing and similar tasks (Petitioner's Exhibit 28). On cross-examination, Dr. Volarich agreed that there was no muscular spasm present and that Petitioner informed him that, since the accident, he had not been able to do yard work and drive his mud truck (Petitioner's Exhibit 28).

Petitioner testified that he has an eighth-grade education and has considerable difficulties reading. At his attorney's direction, Petitioner was evaluated by Jack Strader, a vocational rehabilitation expert, on September 20, 2010. Strader reviewed medical records, obtained a vocational/work history from Petitioner and administered a variety of tests. He opined that Petitioner was not employable based on his injuries, limited work capacities and academic abilities. Strader was deposed on July 23, 2013, and his deposition testimony was received into evidence at trial. Strader's testimony was consistent with his report; however, he agreed on cross-examination that Petitioner was able to establish and run his own business and that he had to rely on Petitioner's complaints and the medical provided to him (Petitioner's Exhibit 26). Given the date of his evaluation, Strader did not have, and therefore did not consider, Dr. Kovalsky's final medical report.

Dr. Ewell was deposed on April 11, 2013, and his deposition testimony was received into evidence at trial. Dr. Ewell testified that he is a family doctor and he is not board certified in any medical field. Dr. Ewell has continued to treat Petitioner primarily with medication and has authorized Petitioner to remain off work because of his complaints. He agreed that the transverse process fractures were completely healed and that Petitioner did not have a herniated disc (Petitioner's Exhibit 14).

Petitioner testified that he has continued to treat with Dr. Ewell who has authorized him to remain off work. Petitioner testified he spends most of his day on the couch and that he no longer engages in bike riding, basketball or football with his children. On cross-examination, Petitioner admitted to power washing a building in June, 2009. Petitioner also testified that one of his hobbies is "mud running." Mud running is a competitive racing event in which the participant drives a vehicle from one end of a muddy area to another to see how far they can go. Petitioner owns a Chevrolet Blazer with big wheels and raised suspension as well as a pickup truck that he uses in participating in these mud running events. Petitioner agreed that he had been participating in these mud running events for about 10 years and that he participated in a number of them from 2008 through 2011.

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, in part, causally related to the accident of June 12, 2006.

In support of this conclusion the Arbitrator notes the following:

The Arbitrator finds that Petitioner sustained fractures of the right transverse processes of L2, L3 and L4 as a result of the accident of June 12, 2006.

In addition to the transverse process fractures, the Arbitrator finds that Petitioner sustained a low back strain/sprain as a result of the accident of June 12, 2006, and that Petitioner reached MMI with respect of both of these conditions on September 22, 2010.

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

The Arbitrator concludes that all of the medical services provided to Petitioner through December 6, 2010, were 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 29 for medical services provided to Petitioner from June 12, 2006, through December 6, 2010, but not thereafter, 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 noted herein, Petitioner was at MMI on September 22, 2010; however, the report of Dr. Kovalsky opining that Petitioner was at MMI on September 22, 2010, was not tendered to Respondent's counsel until December 6, 2010.

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

The Arbitrator concludes Petitioner is entitled to temporary total disability benefits of 232 5/7 weeks commencing June 13, 2006, through January 4, 2007, and January 10, 2007, through December 6, 2010.

In support of this conclusion the Arbitrator notes the following:

Dr. Park examined Petitioner on December 13, 2006, on referral from Dr. Ewell, and, after reviewing the MRI scan, opined in his office note of January 3, 2007, that Petitioner could return to work without restrictions.

Dr. Kovalsky opined in his report of November 18, 2010, that Petitioner was at MMI and could return to work. This report was tendered to Petitioner's counsel on December 6, 2010.

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 15% loss of use of the body as a whole, this includes the compensation owed to Petitioner for the fractured transverse processes.

In support of this conclusion the Arbitrator notes the following:

As previously stated, Petitioner sustained fractures to the right transverse processes of L2, L3 and L4 as a result of the accident and is entitled to compensation pursuant to Section 8(d)2 of the Act.

Petitioner claimed to be permanently and totally disabled as a result of the accident; however, the Arbitrator finds the evidence in the record does not support this claim. At best, Petitioner has sustained a low back strain/sprain in addition to the fractured transverse processes.

The Arbitrator finds the opinions of Respondent's Section 12 examiner, Dr. Kovalsky, to be more persuasive and credible than those of Petitioner's primary treating physician, Dr. Ewell, and Petitioner's Section 12 examiner, Dr. Volarich. Dr. Kovalsky is an orthopedic specialist and is more qualified than both Dr. Ewell and Dr. Volarich. Further, Dr. Kovalsky examined Petitioner on multiple occasions; reviewed medical reports/records, diagnostic studies and FCE reports and ultimately released Petitioner to return to work without restrictions.

Petitioner has undergone numerous diagnostic studies including, MRI and CT scans and he has never been diagnosed with a disc herniation or any condition that would require surgery. Dr. Park, a neurosurgeon, evaluated Petitioner on December 13, 2006, at the request of Petitioner's treating physician, Dr. Ewell, and subsequent to his review of the MRI, found no evidence of a

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 June 12, 2006. According to the Application, Petitioner was working on a belt crew and he slipped while crossing the belt and sustained an injury to the low back and multiple fractures. Respondent stipulated that Petitioner sustained a work-related accident; however, Respondent disputed liability on the basis of causal relationship. Petitioner claimed to be permanently and totally disabled and that he was entitled to an additional period of temporary total disability benefits and medical bills.

Petitioner worked for Respondent as a member of the "belt crew." This required Petitioner to work underground and he and the other members of the crew were required to set up the belts for moving coal, lift buckets that weighed 100 pounds or more, and various other tasks that required pushing/pulling and repetitive bending. On June 12, 2006, Petitioner was waiting for power to be restored and when he attempted to climb over the belt, he lost his balance and fell landing on a roller. When Petitioner fell, he struck the right side of his low back.

Petitioner initially sought medical treatment at the ER of Harrisburg Medical Center. X-rays of the lumbar spine were taken which revealed some mild degenerative bony changes but were otherwise normal. Petitioner complained of low back pain with radiation into his right leg. Petitioner was diagnosed with an acute myofascial strain, given some medication and instructed to see Dr. Kimball Ewell, a family physician (Petitioner's Exhibit 15).

Petitioner was seen by Dr. Ewell on June 15, 2006. Dr. Ewell diagnosed Petitioner with a lumbosacral strain and authorized him to be off work. When Dr. Ewell saw Petitioner on June 21, 2006, he diagnosed sciatica and referred Petitioner to Dr. Charles Hester, a chiropractor, for therapy. Petitioner was treated by Dr. Hester from June 26, through August 9, 2006 (Petitioner's Exhibits 1 and 17).

At Dr. Ewell's direction, an MRI scan of Petitioner's lumbar spine was performed on July 11, 2006. The scan was negative for disc herniations/bulges, stenosis and compression of neural structures. When Dr. Ewell saw Petitioner on July 26, 2006, he noted that the MRI was negative and his diagnosis remained back strain with sciatica (Petitioner's Exhibit 1).

Petitioner continued to see Dr. Ewell and, because of his continuing complaints, Dr. Ewell ordered a CT myelogram. This procedure was performed on August 30, 2006, which revealed old healed fractures of the right transverse processes of L2, L3 and L4, a minimal anterior disc bulge at L4-L5, mild spondylosis and atherosclerosis (Respondent's Exhibit 9). When Dr. Ewell saw Petitioner on September 21, 2006, he noted the presence of the fractures of the transverse processes and opined that Petitioner did not have a "surgical problem" and that, hopefully, with physical therapy Petitioner would be able to return to work in the near future (Petitioner's Exhibit 1).

At the direction of Respondent, Petitioner was examined by Dr. Don Kovalsky, an orthopedic surgeon, on September 27, 2006. At that time Petitioner complained of low back pain with

disc herniation or nerve root compression and opined that Petitioner could return to work without restrictions.

Petitioner was noncompliant and uncooperative at work hardening at Farrell Hospital in May and June, 2009.

Petitioner's testimony regarding his ongoing symptomatology and inability to return to work lacks credibility and is contrary to his observed use of a power washer (the video as noted by Dr. Kovalsky and admission of Petitioner on cross-examination) as well as his continued participation in mud running events from 2008 through 2011, a period in which he claimed to be totally disabled.

The Arbitrator finds the opinion of Petitioner's vocational expert, Jack Strader, to be without probative value because it is based on medical opinions and the Petitioner's statements of inability to work, both of which the Arbitrator has found not to be persuasive or credible.

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 up	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Edward Kolkovich,

Petitioner,

14IWCC0764

vs.

NO: 11 WC 01296

Basler Electric 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, temporary total disability (TTD), medical expenses, and permanent partial disability (PPD) and being advised of the facts and law, modifies the Decision of the Arbitrator as stated below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

FINDINGS OF FACTS AND CONCLUSIONS OF LAW

- Petitioner was a 62 year old employee of Respondent, who described his job as a machine shop worker. Petitioner indicated his job was to do whatever they had to do. He made cabinets and they did a lot of in-house work. Petitioner indicated that he used a drill press and a break press; worked with metal and was on his feet all day at work utilizing different tools. On the date of accident, May 11, 2010, Petitioner testified that he went to get a fixture to drill the little brass pieces as they solder the pieces. Petitioner stated that when he stepped up he felt his LEFT knee crunch and then something popped (indicating the lower part of the left knee) and pulled something into his groin. Petitioner was initially referred to the company doctor, Dr. Fulton, who eventually referred Petitioner to Dr. Felix Ungacta. When Dr. Ungacta saw Petitioner, Petitioner had an MRI done that revealed that Petitioner had a problem in his LEFT knee and Dr. Ungacta scheduled

surgery. Petitioner testified that about four days (about Saturday) after the June 8, 2010 (Tuesday) surgery, Petitioner began to have problems in his left calf. Petitioner saw Dr. Nyquist from Dr. Fulton's office and was then admitted to St. Joseph's Hospital. Petitioner indicated that he had initially called Dr. Ungacta's office on Monday but got no answer. Petitioner stated that when he called on Tuesday, they had Petitioner go to the emergency room and he was admitted to the hospital. The hospital ran tests and discovered that Petitioner had a bilateral pulmonary embolism and clotting in his LEFT calf/knee. Petitioner was transferred to Barnes-Jewish Hospital (6/18/10) and there they inserted filters to keep the clots from migrating up towards his vital organs. After Petitioner was treated at Barnes Petitioner he returned under the care of Dr, Ungacta. During that time Petitioner was still having problems with his LEFT knee; Petitioner testified that at that time the RIGHT knee was no problem. Petitioner stated that prior to his May 2010 accident his right knee was fine.

- Petitioner was seen for a §12 examination, at Respondent's request, by Dr. Gross on November 11, 2010. Petitioner testified that they (Petitioner and his wife) had gone for the exam. Petitioner stated that he had filled out some papers and the receptionist went over things with them. Petitioner testified that he shook hands when he met the doctor and the doctor stated that he hoped he doesn't hurt Petitioner. Petitioner stated that he just kind of laughed and Petitioner told the doctor he hoped the doctor did not hurt him either. Petitioner stated they went into the exam room and the doctor had him get on the table. Petitioner testified that all the other doctors had treated his knee with care. Petitioner testified that after he got on the table, the doctor kind of grabbed Petitioner's foot and heel with both hands. Petitioner stated the doctor was nicer with his left leg first and then the doctor actually got violent with Petitioner's right leg. Petitioner testified that as the doctor was performing the exam on his right leg, it hurt and then all of a sudden, Petitioner stated that his right knee popped out. Petitioner testified that the doctor said, 'look, I can even pop this knee out.' Petitioner stated that it popped out twice and that he didn't what he said but he stated that he had hollered "awe" a couple of times. Petitioner stated that the doctor said he had to do the evaluation. Petitioner stated that the doctor popped it out again, then more push and pull, and then he, the doctor, popped it out two more times. Petitioner testified that his wife was there sitting about four to six feet away from Petitioner at the time. Petitioner stated that there was a therapist that stood overhead also. Petitioner testified that after the examination was completed the doctor showed him the x-rays. Petitioner testified that when he walked towards the room, his right leg hurt. After they were shown the x-rays, Petitioner indicated that the therapist took him in a room and said she was going to tell Petitioner what kinds of exercises he could do to help his leg now. Petitioner testified that after the exam the doctor walked them out towards the elevator. Petitioner stated that after he walked out and got into the car his right leg was hurting and that he almost rolled into a car at a stop sign because it was giving away again. Petitioner stated that he told his wife that if he could not drive with his left foot on the brake then she would have to drive.

- Petitioner testified that he called Dr. Ungacta's office the next day and left a message, but the doctor was gone. Petitioner stated he had talked to the nurse and that he had also seen his family doctor as he had a regular check-up and he told his doctor about it. Petitioner

testified regarding his RIGHT leg problems that they did not calm down after the exam with Dr. Gross; it never went away. Petitioner testified in the days following that exam he fell. Petitioner stated that he had been walking to get the mail, about 100 feet, and he found himself laying on the ground. Petitioner stated at first he thought he tripped or slipped as he was pre-occupied, he did not know what had happened the first few times he fell, but then he knew that it was his knee. Petitioner stated that it was similar to not having strength on the brake on the way home from the exam. Petitioner testified that he never had any problems with his knee giving away prior to that examination. Petitioner stated that he had office visits after with Dr. Ungacta who looked at his right knee. Petitioner testified that at that time he had pain on the inside of his right knee **(medial side indicated)** where it had popped. Petitioner testified that the right knee pain was a constant pain and that sometimes when he is walking it gives away and many times he cannot catch himself. Petitioner stated that sometimes if he is not paying attention, all of a sudden he finds himself on the floor. As to his LEFT knee, Petitioner stated that hurts too, but nowhere as bad as his right knee.

- Petitioner had also been seen by Dr. Frank Petkovich. Petitioner had originally been scheduled to see Dr. Gross for an additional §12 examination, but Respondent agreed to change doctors and sent Petitioner to Dr. Petkovich instead. Petitioner stated that Dr. Petkovich seemed to be concerned, was decent and knowledgeable and moved Petitioner's leg with some consideration. Petitioner indicated that when Dr. Petkovich checked his left leg, Petitioner felt the movement, but that Dr. Petkovich did not grab him and slide him back and forth on the table to where he had to grab the sides to hold on. Petitioner testified that Dr. Petkovich showed consideration. Petitioner indicated the difference in exams was Dr. Petkovich being 5% violent and Dr. Gross being 95% violent. Petitioner indicated that he had been examined by Dr. Ungacta and he was 95% better/easier on Petitioner than Dr. Gross. Petitioner testified his overall feeling after Dr. Gross' exam was terrible; Petitioner indicated that he could not believe a man who is supposed to repair people would do what he did. Petitioner testified that after he saw Dr. Ungacta, he was taken off work from February 15 to March 1, 2011 for the right knee.

- Petitioner eventually voluntarily left employment with Respondent. Petitioner stated when he fell at work he had asked his boss to go to the emergency room and the boss said he had to make a phone call to Lisa Gurner. Petitioner understood she told the boss to tell Petitioner that whatever happened it did not happen there. Petitioner testified the fall was more of his knee giving out. Petitioner stated that he chose not to return as he was worried about safety of his knee, his life.

- On cross examination, Petitioner testified that his left knee was not too bad; he stated that it hurts and sometimes he just stays in the house. Petitioner does follow up with his family doctor, Dr. Poirot with Mt. Olive Family Practice Center. He agreed with the 3/23/12 record from there indicating the doctor said "The patient feels well with minor complaints (knee pain complaints)." Petitioner indicated it is still persistent and actually a little worse now. Petitioner denied having any left or right leg problems prior to this injury and he had no non-work related problems with either leg. Petitioner indicated that after the 2 weeks, February-March 2011, when he was taken off work for the right knee,

he did not return to Respondent. Petitioner stated he told them he was quitting and he retired after that; Petitioner stated that he had called to tell Respondent that. Petitioner indicated that it was after that Friday when he fell into the grinder and asked his boss, Dick Smith, if he could go to the ER and his boss called Lisa. Petitioner stated that was the last time he was at Respondent. It was after that he went to the doctor and was taken off for the 2 weeks. Petitioner agreed that there was work available for Petitioner after that but he chose not to return to work for Respondent. Petitioner testified at the time he fell into the grinder, other than his knees he had no unrelated health problems that affected him. Petitioner had no medical treatment regarding his knees during this year; he had a shot from Dr. Beyer the year before or so (records indicated last Dr. Beyer December 11, 2011).

- Petitioner testified that when he had been examined by Dr. Gross he had complained to Dr. Gross. Petitioner indicated he would dispute if Dr. Gross said Petitioner did not complain of pain at that time. Petitioner stated that he was hollering and screaming and he thought that would be a sign and Petitioner asked him why he had to do what he was doing.

- Mrs. Kolkovich, Petitioner's wife, testified for Petitioner. She had attended Petitioner's §12 examination with Dr. Gross. Mrs. Kolkovich testified that Dr. Gross and a therapy person came in the exam room, and the doctor introduced himself and began the exam. She stated it was very forceful and painful for Petitioner. Mrs. Kolkovich stated the doctor actually took 2 hands on Petitioner's lower right leg, and then went up towards his stomach with it and started rotating it. Mrs. Kolkovich stated that there was audible popping and Petitioner yelled out and grabbed the table. Mrs. Kolkovich stated that the therapy girl's eyes were then locked with hers and Mrs. Kolkovich stated that she had to look away from what he was doing and was hopeful he would not do that to Petitioner's left leg. She indicated when she looked away Petitioner was moaning and the doctor told Petitioner he was sorry he hurt him. Mrs. Kolkovich indicated that after the exam they sat in the room because the therapy girl mentioned something about showing Petitioner some exercises for the left leg and then a nurse or nurse practitioner came in and said no and escorted her out. Petitioner and Mrs. Kolkovich sat there and the doctor came back in and said he would show them out; the office was very complex, in and out. Mrs. Kolkovich testified that they had taken the x-rays for the doctor to review and when they went to the other room for the doctor to review the x-rays she stated that Petitioner was limping, like his left leg was suddenly better than the right. Mrs. Kolkovich testified that she observed that after the exam Petitioner could not stand or walk on it good anymore. She stated that Petitioner was slow before but then Petitioner was even slower and she did not know how they were going to get home. She stated that she was thankful that Petitioner had been laid off at that time because she knew there was no way he could have worked from the pain that he was in. Mrs. Kolkovich testified that she had observed Petitioner having a give way sensation and that he will grab things that would support him in the house. Ms. Kolkovich stated that Petitioner had never done that before. She testified Petitioner never before the injury had any trouble with his legs.

- Depositions were taken of Petitioner's Dr. Ungasta and Respondent's §12 examiners, Dr.

Petkovich and Dr. Gross.

The Commission notes that the LEFT leg injury, accident, and causal connection were not disputed.

The Commission finds that Petitioner testified of his accident and resulting left knee injury. Petitioner's testimony is unrebutted. There was no right knee or shoulder injury noted from this accident and, in fact, the Application for Adjustment of Claim only noted injury to the left leg/knee. As to the shoulder, there is absolutely no evidence of anything arising from the accepted injury to warrant shoulder treatment. There is clearly established a causal relationship between the accident and Petitioner's condition of ill-being regarding his left knee as an aggravation of his underlying degenerative arthritic condition that ultimately resulted in the left knee surgery and need for the other care for the post operative complications of DVT and a pulmonary emboli. While Petitioner testified regarding his right knee, Petitioner clearly had similar degenerative arthritic changes in his right knee as he did on the accepted left knee condition. The Commission notes that Dr. Ungacta opined Petitioner has mild to moderate arthritis in both knees and with that condition any minor trauma can cause a prolonged pain in the knee after you aggravate a knee that already has arthritis. Dr. Ungacta believed Petitioner's condition is one of baseline arthritis with aggravation or initiation/aggravation of his symptoms after that physical examination. Dr. Ungacta's initial deposition testimony indicated that Dr. Gross's exam did not cause the right knee condition; however, after he reviewed his assistant's note he said it was possible. It is hard to comprehend that, if in fact, Petitioner had been injured by Dr. Gross, Dr. Ungacta would not have been told by the patient, not just the assistant. One would have certainly expected Petitioner to have voiced the right knee complaints to Dr. Ungacta at that point, even if Petitioner was there for the left knee. Dr. Ungacta's second deposition opinion is therefore less credible; Dr. Ungacta's second deposition opinion does appear to be advocating for Petitioner as Petitioner had voiced his displeasure of the opinion after that first deposition. Further, Dr. Ungacta's second deposition opinion, relative to the right knee being injured at Dr. Gross' §12 examination, appears as very speculative in nature, again noting that any minor trauma can cause pain with that underlying condition. Dr. Ungacta and the other medical opinions seem to agree that an exam can cause some discomfort/pain for a time after an exam, which does not equate to any real permanent aggravation or injury. Both of Respondent §12 IME's testified that any sequelae would be of a temporary nature as anything done on exam would be of less force than normal daily activities so nothing of permanence would be of consequence. There would be no permanent aggravation of the pre-existing condition. The evidence and credible testimony (Respondent's IME's and Petitioner's Dr. Ungacta 1st deposition) finds that Petitioner failed to meet the burden of proving any causal connection between the accident and his shoulder condition, as well as the right knee conditions of ill-being. The evidence and credible testimony finds that Petitioner met the burden of proving a causal connection (aggravation of the pre-existing degenerative arthritic left knee condition) between the accident and Petitioner's current condition of ill-being regarding the left knee only. The Commission finds the decision of the Arbitrator as not contrary to the weight of the evidence, and, herein, affirms and adopts the Arbitrator's finding as to causal connection; left leg/knee only.

The Commission, with the above finding of only a causal connection regarding the left leg/knee, further finds Petitioner was released from treatment regarding the left leg and to regular duty by February 1, 2011. Consequently, when Dr. Ungacta gave Petitioner the additional two weeks, it was clearly regarding the right leg which was herein found unrelated, so Petitioner failed to meet the burden of proving entitlement to the further temporary total disability (TTD) period. The Commission finds the decision of the Arbitrator as not contrary to the weight of the evidence and, herein affirms and adopts the Arbitrator's finding as to total temporary disability. The Commission notes that all TTD benefits had been paid until February 15, 2011, and there was no credible evidence of an inability to work, regarding the left leg, beyond that.

The Commission notes that Petitioner indicated medical expenses as an issue on their Petition for Review but did not argue the issue; it is therefore deemed as waived. The Commission finds the decision of the Arbitrator as not contrary to the weight of the evidence and, herein, affirms and adopts the Arbitrator's finding as to medical expenses.

The Commission, with the above findings of only a causal connection regarding the left leg/knee, further finds Petitioner was released regarding the left leg to regular duty by February 1, 2011. Petitioner did have the surgery and injections recommended and he did lose the time from work, and Petitioner still does have the ongoing significant subjective complaints. The Commission finds, under the facts and circumstances and the evidence and testimony presented that an increase of the left leg permanent partial disability (PPD) award to 25% loss of use of the left leg as more consistent with prior Commission decisions and more of an appropriate award here. The Commission finds the decision of the Arbitrator, while not totally contrary to the weight of the evidence, is of an insufficient nature given the weight of the evidence, and the Commission, herein, modifies/increases the left leg PPD award to find a 25% loss of use of Petitioner's left leg (53.75 weeks at $370.08 per week for a total PPD award of $19,891.80).

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $370.08 per week for a period of 53.75 weeks, as provided in §8(e)(12) of the Act, for the reason that the injuries sustained caused the loss of 25% of use of Petitioner's left leg.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $111.65 (Dr. Ungacta) 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.

14IWCC0764

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $20,200.00. 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: SEP 0 9 2014
o-6/26/14
DLG/jsf
45

David L. Gore

Stephen Mathis

Mario Basurto

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

KOLKOVICH, EDWARD
Employee/Petitioner

Case# **11WC001296**

14IWCC0764

BASLER ELECTRIC
Employer/Respondent

On 11/5/2013, 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:

1580 BECKER SCHROADER & CHAPMAN PC
TODD J SCHROADER
3673 HWY 111 PO BOX 488
GRANITE CITY, IL 62040

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

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

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION 14IWCC0764

Edward Kolkovich
Employee/Petitioner

Case # **11** WC **001296**

v.

Consolidated cases:

Basler Electric
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 **Joshua Luskin**, Arbitrator of the Commission, in the city of **Collinsville**, on **August 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

14IWCC0764

FINDINGS

On **5-11-10**, 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 in part*** causally related to the accident.

In the year preceding the injury, Petitioner earned $**3,081.60**; the average weekly wage was $**616.60**.

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 $**3,801.60** for TTD, $ for TPD, $ for maintenance, and $ for other benefits, for a total credit of $**3,801.60**.

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

ORDER

The respondent shall satisfy the outstanding balance of $111.65 to Dr. Ungacta within the limits of Section 8.2 of the Act.

The respondent shall pay the petitioner is entitled to receive the sum of $370.08 for a period of 43 weeks because his injuries caused 20% permanent loss to his left leg pursuant to 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/ Arbitrator Joshua Luskin

November 5 /2013
Date

NOV - 5 2013

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

EDWARD KOLKOVICH,	)	
	)	14IWCC0764
Petitioner,	)	
	)	
vs.	)	No. 11 WC 01296
	)	
BASLER ELECTRIC,	)	
	)	
Respondent.	)	

ADDENDUM TO ARBITRATION DECISION

STATEMENT OF FACTS

The petitioner worked in the respondent's machine shop. On May 11, 2010, he stepped up on a chair to retrieve something from a tall cabinet and injured his left knee. Accident was not disputed.

The petitioner sought care with Dr. Fulton, who prescribed an MRI of the left knee. The petitioner underwent the MRI scan on May 24, 2010, which revealed a tear of the medial meniscus with a cartilage flap and a MCL sprain. PX3, PX9.

The petitioner was referred to Dr. Ungacta, who recommended arthroscopy. The petitioner underwent left knee arthroscopy on June 8, 2010. Substantial patellar arthritis was debrided and meniscectomy was performed to repair the meniscal tear. PX3.

Post-operatively the petitioner was originally discharged without complications, but thereafter went to the emergency room and was admitted for DVT and pulmonary embolism treatment which were determined to be complications from the surgery. He was hospitalized and treated with blood thinners. See PX1, PX3, PX4, PX12-13. He was discharged on June 21, 2010. PX2. The petitioner remained on Coumadin until March 2011, at which time he ceased blood thinners. PX5.

The petitioner underwent postoperative physical therapy. On October 15, 2010, he reported to the therapist that he had been laid off from work. PX3. On October 20, he reported ongoing pain to Dr. Ungacta, who recommended Hyalgan injections due to the petitioner's underlying arthritis. PX3.

The petitioner underwent an IME with Dr. Gross on November 11, 2010. Dr. Gross noted that the injury was causally related to the treatment incurred but believed further treatment would be due to non-work-related factors and that he was at MMI. The petitioner asserted that during the course of this examination, Dr. Gross manhandled the

petitioner's right knee, injuring it and causing persistent pain and weakness in the right knee. Dr. Gross testified in deposition that he did nothing out of the ordinary course of evaluations when he saw the petitioner, and that while examinations can produce discomfort, nothing was done in the examination that could have produced a lasting injury of the kind described by the claimant. He further testified that the claimant reported no such complaints at the time to him. See RX2.

The petitioner saw Dr. Ungacta on November 17 and November 24. On November 17, the petitioner reported that he did not feel he could complete a full shift even on light duty, and Dr. Ungacta prescribed part time employment. On November 24, the petitioner complained of right knee pain. Dr. Ungacta prescribed full duty without restrictions at that time. PX3.

On December 13, 2010, the petitioner reported to Dr. Ungacta that he was doing somewhat better. Dr. Ungacta noted full range of motion of both knees with minimal tenderness. He maintained full duty and prescribed Ultram. PX3.

On January 10, 2011, the petitioner saw Dr. Ungacta. He had fallen about a week before, and stated his right knee had given out. The petitioner asserted that his right knee had been giving out since he was evaluated by another orthopedist. Examination of the right knee noted full range of motion with no effusion and 5/5 strength. Dr. Ungacta maintained full duty work. On January 27, 2011, the petitioner told Dr. Ungacta that he twisted his right knee at work. He asserted weakness in the knees. Following examination, Dr. Ungacta noted full extension with some tenderness and assessed the petitioner with chronic knee pain, likely related to osteoarthritis. Dr. Ungacta maintained full duty without restrictions. PX3.

On February 14, 2011, the petitioner saw Dr. Ungacta and complained of bilateral knee pain. Dr. Ungacta noted "I think that most of his pain at this point is coming from osteoarthritis and the patient does not feel that he is able to return to work secondary to this." The petitioner reported "he would prefer not to go to work" and Dr. Ungacta prescribed him off work for two weeks. PX3.

The petitioner testified that he voluntarily retired on March 1, 2011.

On March 31, 2011, Dr. Ungacta testified in deposition. See PX31. Dr. Ungacta related the history of injury and the medical condition of the left knee and the postoperative DVT and opined the work injury had caused the meniscal tear and the need for surgery, which in turn led to the postoperative complications. Dr. Ungacta opined with regard to the arthritis, it was "very unlikely" the injury had caused or aggravated that condition. See PX31 p.15. He was asked about the petitioner's unsteadiness on his feet and whether he could explain it: "Not really. I don't think I can." He hypothesized that it might be due to someone walking stiff-legged. See PX31 p.21. Lastly, he was asked about the right knee condition and its relationship to the Section 12 examination. Dr. Ungacta testified "I wasn't there. All I can tell you is what I have in my note and that's what he told me. I don't know if that's really possible, you know, to injure somebody's

knee in an exam, but that's what he – a patient can subjectively feel that and – I don't know. I can't say with significant certainty that that's what caused his [right] knee problem." See PX31 pp. 22-23. Dr. Ungacta confirmed that right knee treatment was not related to the work injury or sequela of the examination. PX31 p.24.

On April 20, 2011, the petitioner presented to Dr. Ungacta's office "to discuss the deposition that was done for his case." The petitioner "is not happy secondary to the fact that the deposition was not in his favor." Dr. Ungacta advised him that the opinions he related in the deposition remained his opinions, and noted the petitioner would be seen on an as needed basis only. PX3.

On October 19, 2011, the petitioner saw Dr. Craig Beyer. See PX6. He reported right knee and left shoulder pain following a fall and noted a pop on October 16, 2011. Dr. Beyer noted a bicep tendon rupture after what appeared to be a minor incident. An MRI suggested chronic meniscal pathology and Dr. Beyer noted "an old chronic ACL deficient knee." He noted the petitioner reported pain in the knee following Dr. Gross' examination, but did not opine whether there was a causal connection.

On July 12, 2012, Dr. Ungacta testified in deposition for a second time. He stated that he had not had available certain notes from his assistant at the time of the first deposition, and now opined that Dr. Gross' examination had aggravated the petitioner's symptoms given the pre-existing arthritic condition. On cross-examination, he admitted that it would be "uncommon" for a knee to be injured in the course of an evaluation. PX32 p.43. He noted nothing in Dr. Gross' examination that was out of the routine course of orthopedic examinations and that "the likelihood of it causing pain in the knee is low" although some of the maneuvers to test knees can involve force. PX32 p.44. He admitted that something that was not aggressive in the mind of a physician could be aggressive in the mind of a patient. PX32 p.45.

The respondent commissioned a second Section 12 examination, with Dr. Frank Petkovich. This examination took place on January 21, 2013. Dr. Petkovich testified in deposition on June 3, 2013. See generally RX1. Dr. Petkovich noted that a normal orthopedic examination could provoke symptoms but would not injure a knee. Dr. Petkovich opined the petitioner's right knee was not injured during the physical examination performed by Dr. Gross and that the petitioner had degenerative arthritis in his right knee based on x-rays taken both before Dr. Gross' examination and on the date of Dr. Petkovich's examination.

OPINION AND ORDER

Causal Relationship to the Injury

The parties did not dispute the left knee surgery being related to the initial injury, and the Arbitrator finds the work-related accident resulted in the meniscal tear which

prompted the surgery. For obvious reasons, the postoperative DVT and pulmonary emboli are similarly related to the original injury.

Relative to the right knee, the credible medical evidence does not support a causal connection to any current condition of ill-being. All the physicians are in accord that while a normal orthopedic examination can provoke symptoms, it would not injure the examinee. Moreover, all physicians are in accord that the examination performed by Dr. Gross was consistent with usual and expected orthopedic examination technique. Dr. Ungacta's latter deposition demonstrates patient advocacy, but his earlier skepticism weighs more heavily on the Arbitrator's mind. Moreover, even were one to discount Dr. Gross' testimony, Dr. Ungacta's first deposition is corroborated by the opinions of Dr. Petkovich and the fact that later objective examinations showed only longstanding and chronic findings, consistent with the claimant's age and health. The right to recover benefits cannot rest upon speculation or conjecture. *County of Cook v. Industrial Commission*, 68 Ill.2d 24 (1977). The claimant may well be sincere in his belief that Dr. Gross injured him, but substantive evidence does not support this conclusion.

Relative to the shoulder treatment with Dr. Beyer, no compelling evidence was presented suggesting a causal connection between the original injury and that condition, and the Arbitrator does not find any relationship to have been established.

Medical Services

As it appears the medical bill to Dr. Ungacta with remaining balance of $111.65 is related to that treatment that was causally related to the injury, the respondent shall satisfy it within the limits of Section 8.2 of the Act. If that amount is overage following reductions per the fee schedule cap, then it shall be reduced to zero and dismissed pursuant to Section 8.2 of the Act. Respondent shall receive credit for any and all amounts previously paid but shall hold the petitioner harmless, pursuant to 8(j) of the Act, for any group health carrier reimbursement requests for such payments.

Temporary Total Disability

The parties stipulated all appropriate TTD was paid up until February 15, 2011. At that time Dr. Ungacta prescribed the claimant off work for two weeks for subjective symptoms. In light of the above findings as to causal connection, coupled with the earlier findings that the claimant was physically capable of full duty work, the Arbitrator finds a lack of credible evidence substantiating medical inability to work during that period.

Nature and Extent of the Injury

The petitioner's work-related accident was causally related to the left knee meniscal tear, which was corrected surgically. Following his rehabilitation, the petitioner

was released to full duty by his treating physician. The petitioner having reached maximum medical improvement, respondent shall pay the petitioner the sum of $370.08 per week for 43 weeks, as provided in Section 8(e) of the Act, as the injuries sustained caused the permanent loss of use the petitioner's left leg to the extent of 20% thereof.

STATE OF ILLINOIS)
) SS.
COUNTY OF DUPAGE)

☒ 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

Mary Patricia Marchand,
Petitioner,
vs.

Drury Lane Theater,
Respondent.

14IWCC0765

NO: 09 WC 17535

DECISION AND OPINION ON REVIEW

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

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 $6,900.00. 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: SEP 0 9 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

14IWCC0765

MARCHAND, MARY PATRICIA
Employee/Petitioner

Case# 09WC017535

DRURY LANE THEATRE
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:

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

0766 HENNESSY & ROACH PC
AUKSE R GRIGALIUNAS
140 S DEARBORN 7TH FL
CHICAGO, IL 60603

STATE OF ILLINOIS)
)SS.
COUNTY OF Dupage)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

14IWCC0765

Mary Patricia Marchand
Employee/Petitioner

v.

Drury Lane Theater
Employer/Respondent

Case # **09** WC **17535**

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 **July 10, 2013**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☐ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☐ What was the date of the accident?
E. ☐ Was timely notice of the accident given to Respondent?
F. ☒ Is Petitioner's current condition of ill-being causally related to the injury?
G. ☐ What were Petitioner's earnings?
H. ☐ What was Petitioner's age at the time of the accident?
I. ☐ What was Petitioner's marital status at the time of the accident?
J. ☒ Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. ☒ 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 8, 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 condition of ill-being subsequent to 3/6/09 *is not* causally related to the accident. SEE DECISION

In the year preceding the injury, Petitioner earned $**16,640.00**; the average weekly wage was $**320**.

On the date of accident, Petitioner was **68** years of age, ***single*** with **0** dependent children.

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

Respondent *has not* paid all appropriate charges for all reasonable and necessary medical services. SEE DECISION/ ARB EX 1.

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 the reasonable and necessary medical expenses incurred through 3/6/09 pursuant to Sections 8 and 8.2 of the Act. SEE DECISION. Respondent shall receive credit for amounts paid, if any, and hold Petitioner harmless for payments made by the group carrier, if any.

No award of TTD is made. SEE DECISION

No award of PPD is made. SEE DECISION

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

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

Signature of Arbitrator

8/27/13
Date

AUG 27 2013

FINDINGS OF FACT

Petitioner, a 68 year old telemarketer, testified that on 1/8/09, she had worked 4 years for Respondent. Petitioner testified that all of her duties for Respondent were done by hand. At trial, the parties stipulated that on 1/8/09, Petitioner sustained a work-related accident when she fell down a set of stairs while rushing to a meeting. ARB EX 1. Petitioner testified that she fell forward landing on her knees with her hands in front before falling on her right side. Petitioner testified that immediately after the fall she was stunned and felt pain in both knees and wrists and in her right arm and neck. The parties also stipulated to proper notice. ARB EX 1.

Petitioner drove herself to Concentra the same day giving a consistent history of accident and pain in the right shoulder, neck, knees and wrists. Petitioner was diagnosed with a right shoulder strain, cervical strain, wrist contusion and knee contusion and told to follow up the next day. She was advised to take over the counter medication for pain and to return to regular activity. X-rays taken on 1/9/09 of all areas were normal. On 1/9/09, Petitioner's complaints were mainly of pain in the right side of her neck and right shoulder. She was advised to continued taking the medication, apply ice and continue regular activity including work. On 1/16/09, Petitioner returned for follow up and reported improving wrist and knee pain with only minimal tenderness but persistent right shoulder and neck pain and stiffness. Petitioner was advised to continue the otc medication and attend PT 3 times per week for 1 to 2 weeks. It was noted on this visit that Petitioner opted to "treat with the PT group she previously treated with for prior neck and shoulder issues." PX 1.

On 2/6/09, Petitioner returned to Concentra again noting persistent right shoulder and neck pain and stiffness along with some right wrist tenderness and pain at the top of the right foot. The knee symptoms had "improved significantly." Petitioner reported some improvement with physical therapy and that she had been working regularly. PT and Ibuprofen were continued. The visit of 2/20/09 is substantially the same as that of 2/6/09. At her last Concentra visit of 3/6/09, Petitioner reported improvement in the symptoms as "75%" better. Petitioner described her continued pain in the right neck and right trapezius region to be moderate and intermittent and exacerbated by activity. Petitioner now reported soreness in the ventral/radial elbow and dorsal wrist and hand. Petitioner was to continue with PT, follow a home exercise plan, use a tennis elbow strap and was given a prescription for a Medrol Dosepak. PX 1.

Petitioner chose to follow up with her own doctor, Dr. Couri. Petitioner testified that she treated with Dr. Couri for prior cervical spine and right shoulder problems but that she had not treated for those problems since 2008 and that she was working full duty from her last treatment date in 2008 (September 2008) through the January 2009 accident. Dr. Couri's record of 3/9/09, indicates that he had last seen Petitioner on 9/15/08 and that she had fallen at work since that date. Her symptoms from the fall were 75 to 80% improved with intermittent neck pain, right shoulder pain, right elbow and right hand pain remaining. The pain is reported at 7-8/10. PX 4. Petitioner was diagnosed with de Querveins tenosynovitis, rotator cuff weakness, right lateral epicondylitis and a bulging disc at C6-7.(Px.4). She was prescribed a counterforce brace, a thumb spica splint and to continue PT. PX 4.

Petitioner testified and the records reflect that she continued to treat with Dr. Couri through April & May of 2009. She was prescribed PT, injections, medications and limited work hours. PX 4. In May 2009 she

had an MRI of her cervical spine that showed "degenerative disc bulging/bony proliferation at multiple cervical levels. ... there is minimal central canal stenosis at C5-6. Bilateral neural foraminal narrowing is seen at C3-4 and at C5-6, greater on the right than left." PX 4.

Petitioner attended a Section 12 exam with Dr. Levin on June 23, 2009. RX 3. He reviewed the petitioner's medical records and performed an examination of the petitioner's bilateral arms and wrists. At that time Dr. Levin opined that the petitioner has arthritic changes in her bilateral wrists, but the examination was unremarkable. She had negative Phalen's and Tinel's tests. He stated that she has residual discomforts of right lateral epicondylitis. Dr. Levin stated that the petitioner is at maximum medical improvement and "has subjective complaints of pain that wax and wane." He stated that the petitioner does not need any further orthopedic treatment. He stated an FCE should be performed in order to determine the petitioner's work capabilities because "objectively there should be no reason why she could not work greater than [three hours]. RX 3.

On July 29, 2009, the petitioner underwent a functional capacity evaluation at ATI which was found to be valid. PX 3. The FCE indicated that Petitioner was capable of working at the light-medium level and that her job was sedentary. On August 14, 2009, Dr. Mark Levin reviewed the petitioner's valid functional capacity evaluation and opined that the petitioner can return to her regular duty position without restriction. RX 2.

Petitioner testified that she continued to work while undergoing a series of injections to her cervical spine and right arm through March of 2010 by Dr. Couri. PX 4. In March 2010, Dr. Couri noted continued problems of cervical radiculopathy C6 right, right C5-6 foraminal stenosis, C5-8 right moderate lateral bulging disc, right shoulder pain and lateral epicondylitis right. PX 5. Petitioner had a normal EMG study of the right arm. Petitioner received another injection to the right glenohumeral joint and continued with PT. Petitioner testified that she stopped working for Respondent on 4/25/10 and continued to treat with Dr. Couri through August 2010. In the interim, Petitioner was referred to Dr. Brown by Dr. Couri.

On 6/10/10, Dr. Brown gives an exhaustive recitation of his prior treatment of Petitioner who he first saw in June 2007 for right cervical radiculopathy and right shoulder pain including symptoms of right sided neck pain and right arm pain down to her right hand. Petitioner underwent extensive prior physical therapy for her cervical and right shoulder complaints as well as injections. In September 2007, Dr. Brown noted that if Petitioner did not improve with the conservative care, he would consider a "Ct myelogram and perhaps a decompression and fusion at least at C5-6." Dr. Brown noted that Petitioner did not return to him between September 2007 and the visit of 6/10/10. Petitioner reported that following her last visit with Dr. Brown on 2007, she continued to treat with Dr. Couri with epidurals and PT and "continued to do extremely well until she fell at work in January 2009 and apparently injured her neck, t which time she developed recurrent symptoms." PX 5. Dr. Brown noted that Petitioner's right shoulder MRI of March 16 2010 showed degenerative changes and that Petitioner was told her problems were not emanating from her right shoulder but from her cervical spine. Due to the failure of conservative care to relieve Petitioner's cervical and right arm complaints, Dr. Couri referred her to Dr. Brown for further neurosurgical evaluation. Dr. Brown noted "It is my impression that Mrs. Marchand has a chronic recurrent right cervical radiculopathy." Dr. Brown reviewed the cervical MRI from May 18, 2009 and read it to show no cord compression or abnormal signal. He further noted, "there are mild diffuse disc degenerative changes with mild narrowing of the foramina at C3-4 and C5-6, right more than left. Again, I think the foraminal narrowing at C5-6 on the right most likely explains her symptoms. I told her if she

felt surgery were a reasonable option, would repeat MRI and … discuss surgical options." Petitioner was not interested in surgery at that time so Dr. Brown referred her back to Dr. Couri.

Dr. Couri ordered a repeat cervical MRI on 6/30/10 and thereafter Petitioner returned to Dr. Brown who noted that the June 2010 MRI results "overall… did not look much different compared to the one done in May of 2007, though she did not bring along the disk of the MRI done in May of 2009." Again due to the lack of response to conservative care, a C5-6 anterior decompression and fusion was recommended. After seeing Dr. Koutsky who concurred with the surgical recommendation, Drs. Brown and Koutsky performed the C5-6 anterior cervical diskectomy and fusion on August 25, 2010. PX 7. The pre-operative and post-operative diagnosis was chronic right cervical radiculopathy due to spondylosis at C5-6. PX 7.

Following surgery, the petitioner wore a cervical collar for six weeks, and she followed up with Dr. Koutsky through February of 2011, and had a corresponding diagnoses of bi-lateral carpal tunnel syndrome in January 2011. PX 7. She received more injection in March 2011 for her right lateral and medial epicondylitis. PX 7. On July 14, 2011, Dr. Koutsky stated that the petitioner should continue doing home exercises and was released from care regarding her cervical spine. (Px.7).

On May 11, 2011, Dr. Koutsky prepared a narrative report where he opined "I do believe Ms. Marchand's current condition, including her cervical fusion surgery as well as the post operative rehabilitation required following her surgery, were directly related to her being involved in the work related injury. I do believe the work-related injury aggravated her preexisting degenerative condition to the point where it necessitated cervical decompression and fusion with instrumentation and bone graft." PX 7. Dr. Koutsky indicated that she should have been off work beginning with the surgery on August 25, 2010 through "a few months following surgery and into her rehabilitation" and deferred to the FCE. PX 7. Dr. Koutski made no mention of Petitioner's treatment for her cervical and right arm complaints in 2007 or the prior surgical recommendation.

Petitioner was examined by Dr. Ghanayem on September 11, 2011. Dr. Ghanayem reviewed Petitioner's medical records from 2007 including the 2007 cervical MRI. Dr. Ghanayem writes, "It appears Ms. Marchand had a symptomatic condition of cervical stenosis at C5-6 dating back to at least 2007. She was a surgical candidate at that time. I reviewed her actual cervical MRI scans from May of 2007 and May of 2007 [sic]. They are in fact identical with degenerative stenosis at the C5-6 level. Her March 2007 cervical radiographs reveal degenerative spondylolisthesis at C5-6. Her post surgical MRI scan shows just that- surgical changes at C5-6." RX 1. Petitioner denied a history of prior cervical problems at her exam. Dr. Ghanayem opined that Petitioner had "fallen off a couple of stairs landing on all four extremities. That in and of itself would not change the natural history of an already known symptomatic condition of cervical stenosis with a spondylolisthesis at C5-6 that he been previously symptomatic for a couple of years and already had a surgical recommendation/consideration. The mechanism appears to have caused some other soft tissue injuries in her upper extremity which is not my area of expertise. Therefore, relative to her cervical spine problem, it does not appear that she sustained any structural injury which would change the natural history of her already known symptomatic and surgically amenable problem. The MRI scans before and after the injury are identical. Certainly the cervical diskectomy and fusion at C5-6 is medically acceptable for the condition that was seen back in 2007. The surgical consideration given at that time was appropriate. As stated above, the mechanism of injury would not

accelerate the need for surgery given that she was already a surgical candidate prior to the injury." He further opined that Petitioner could return to her regular job duties as it relates to her cervical spine.

Petitioner testified and the records reflect that she followed up with Dr. Koutsky in September, October and November of 2011 for her Neck and right elbow complaints. Petitioner received intermittent injections and PT prescriptions. PX 7. In May 2012, Dr,. Koutsky referred Petitioner to Dr. Bartucci for evaluation of right tennis elbow release surgery. PX 7.

Petitioner testified and the records reflect that she saw Dr. Bartucci originally on May 7, 2012 for her right elbow. She was diagnosed with chronic lateral epicondylitis of the right elbow and had already had many injections and deferred one that day however was proscribed a gel for her constant pain. PX 6. The petitioner returned to Dr. Bartucci on July 27, 2012 feeling no relief, and was given an injection in her right elbow. PX 6. On December 7, 2012, Dr. Bartucci wrote, "she has bilateral carpal tunnel syndrome that EMG documented a while ago. She is dropping things. She has a positive Tinel and weak grip. She will undergo bilateral release." PX 6. Petitioner underwent left wrist carpal tunnel release in January 2013. An MRI of the right elbow was had on 2/18/13 and showed tendinosis and partial tearing of the common extensor tendon attachment from the lateral epicondyle. At the time of the left carpal tunnel release, Petitioner had a right elbow injection. Petitioner had another right elbow injection on March 29, 2013. Dr. Bartucci noted that after the January 2013 injection, Petitioner's right elbow pain was "getting better." The records indicate one final injection to the right elbow on June 26, 2013. PX 6. The records do not contain any mention of a relationship between the work accident in 2009 and the diagnosed conditions.

Petitioner is claiming injury to her cervical, right shoulder, right elbow epicondylitis and left wrist carpal tunnel as a result of the 1/9/09 work accident. Currently, she notices that she is weak on the right side. Her neck still bother her but she does exercises at home and pool therapy on her own. Her right arm and right neck are stiff and she does not feel she has full range of motion in the right sided cervical area. She testified that her right elbow problems are ongoing but that the injections are helping. Petitioner asserts that she would "like to stop treating" for the right elbow problem. She further stated that she does not have full grip in her left hand and wrist and that she is not as physically active as she was prior to the work accident. She is no longer able to dance, swim or sail as she did before the accident.

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 finds no causal connection between Petitioner's cervical condition for which she underwent a cervical diskectomy and fusion and the accident of 1/8/09. In so finding, the Arbitrator places greater weight on the opinion of Dr. Ghanayem as buttressed by the treating records from 2007 and the comments of Dr. Brown in 2010. Specifically, both Drs. Ghanayem and Brown note that Petitioner's degenerative cervical condition as noted on the MRI's of 2009 and 2010 respectively, is substantially the same as seen on the May 2007 MRI. Dr. Ghanayem logically concluded that the accident "... would not change the natural history of an already known symptomatic condition of cervical stenosis with a

spondylolisthesis at C5-6 that had been previously symptomatic for a couple of years and already had a surgical recommendation/consideration. ... it does not appear that she sustained any structural injury which would change the natural history of her already known symptomatic and surgically amenable problem. The MRI scans before and after the injury are identical. Certainly the cervical diskectomy and fusion at C5-6 is medically acceptable for the condition that was seen back in 2007. The surgical consideration given at that time was appropriate. As stated above, the mechanism of injury would not accelerate the need for surgery given that she was already a surgical candidate prior to the injury." Dr. Brown also noted "It is my impression that Mrs. Marchand has a chronic recurrent right cervical radiculopathy." Dr. Brown later noted that the June 2010 cervical MRI results "overall... did not look much different compared to the one done in May of 2007..." The Arbitrator is not persuaded by Petitioner's testimony that she was asymptomatic for three months before this accident given the extensive treatment she received in the two years before the accident for the identical cervical condition and right shoulder complaints for which surgery was recommended in 2007 and performed in 2009.

The Arbitrator further finds no causal connection for Petitioner's complaints of right shoulder pain, bilateral carpal tunnel, including the left wrist for which she underwent surgery, or right elbow epicondylitis. The right shoulder condition was ultimately attributed to the cervical condition for which the Arbitrator has found no causal connection and no separate right shoulder condition was identified. Further, the Arbitrator notes there is no medical opinion causally relating the development or acceleration of Petitioner's right or left carpal tunnel or the right epicondylitis to the accident of 1/8/09. Petitioner's initial wrist complaints were too diffuse to support a much later diagnosis of bilateral carpal tunnel and the first mention of right elbow complaints to a treating physician was after the accident during treatment for right cervical and diffuse "right arm" complaints.

With regard to the initial injuries to Petitioner's bilateral knees and wrists, the Arbitrator notes that Petitioner was initially diagnosed at Concentra after the accident with wrist contusion and knee contusion. She was advised to take over the counter medication for pain and to return to regular activity. X-rays taken on 1/9/09 of all areas were normal. On 1/9/09, Petitioner's complaints were mainly of pain in the right side of her neck and right shoulder. She was advised to continued taking the medication, apply ice and continue regular activity including work. On 1/16/09, Petitioner returned for follow up and reported improving wrist and knee pain with only minimal tenderness. Petitioner was advised to continue the otc medication and attend PT 3 times per week for 1 to 2 weeks. It was noted on this visit that Petitioner opted to treat with the PT group she previously treated with for prior neck and shoulder issues." PX 1.

On 2/6/09, Petitioner returned to Concentra reporting that the knee symptoms had "improved significantly." Petitioner reported some improvement with physical therapy and that she had been working regularly. PT and Ibuprofen were continued. The visit of 2/20/09 is substantially the same as that of 2/6/09. At her last Concentra visit of 3/6/09, Petitioner reported improvement in the symptoms as "75%" better. Petitioner treated thereafter with Dr. Couri for her continued right neck and right elbow complaints.

Petitioner attended a Section 12 exam with Dr. Levin on June 23, 2009. RX 3. He reviewed the petitioner's medical records and performed an examination of the petitioner's bilateral arms and wrists. At that time Dr. Levin opined that Petitioner has arthritic changes in her bilateral wrists, but the examination was unremarkable. She had negative Phalen's and Tinel's tests. Dr. Levin stated that the petitioner is at maximum medical improvement and "has subjective complaints of pain that wax and

wane." RX 3. A subsequent valid FCE on July 29, 2009, indicated that Petitioner was capable of working at the light-medium level and that her job was sedentary. On August 14, 2009, Dr. Mark Levin reviewed the petitioner's valid functional capacity evaluation and opined that the petitioner can return to her regular duty position without restriction. RX 2.

Based on the foregoing, with regard to the initial injuries to Petitioner's bilateral knees and wrists, the Arbitrator finds causal connection between the accident of 1/8/09 and those initial complaints and corresponding treatment through 3/6/09, the last date of treatment at Concentra. The Arbitrator finds Petitioner was at MMI for those initial complaints thereafter per Dr. Levin.

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

Respondent's objection on the issue of medical expenses was based on liability. ARB EX 1. Based on the Arbitrator's findings on the issue of causal connection, the Arbitrator further finds that Respondent is to pay Petitioner the medical expenses incurred in connection with the reasonable and necessary care and treatment received for her initial injuries of bilateral knee and wrist contusions pursuant to Sections 8 and 8.2 of the Act. Specifically, Respondent is to pay Petitioner for the expenses incurred in the treatment of these causally related complaints at the initial providers through 3/6/09, the date of her last Concentra visit. To the extent Petitioner received physical therapy at CINN during this period for her bilateral knee and wrist complaints, Respondent is to pay Petitioner the CINN expenses incurred during the 12 physical therapy visits at CINN between 1/27/09 and 3/5/09. PX 1, PX 8, RX 5. Respondent shall receive credit for amounts paid, if any.

K. What temporary benefits are in dispute? TTD

The Arbitrator notes that Petitioner is not claiming TTD for any period of time covered by the Arbitrator's findings as stated above. ARB EX 1. Therefore, no TTD benefits are awarded.

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

Based on the Arbitrator's findings on the issue of causal connection, the Arbitrator finds that Petitioner sustained contusions and strains to her bilateral knees and wrists as a result of this accident. However, those initial complaints essentially resolved as of 3/6/09 after Petitioner received conservative care and treatment for these injuries. Based on the record in its entirety and in accordance with the findings on causal connection, the Arbitrator further finds that the record does not support a finding of permanent disability in connection with these initial complaints. No award of PPD benefits is made.

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

Keri Taylor,

Petitioner,

vs.

NO: 10WC 1096

Caterpillar, Inc.,

14IWCC0766

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

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

14IWCC0766

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: SEP 0 9 2014
o082614
CJD/jrc
049

Charles J. DeVriendt

Daniel R. Donohoo

Ruth W. White

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

TAYLOR, KERI
Employee/Petitioner

Case# **10WC001096**

CATERPILLAR INC
Employer/Respondent

14IWCC0766

On 9/5/2013, 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 0.05% 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:

4707 LAW OFFICE OF CHRIS DOSCOTCH
2708 N KNOXVILLE AVE
PEORIA, IL 61604

2994 CATERPILLAR INC
MARK FLANNERY
100 N E ADAMS ST
PEORIA, IL 61629-4340

14IWCC0766

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)

Keri Taylor
Employee/Petitioner

v.

Caterpillar Inc.
Employer/Respondent

Case # **10** WC **01096**

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 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. ☒ 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, **November 5, 2009**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**24,529.60**; the average weekly wage was $**681.38**.

On the date of accident, Petitioner was **32** years of age, ***married*** with **3** dependent children.

Petitioner has received all reasonable and necessary medical services.

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

Petitioner was temporarily totally disabled from 11.12.09 through 11.17.09, 1.21.10 through 4.18.10, 8.20.10 through 9.20.10, and 10.15.10 through 7.9.13, a period of **136 3/7** weeks. Petitioner was entitled to temporary partial disability benefits from 9.21.10 through 10.14.10, a period of **3 2/7** weeks.

Respondent shall be given a credit of $**61,907.77** for TTD, $**162.08** for TPD, $**0** for maintenance, and $**0** for other benefits.

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

ORDER

Petitioner's current condition of ill-being is causally related her November 5, 2009 accident; however, Petitioner failed to establish the medical necessity and reasonableness for the Sleep Number mattress in the amount of $8,099.98.

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

9.2.13
Date

ICArbDec19(b)

SEP 5 - 2013

Petitioner works for Respondent as an assembler. Petitioner sustained an undisputed accident on November 5, 2009. At the time of arbitration the disputed issues included causal connection and prospective medical (a prescription for a special type of bed). Petitioner was the sole witness testifying at the arbitration hearing.

Having considered all of the evidence presented the Arbitrator finds as follows:

Petitioner's past medical history regarding her low back is unremarkable other than one injection in 2006. Petitioner recovered well following the 2006 injection and was able to work full duty without any problems.

On November 5, 2009, Petitioner was a 33 year old factory worker employed by Respondent. On that date, Petitioner was masking the exhaust of a heavy piece of equipment. Petitioner was on top of a wheel tractor scraper wearing full protection and working in an extended back-bent position. Petitioner then went to straighten up and developed low back pain. Petitioner was in a prolonged extended position for approximately 20 minutes. According to medical records, Petitioner continued working for several days but then experienced pain so severe that she had to leave work by ambulance. (PX 3)

Petitioner's initial medical care was provided by Respondent's medical department.[1] Petitioner underwent a lumbar spine MRI on November 16, 2009 which revealed a completely extruded "huge" herniated disc lateralized to the left of midline at L3-4 along with focal degenerative changes at L4-5 and L5-S1. (PX 3) Petitioner testified Respondent referred her to Dr. Thomas Fulbright.

Petitioner was examined by Dr. Fulbright on November 17, 2009, at which time her complaints included lower back pain radiating down her left buttock, hip and thigh along with an intermittent "hot sensation" in her left buttock/hip region which had begun on November 5, 2009, and progressively worsened beginning the next day. Petitioner had been taking skelaxin and vicodin, as needed, since the injury with little relief. Petitioner was still working for Respondent but with restrictions. Dr. Fulbright described Petitioner's condition as "improved significantly" and he did not recommend any epidural steroid or oral steroids. Instead it was agreed to continue Petitioner on prescriptions and see her again in six weeks. (PX 3)

Petitioner returned to see Dr. Fulbright on December 8, 2009, earlier than previously scheduled, as Petitioner was experiencing increasing difficulty with pain. In particular, Petitioner complained of bilateral hip pain worse on the left. Petitioner displayed a decreased knee and ankle jerk on the left compared to the right and pain in her neck and extending into her right upper extremity. Dr. Fulbright did not believe Petitioner's neck and right arm pain was related to her low back herniation; he recommended an epidural steroid injection for the low back pain. (PX 3)

Petitioner telephoned Dr. Fulbright's office on December 17, 2009 reporting ongoing back pain. Petitioner was advised she would continue to feel that way until she receoves the injection scheduled for

[1] These records are not a part of the record.

December 22, 2009. Petitioner expressed pessimism regarding the upcoming injection but reluctantly agreed to proceed. The injection was given as scheduled. (PX 3)

As of January 4, 2010 Petitioner was reporting severe pain especially in the hip and groin region and she expressed the desire to proceed with aggressive management. At her request surgery was scheduled for February 10, 2010. (PX 3)

Surgery was ultimately performed on January 21, 2010. Petitioner underwent a laminotomy and discectomy at L3-4. (PX 5) Post-operatively, Petitioner denied any benefit or relief from her surgery as she felt worse. While she had been stoic before, Dr. Fulbright now described her as tearful with certain maneuvers of her back. He suspected a residual fragment and scheduled a repeat MRI which came back showing a fragment. Re-exploration was recommended and performed on February 17, 2010 (recurrent herniated disc at L3-4). (PX 3, 6)

Post-operatively Petitioner complained of a great deal of pain and back spasms along with a knot along her suture line. Petitioner's condition continued to improve and as of April 19, 2010, Dr. Fulbright noted Petitioner looked like she felt much better and her wound was healing nicely. Dr. Bahrainwala (Respondent's company doctor) was considering returning Petitioner to work with restrictions and Dr. Fulbright believed she could be reasonably accommodated. Petitioner was advised to continue with physical therapy and return after it had been completed. (PX 3)

Petitioner was released to return to work per the restrictions given by Dr. Braco as of April 21, 2010. (PX 3)

As of May 17, 2010 Petitioner was reportedly doing "somewhat better" and had discontinued her physical therapy and was ready to return to work. Dr. Fulbright recommended some further work restrictions for a bit longer and left a prescription for restrictions with Respondent's medical group. Otherwise, Petitioner was released to return as needed. (PX 3)

Petitioner returned to see Dr. Fulbright on July 13, 2010, after one of her supervisors had seen her limping and sent her to Medical which, in turn, sent her to the doctor. Petitioner complained of pain in her left hip extending down the anterolateral thigh to her knee. Petitioner also reported some "catching" lower back pain which seemed to be worsening. Dr. Fulbright noted a slight decrease in her left knee jerk compared to her right. She could heel and toe walk but had "slight difficulty" getting up on the stepstool on her right side. Dr. Fulbright expressed skepticism about his ability to improve Petitioner's difficulties given her history but ordered a repeat MRI, electrodiagnostic study and a flexion/extension lumbar spine x-ray. (PX 3)

Dr. Dove performed an EMG/nerve conduction study on July 20, 2010. Petitioner denied any right-sided symptoms but complained of left hip pain extending down her thigh to her knee along with low back pain. Petitioner's study was reportedly abnormal as a bilateral L3 lumbar radiculopathic process was noted suggestive of a generalized peripheral polyneuropathy or a specific distal entrapment syndrome. (PX 3, 7)

Petitioner's lower back x-rays were taken on July 22, 2010 and revealed mild motion at lumbar 4-5 and degenerative changes. (PX 3)

Petitioner's lumbar spine MRI was taken the same day and revealed: apparent granulation tissue anterolateral, lateral, and posterolateral to the thecal sac on the left at L3-4, surrounding the left-sided nerve root sleeve, extending into the left neural foramen with moderate mass effect upon the left-sided nerve root sleeve in the left neural foramen; posterior disc bulging at L3-4, L4-5, and L5-S1; foraminal encroachment by disc bulge bilaterally at L4-5, greater than at L5-S1, and on the right at L3-4; and other degenerative changes of the spine. (PX 3, 8)

Petitioner did not return to Dr. Fulbright after the above testing was completed.

Petitioner, accompanied by her husband, presented to Dr. Alexander Ghanayem on November 3, 2010. Dr. Ghanayem is a professor and director of the Division of Spine Surgery in the Department of Orthopaedic Surgery and Rehabilitation at Loyola University Medical Center. Petitioner related ongoing pain complaints in her lumbar spine which referred into her left buttock, lateral hip, and then into her anterior thigh. Petitioner reportedly had not responded favorably to additional conservative care, including physical therapy. Dr. Ghanayem believed Petitioner was suffering from ongoing neuropathic pain after a very large lumbar disc herniation as evidenced by the July 2010 EMG/NCS. Dr. Ghanayem explained to Petitioner that nerve damage can result despite technical success with surgery and that it could take up to a year to see any additional improvement. He recommended Petitioner see a pain management specialist who could help address her residual neuropathic pain. Dr. Ghanayem did not believe Petitioner would be able to resume her old job with Respondent due to functional limitations. He believed she would need a more sedentary to light capacity job with the ability to sit, stand, and move around throughout the day. He recommended Dr. Lipov for pain management and suggested Petitioner might respond favorably to a dorsal column stimulator. Dr. Ghanayem excused Petitioner from work beginning November 3, 2010. (PX 4)

Petitioner initiated treatment with Dr. Benyamin on July 11, 2011. Dr. Benyamin is a pain management specialist with Millenium Pain Center and his treatment was consistent with the treatment recommended by Dr. Ghanayem. Petitioner underwent epidural steroid injections in August and September of 2011. In a letter dated September 26, 2011 Dr. Benyamin requested a trial spinal cord stimulator. Petitioner had been seen by a pain psychologist and felt to be a good candidate for the stimulator. She was complaining of low back pain with radicular symptoms on the left as well as the inability to control the last four toes on her left foot. Dr. Benyamin's formal diagnoses for Petitioner were post laminectomy syndrome and chronic pain syndrome. Petitioner underwent another epidural steroid injection on October 13, 2011. (PX 9)

The trial stimulator was approved and Petitioner tolerated it nicely. Thereafter she underwent insertion of a permanent spinal cord stimulator on December 28, 2011at Advocate Bromenn Medical Center. The procedure was performed in two stages with Dr. Benyamin handling stage 1 and Dr. Seibly handling stage 2. Dr. Benyamin implanted a permanent spinal cord stimulator with leads and generator. Dr. Benyamin's diagnosis was low back pain, leg pain and CRPS. Prior to this procedure, Petitioner's complaints were generally in the low back and left leg. During the procedure, the doctors noted numerous difficulties. Dr. Benyamin wrote that placement of the leads was hindered by scar tissue and that initial introduction of the epidural needle encountered a dural tear. Dr. Seibly wrote that "Dr. Benyamin began the initial portion of the procedure, placing two leads percutaneously within the epidural

space. This portion was quite laborious for Dr. Benyamin, as he was having difficulty placing the leads in the optimal position. (PX 10)

Dr. Benyamin noted during the procedure that Petitioner began experiencing severe right leg pain in addition to her left leg symptoms. Dr. Benyamin attributed the right leg symptoms to right-sided nerve root irritation during troubled lead placement. (PX 10) Dr. Rahman testified Petitioner's right leg condition was related by history to the stimulator procedure. (PX 1)

After being transferred to the recovery room in stable condition Petitioner later began experiencing numbness and burning of her right lower extremity and was admitted for pain control. She was discharged on December 30, 2011 in stable condition. (PX 10)

Petitioner followed up at Millenium Pain Center on January 6, 2012. At that time Petitioner was still complaining of right leg pain and head pain. She mentioned having gone to the emergency room the evening of the 5th for sinus-related issues. Petitioner was seen again on February 1, 2012 with complaints of bilateral hip pain and right leg pain. She completed a pain drawing and questionnaire, indicating most of her pain was at a "10/10." Most notably, Petitioner wrote, "I HURT!" Petitioner received another pain injection on the right side and returned on April 9, 2012 reporting some temporary relief in her pain. Another injection was given. On May 1, 2012 Petitioner presented with a new complaint of having lost feeling in her whole back right side of her thigh. The stimulator was bothering her right foot and she denied any relief from physical therapy. Another injection was given. (PX 9)

Dr. Bilyeu referred Petitioner to Dr. John Furry for a consultation regarding her back and bilateral leg pain. Petitioner's initial consultation was held on September 14, 2012. He noted Petitioner was having right-sided L5 symptoms on the lateral aspect of her leg into the anterolateral aspect of her lower leg below her knee and into the foot. Petitioner also reported paresthesia and some allodynia in the L5 distribution on the right leg and foot corresponding to the L5 nerve root distribution. Petitioner had undergone a disability evaluation and had been certified for disability through the State of Illinois just a week earlier. Petitioner reported the stimulator covered areas of her pain with paresthesia but it did not mitigate her pain and so she wasn't using it very much. On the right side, it seemed to exacerbate her pain.

Dr. Furry further noted Petitioner had difficulty sitting for very long (15 – 20 minutes) and would need to get up and walk around when too much pressure was noted on her left side. Petitioner reported great difficulty getting out of the bed in the morning due to increased pain. Mobility was very difficult. Dr. Furry was of the opinion Petitioner would have a difficult time in any kind of desk job or job requiring extensive or long-term standing in one spot. Beyond her limits of pain, he could not precisely state what she could/could not do functionally. He felt she needed to remain on the Lyrica and Cymbalta as Petitioner was experiencing both nociceptive and neuropathic pain, the former being mostly in her back as a result of the injury, surgeries, and scar tissue formation and the latter resulting from the nerve injuries she sustained from both surgery and placement of the spinal cord stimulator. Petitioner was advised to return in one month. (PX 11)

Petitioner did not respond well to the dorsal column stimulator and eventually the unit was removed. Petitioner sought treatment with a new pain doctor due to the difficulty that she experienced during the implantation. Dr. Furry removed the dorsal column stimulator.

Petitioner continues to treat with Dr. Furry in Decatur for pain management. Dr. Furry is managing some of Petitioner's current medications which include Lyrica 800mg daily, Oxycodone 10-325 1 tablet every 4 hours, Fentanyl time release narcotic patch 1 every 3 days. Dr. Bilyeu prescribes the Ativan, Flexapro, and Lunesta. The Ativan and Lunesta are prescribed to assist Petitioner with sleep. (PX 13)

Petitioner was admitted to St. Mary's Hospital on November 9, 2012 for severe back and leg pain (left leg greater than right). Dr. Rahman was consulted for surgical consideration. Dr. Rahman is a board certified in neurologic and spinal surgery. Following examination and review of further imaging Dr. Rahman diagnosed acute back and leg pain on chronic back and leg pain and performed re-exploration of the L3-4 disc level. (PX 12)

Surgery was performed on November 13, 2012 in the form of re-exploration of L3-4 and a microdiscectomy with microsurgical dissection. Petitioner's post-operative diagnosis was L3-4 foraminal stenosis. Dr. Rahman noted significant scar tissue that encompassed the thecal sac, medial facet and wrapped around the L3 nerve root. The scar tissue was removed and freed from the nerve root. (PX 12)

Petitioner has been released by Dr. Rahman. Dr. Rahman recommended weight loss, continued care with Dr. Furry for medication management and referral to occupational health for review of work capabilities. (PX 12)

Dr. Rahman's deposition was taken on May 9, 2013. (PX 1) Dr. Rahman testified regarding his treatment, surgery and the medical necessity of a split king sleep number bed. Dr. Rahman testified to a post-operative diagnosis of a small disc herniation that was indenting the nerve and robust scar tissue surrounding the L4 nerve root. Dr. Rahman testified that Petitioner's multiple back surgeries predispose her to more instability and surgeries in the future. He did not recommend further surgery to Petitioner's back based upon the level of degeneration she already has. He did feel pain management was appropriate and he referred her for it. He also referred Petitioner to occupational health regarding questions as to return to work, disability, and restrictions. (PX 1, pp. 7-8)

Dr. Rahman testified Petitioner took the initiative and requested a prescription for a sleep number bed (identified as Deposition Exhibit 2) because of difficulty sleeping and getting in and out of bed. The prescription was dated December 28, 2012 and attached to it was a customer quote for Petitioner dated December 22, 2012. Dr. Rahman testified that Petitioner felt the sleep number bed would help her and he agreed. Petitioner also related to Dr. Rahman that she slept better in a hospital bed. (PX 1)

Dr. Rahman was given a hypothetical in which he was asked to assume that Petitioner has been sleeping on a couch for over a year, without her husband, and with pillows between her legs in an effort to find a comfortable pain-free position to sleep. Dr. Rahman agreed to write a prescription for the bed. Dr. Rahman testified that he has rarely has seen 33 year olds with four back surgeries and he felt that the bed would assist her in sleeping. He further testified that he does not typically prescribe these for patients. However, in the case of Petitioner, he thought it was appropriate for her because she had undergone four back surgeries and "[she] took the initiative and felt that this was the most beneficial for her sleep, so he agreed. "(PX 1, p. 12) Dr. Rahman also testified that therapeutic sleep improves function, energy, mood and concentration. Dr. Rahman stated he would not prescribe the bed if he did not believe it was medically necessary.

On cross-examination, Dr. Rahman acknowledged there are no utilization review standards on the medical necessity of a bed. To his knowledge there is no literature supporting the medical necessity for this sort of home apparatus. (PX 1, p. 20)

On re-direct examination, Dr. Rahman testified that Petitioner's complaints were supported by objective findings. Dr. Rahman testified that sleep problems are treated with medications. Dr. Rahman testified that it is recommended that Petitioner try to avoid sleep medication due to her already taking narcotics and anti-anxiety medication. (PX 1)

At the time of arbitration Petitioner testified to the following subjective complaints:

a. Daily back pain
b. Left hip numbness
c. Left leg pain
d. Left foot weakness
e. Left hip pain
f. Hyper-sensitivity to the inside of her right foot
g. A pulsing sensation and pain on the front of her shin, approximately 2 to 3 inches above her ankle.

The Arbitrator touched Petitioner's right shin. The Arbitrator noted that the circular area described by Petitioner was slightly swollen. The Arbitrator was able to feel a dip in Petitioner's leg.

Petitioner testified that her average daily pain level is "6 out of 10." The Arbitrator noted that Petitioner sat tilted to her right buttock. Petitioner indicated that she sat in this matter to avoid pressure on her left hip. Petitioner also was able to sit for 21 minutes before having to stand up and change positions. Petitioner testified that her pain causes weakness and difficulty with her performing activities of daily living such as walking.

Petitioner showed the hard plastic brace that she wears on her left foot for support. It is a hard plastic device that goes underneath her left foot and goes up her leg approximately ¾ of the way to her knee. Petitioner testified that she wears this brace daily.

The Arbitrator also had the opportunity to watch the Petitioner sit, stand, change positions and walk. Petitioner was observed sitting with more weight on her right side than her left side.

Petitioner testified that she usually sleeps on a couch at home as she needs to use various pillows. Petitioner testified that she has slept on her couch for the last 1 ½ years. When she tries to sleep in a regular bed she can only sleep for approximately 1 hour before waking up due to pain. Petitioner testified that if she sleeps on a regular mattress she has increased pain and difficulty walking in the morning. Petitioner testified that she has been sleeping on the couch by herself. She sleeps utilizing approximately 3 pillows underneath her legs and 1 pillow in between her legs in an elevated manner. Petitioner also uses 1 pillow on the side of her body. Petitioner testified that this is the most comfortable position for her to sleep and allows for her to sleep longer. Petitioner testified that sleeping on the couch with her legs and body elevated in a v-shape manner allows her to get a better rest and wake up more functional. Petitioner testified that she wants a new bed so that she can try to get back some of her life.

Petitioner testified that she came up with the idea of a bed after being in hospital because the hospital bed elevation could be adjusted at the head and foot of the bed. Additionally, the hospital bed allowed for the Petitioner to change the firmness of the mattress. Petitioner testified that the ability to adjust the bed in this manner improved her comfort and ability to sleep.

Petitioner testified that she researched adjustable mattresses on the internet. She looked into several companies to include Sleep Number, Tempur-Pedic and off brands. Springfield has a Sleep Number store at White Oaks Mall. Petitioner went to the store on 2 occasions to try out the bed. Petitioner testified that by adjusting the bed she was able to find a comfortable position for sleep. Petitioner testified that the bed that she selected allows for the elevation of the bed to be changed at the head of the bed and the foot of the bed, similar to a hospital bed. Additionally the Sleep Number split mattress also allows for her to change the firmness of the mattress.

Petitioner testified that she selected a split king bed so her husband can adjust the bed individually on his side.

Petitioner testified she wants to have more energy and less pain. Petitioner wants to sleep with her husband. Petitioner wants to try and get a full night's rest. If Petitioner can obtain better sleep, she can stop the sleep medication which was recommended by Dr. Rahman.

Petitioner introduced into evidence the Sleep Number customer quote dated December 22, 2012 showing the cost of the mattress to be $8,099.98 for the split king mattress, flex-fit adjustable base with 2 remotes. Petitioner testified that she did not go to a medical supply store regarding a bed.

Respondent obtained a utilization report from Dr. Skaredoff, a board certified pain management physician licensed in the State of Illinois. (RX 1, p. 8) The report is dated June 13, 2013. Dr. Skaredoff utilization report listed the materials and records reviewed. Dr. Skaredoff non-certified the bed because the Official Disability Guidelines (ODG) states there are no high quality studies to support purchase of a specialized mattress for low back pain and that selection of a bed is subjective and depends on personal preference. He further noted that the studies and guidelines indicate that water beds and foam mattresses might influence back symptoms and function as well as sleep, but the differences are small. (RX 1, p. 8)

The Arbitrator concludes:

The Sleep Number split king mattress and bed is the only type of bed/mattress being presented to this Arbitrator for consideration.

The Arbitrator concludes that the requested bed is not medically necessary or reasonable. Petitioner has a causally related injury to her L3-4 disc which, after surgery, has left residual scar tissue around her nerve root. Petitioner clearly suffers from pain as a result of her injury and Dr. Rahman has recommended pain management for Petitioner. He has referred her elsewhere as that is not his area of specialization.

Petitioner has testified that she would like the sleep number bed to help her deal with her pain which makes getting a good night's sleep difficult. The evidence adduced at arbitration suggests that the Petitioner selected a special bed which she thought felt "wonderful" and would help her sleep. While Dr. Rahman testified that he could not say that the particular bed Petitioner has selected and presented to him for the writing of a prescription would, in fact, improve her sleep, he did believe better rest would help her condition and avoidance of sleep medication would be recommended. However, Dr. Rahman does not

specialize in pain management; he focuses on surgery. He acknowledged that he does not usually prescribe beds such as these for his patients and has never prescribed one before.

Dr. Skaredoff, board certified in pain management and licensed in Illinois, cited to a utilization standard under ODG which suggested that special mattresses or beds were not indicated under these circumstances due to a lack of proof that they are particularly beneficial. Under Section 8.7(i)(4) of the Act, the burden is on Petitioner in the face of the utilization review report of Dr. Skaredoff to produce proof by a preponderance of the evidence that a variance from the standard of care used by the person or entity performing the utilization review pursuant to Subsection (a) is reasonably required to cure or relieve the effects of his or her injury. Taking the evidence on its face, while Petitioner had a disc herniation as a result of a work injury; while she has had suboptimal results from her multiple surgeries; and while she has substantial residual symptoms and a claimed inability to sleep in a normal bed, Petitioner has not brought forth sufficient evidence that this particular mattress/bed, which she picked out rather than a physician, will provide her any medical benefit or relief. Dr. Rahman was unable to state that this device would help her within reasonable medical certainty.

Furthermore, even if a special bed or mattress was deemed necessary, the Arbitrator questions the reasonableness of the sleep number model Petitioner has selected. Petitioner has based her request for the sleep number model on two things: (1) a previous stay on a hospital bed and (2) lying on a model while at the Mall. It is the adjustability of the top and bottom of the bed that she perceives as helpful to her condition. While the Arbitrator understands and sympathizes with Petitioner's desire to get a good night's sleep the bed/mattress she is seeking appears to be a top of the line. No evidence was presented showing that other less expensive types of adjustable mattresses/beds might achieve the same result. This was simply the first bed Petitioner had tried out other than a hospital bed. Thus, while an adjustable bed might be appropriate to help improve Petitioner's sleep and, in turn, her function, less expensive models might do just that.

Petitioner has failed to meet her burden of proof and her request for the Sleep Number split king bed/mattress, as well as future medical expenses in the amount of $8,099.98, 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

Aaron Hawk,

Petitioner,

vs. NO: 11WC 32717

State of Illinois/Pickneyville Correctional Center,

14IWCC0767

Respondent,

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed November 26, 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.

DATED: SEP 0 9 2014
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CJD/jrc
049

Charles J. DeVriendt

Daniel R. Donohoo

Ruth W. White

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

HAWK, AARON
Employee/Petitioner

Case# **11WC032717**

SOI/PINCKNEYVILLE CORRECTIONAL CENTER
Employer/Respondent

14IWCC0767

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:

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#6 EXECUTIVE DR
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FAIRVIEW HTS, IL 62208

1350 CENTRAL MGMT SERVICES RISK MGMT
WORKERS' COMPENSATION CLAIMS
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0558 ASSISTANT ATTORNEY GENERAL
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0498 STATE OF ILLINOIS
ATTORNEY GENERAL
100 W RANDOLPH ST
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CHICAGO, IL 60601-3227

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

NOV 26 2013

KIMBERLY B. JANAS Secretary
Illinois Workers' Compensation Commission

14IWCC0767

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)

Aaron Hawk
Employee/Petitioner

v.

State of Illinois/Pinckneyville Correctional Center
Employer/Respondent

Case # 11 WC 32717

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. ☒ 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 _____

14IWCC0767

FINDINGS

On the date of accident, April 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 $56,423.00; the average weekly wage was $1,085.06.

On the date of accident, Petitioner was 41 years of age, married with 2 dependent child(ren).

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

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

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

ORDER

Respondent shall pay for reasonable and necessary medical services as identified in Petitioner's Exhibit 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. Barr and Dr. Paletta, including, but not limited to, left knee surgery.

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

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

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

William R. Gallagher, Arbitrator
ICArbDec19(b)

November 19, 2013
Date

NOV 26 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, 2011. According to the Application, Petitioner was lifting an inmate and sustained injuries to his left knee/leg. There was no dispute that Petitioner sustained a work-related injury on April 24, 2011; however, Respondent disputed liability on the basis of causal relationship. This case was tried in a 19(b) proceeding and Petitioner sought an order for payment of medical bills and prospective medical treatment.

Petitioner worked for Respondent as a Correctional Officer and, on April 24, 2011, Petitioner had to break up a fight that occurred in the dietary unit. One of the inmates involved in the altercation was handicapped and in a wheelchair. As a result of the fight, the inmate got knocked out of the wheelchair. As Petitioner was in the process of helping this inmate get up and back into his wheelchair, he sustained a twisting type injury to his left knee that resulted in immediate pain. This accident was reported to Respondent in a timely manner. Further, Petitioner testified that he had no prior knee injuries or symptoms.

Petitioner continued to work following the accident and initially sought medical treatment from Dr. J. Gregg Fozard, his family physician, on May 17, 2011. Dr. Fozard's record of that date contained the history of the accident of April 24, 2011, and that on the evening of May 16, 2011, the night before his appointment Petitioner was sitting on the tailgate of a truck swinging his knee and the knee locked up on him. Dr. Fozard diagnosed Petitioner with a knee strain and treated it conservatively with ice/heat to the area and anti-inflammatory medications.

Dr. Fozard saw Petitioner on May 23, 2011, and Petitioner still had left knee symptoms. Dr. Fozard ordered an MRI which was performed on June 1, 2011, which was suspicious for a torn medial meniscus.

Petitioner was subsequently seen by Dr. Roland Barr, an orthopedic specialist, on July 7, 2011. Dr. Barr's record of that date contains a history of the work-related accident and that Petitioner had no symptoms prior to that time. Dr. Barr reviewed the MRI and opined that it revealed a torn medial meniscus. Dr. Barr recommended that Petitioner have arthroscopic surgery performed consisting of a medial meniscectomy.

At the direction of the Respondent, Petitioner was examined by Dr. Richard Lehman, an orthopedic surgeon, on September 8, 2011. Dr. Lehman examined the Petitioner and reviewed various medical records provided to him as well as the MRI scan. Dr. Lehman opined that Petitioner had a torn medial meniscus and chondromalacia of the patella; however, he also opined that the torn meniscus was degenerative in nature and not related to the accident of April 24, 2011. Dr. Lehman's opinion was based on the lack effusion at the time that the MRI was performed and that there was not an acute component to the meniscal tear. However, he did agree that Petitioner should have arthroscopic surgery for the torn medial meniscus.

Dr. Barr was provided with a copy of Dr. Lehman's report and commented about it in a narrative medical report dated December 8, 2011. Dr. Barr disagreed with Dr. Lehman's opinion in regard

to causality and opined that Petitioner's meniscal tear and need for surgery was related to the accident of April 24, 2011. Dr. Barr noted that because the MRI was performed approximately five to six weeks post-injury that it would no longer be in an acute phase and that the presence or absence of effusion was irrelevant. Dr. Barr opined that Petitioner was not at MMI and he renewed his recommendation that Petitioner have arthroscopic knee surgery.

Petitioner's counsel had him examined by Dr. George Paletta, an orthopedic surgeon, on December 21, 2011. Dr. Paletta examined the Petitioner and reviewed the various medical treatment records and the MRI scan as well as the medical report of Dr. Lehman. Dr. Paletta opined that there was a causal relationship between the accident of April 24, 2011, and the torn medial meniscus was a result of the twisting nature of the accident describing it as "...a classic mechanism for meniscus tear." He also noted the fact that Petitioner sustained an immediate onset of pain at the time of the accident, had persistent pain since that time and had no symptoms at all that predated the work injury. He agreed with both Dr. Barr and Dr. Lehman that Petitioner should have arthroscopic surgery on the left knee. (Petitioner's Exhibit 6).

Dr. Paletta was deposed on April 19, 2013, and his deposition testimony was received into evidence. Dr. Paletta reaffirmed his opinions that the meniscal tear was related to the accident and that arthroscopic surgery was indicated. He further opined that even if Petitioner had some pre-existing degeneration in the knee that the accident could have aggravated it and caused the need for treatment including surgery.

Dr. Lehman was deposed on September 11, 2013, and his deposition testimony was received into evidence at trial. Dr. Lehman reaffirmed his opinion that the Petitioner's torn medial meniscus was degenerative in nature and not related to the accident of April 24, 2011. Dr. Lehman did agree that there was no evidence of Petitioner having any left knee symptoms prior to this accident.

At trial, Petitioner testified that his left knee still locks up on him at least once or twice a week and he takes over-the-counter medication on an as needed basis. He does want to have the surgery that was recommended by Dr. Barr and Dr. Paletta.

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, 2011.

In support of this conclusion the Arbitrator notes the following:

There was no dispute that Petitioner sustained a work-related accident on April 24, 2011, and Petitioner's description of the accident as involving a twisting type injury to the left knee was unrebutted, as was his testimony that he had no prior left knee symptoms.

The Arbitrator concludes the opinions of Dr. Barr and Dr. Paletta, in regard to the issue of causal relationship, to be more credible and persuasive than the opinion of Respondent's Section 12 examiner, Dr. Lehman.

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

The Arbitrator concludes that all of the medical services provided to Petitioner were reasonable and necessary and that Respondent is liable for payment of the 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 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 care including, but not limited to, the left knee surgery recommended by Dr. Barr and Dr. Paletta.

In support of this conclusion the Arbitrator notes the following:

All of the doctors that examined or treated Petitioner agree that left knee surgery is appropriate.

William R. Gallagher, Arbitrator

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Jose Perez,
Petitioner,

vs.

NO: 10 WC 09118

14IWCC0768

Transformer Manufacturing, Inc.,
Respondent.

DECISION AND OPINION ON REMAND

Petitioner appealed the decision of Arbitrator Kane finding Petitioner failed to prove he sustained an accidental injury arising out of and in the course of his employment on September 1, 2009. On February 21, 2013, the Commission affirmed the Arbitrator's findings. Petitioner filed a Review of the Commission's decision to the Circuit Court of Cook County. On October 30, 2013, the Circuit Court remanded the decision to the Commission with instructions to provide reasonable facts as a basis for its credibility determination. On remand the Commission finds as follows:

FINDINGS OF FACT AND CONCLUSIONS OF LAW

The Commission finds:

1. Petitioner filed two separate Applications for Adjustment of Claim. Petitioner filed a case that was assigned claim number 09 WC 032247 in which he alleged that he sustained accidental injuries to his right hand and arm as a result of a June 23, 2009 work accident. This case was settled by the parties prior to the June 16, 2011 Arbitration Hearing. Petitioner also filed a case that was assigned claim number 10 WC 09118 in which he alleged he sustained accidental injuries to his right arm which manifested themselves on September 1, 2009. Only the latter 10 WC 09118 claim was before the Commission.

2. At the June 16, 2011 Arbitration hearing, Petitioner testified he received six years of primary education. He has no special training. On September 1, 2009 he had worked for Respondent for 22 years. He worked five days a week and eight hours a day. Occasionally he worked six days a week and he worked overtime.

3. Petitioner testified his title was hand winder. His duties consisted of rolling heavy copper wire around a transformer. He would obtain the wire from a 300 pound spool behind him, using a pedal to feed the wire, he would then feed the wire onto the transformer with his right hand and then use a heavy hammer to hit the transformer and make the copper square. He would estimate that he used the hammer 50-60 times a day. He held the hammer in his right dominant hand and he would feel a vibration in his right hand. Depending on the size of the transformer he would complete 6-8 transformers a day if they were larger or 12-15 a day if they were smaller. As he pulled the wire he would experience pain in his right arm. The pain would extend from the wrist to the neck. He experienced "drying" and pain in his arm/hand. He experienced numbness in his fingers, hand and elbow. He started noticing this approximately two years ago. He continued to work and the pain became worse.

4. On June 23, 2009 Petitioner's right hand was crushed by a transformer. The parties stipulated to the June 23, 2009 accident and they settled this claim.

5. On June 23, 2009 Petitioner was seen at Advocate Occupational Health by Dr. Richardson. Petitioner reported he smashed his right hand on a laminator/transformer weighing approximately 50 pounds. He suffered an abrasion on the right hand. He had some edema at digits 2 and 3 and at the metacarpal phalangeal joints. Petitioner was diagnosed as having a right hand contusion/abrasion. The treatment plan was to check the x-ray to rule out any fracture, to rest with no lifting greater than five pounds or tight gripping or pinching with the right hand. Medication was prescribed along with instructions to ice the hand and return to the clinic in 48 hours for a re-evaluation.

6. On June 25, 2009 Petitioner followed up with Dr. Richardson at Advocate Occupational Health. Petitioner complained of some stiffness in the area. Petitioner was diagnosed with a slowly healing right hand contusion. Petitioner lifting restrictions were increased to no lifting greater than of 7-1/2 pounds with the right and Petitioner was instructed to return to the clinic in one week.

7. On July 2, 2009 Petitioner followed up at Advocate Occupational Health where he saw Dr. Piotrowski. Petitioner reported he has been working light duty but he is in more pain than before. His hand x-rays reveal an old fracture of his right hand. Petitioner was mostly complaining of stiffness in the morning and more pain after work. He denies numbness. He pointed to the right wrist and middle hand as the point of his pain.

Petitioner had a full range of motion in the right wrist and hand. He did not complain of any pain during the examination. His superficial abrasions were almost healed. He was diagnosed as having right hand pain and weakness along with right hand abrasions that were healing well. Petitioner was instructed to begin treatment at physical/occupational therapy, continue taking his medication and to follow up in one week's time.

8. On July 27, 2009 Petitioner again followed up at Advocate Occupational Health with Dr. Richardson. Petitioner reported that his right hand felt worse. He reported experiencing persistent pain, weakness and a tremor in his right hand. He was diagnosed as having right hand persistent pain/weakness and tremors after a crush injury. Petitioner was referred to Dr. Firlit, a hand specialist.

9. On August 18, 2009 Petitioner saw Dr. Firlit. At that time Petitioner reported that since the June 23rd accident he has experienced pain and weakness when using his right hand. He reported that while at the age of five he underwent surgery in Mexico on his right elbow. Petitioner reported he has been experiencing numbness of and weakness in his hand while grasping. He admitted to utilizing his upper extremities for 22 years while winding transformers. On examination, Dr. Firlit noted that Petitioner has a well healed scar about the medial elbow suggesting an ulnar nerve transposition took place. He was unable to appreciate any gross deformity about the elbow, but noted x-rays were not taken. Petitioner was able to demonstrate full extension and flexion of the right elbow. There was gross atrophy of the interoseel of his right hand. Adduction of the thumb, ring and little digits were of poor degree. There was a clawing noted of the ring and little finger with decreased light touch sensation involving the ring and little finger. Grip strength was noted to be poor, most notably involving the ring and little finger. There was tenderness about the second metacarpal. Dr. Firlit opined that Petitioner demonstrated a chronic ulnar neuropathy with an acute contusion to his hand. The diagnosis was blunt trauma to second metacarpal with extensor tendinitis with a chronic ulnar neuropathy. Dr. Firlit ordered an EMG/NCV of right upper extremity. He did not believe that Petitioner's atrophy was of a recent nature. He recommended that Petitioner have modified duties of no lifting greater than 7 pounds and avoiding gripping type activities.

10. On August 28, 2009 Dr. Wolf performed the EMG/NCV. The doctor noted that this is a difficult study to interpret. It is most consistent with a lesion of the ulnar nerve at the level of the right brachial plexus. There is no electrophysiologic evidence of a right ulnar neuropathy at the elbow or wrist.

11. On September 1, 2009 Petitioner followed up with Dr. Firlit. He noted that the August 28, 2009 EMG showed findings consistent with lesion of the ulnar nerve at the level of the right brachial plexus. There was no electrophysiologic evidence of right ulnar neuropathy at the elbow or wrist. He noted that a long discussion was had regarding Petitioner's acute upon chronic situation of his upper extremity. He noted Petitioner had a contusion type pattern which was not contributing to his weakness. He has chronic

neuropathy that should be looked at further through his private doctor. He was told to maintain work his restrictions and he discharged him from his care.

12. On September 2,2009, Petitioner began seeing Dr. Patari. Petitioner reported that his hand has been shrinking and he had been experiencing numbness over the last three years. On June 23, 2009 he hit the dorsum side of his right hand with a 46-48 pound weight and he developed pain in the dorsum area of his right hand. He reported he had undergone surgery on his right elbow as a child in South America but he does not know what type of surgery it was. On examination he has a healed scar along the medial aspect of the right elbow centered at the medial epicondyle. There has been negative Tinel's noted. There are palpable ulnar nerve antecubital tunnel. The patient has a sharp positive Tinel's sign anterior to the medial epicondyle, which radiates to the fifth finger. The patient has obvious interosseous wasting and severe weakness of the first dorsal interosseous in the intrinsic muscular hand. He also has some weakness but active 4/5 with good finger extension. He has tenderness at the base of the third metacarpal. Dr. Patari diagnosed Petitioner with right ulnar neuropathy He ordered an EMG to evaluate the ulnar mapping and the integrity of the ulnar nerve. He noted Petitioner's prior EMG demonstrated brachial plexus lesions. However, the diagnosis of brachial plexus does not correlate with the conduction velocity in his feet and the ulnar nerve throughout the entire arm.

13. On September 21, 2009 follow-up with Dr. Patari, the doctor noted Petitioner was not able to get his EMG/NCV because his insurance rejected his claim stating it is a workmen's compensation injury. So he had to file a workmen's compensation claim. On physical examination there is a positive Tinel sign at the cubital tunnel. There was deceased sensation along the medial forearm and dorsal sensory branch of the ulnar nerve. The two point discrimination is greater than 10 mm along the ulnar nerve distribution. There is a positive Tinel sign at the hook of the hamate and Guyon's canal. There is right ulnar neuropathy entrapment at the cubital tunnel as well as Guyon's canal. Dr. Patari recommended surgery consisting of a right Guyon's canal release as well as ulnar nerve transposition.

14. On October 12, 2009 the EMG/NCV test took place. It showed an abnormal neurophysiologic study. There is electrodiagnostic evidence most consistent with an ulnar mononeuropathy at the cubital tunnel on the right side. It is moderately severe. The changes seen appear to reflect predominantly chronic changes. There is evidence of median nerve entrapment compression at the wrist (carpal tunnel syndrome) on the right side. There is no evidence that this represents right-sided cervical radiculopathy or brachial plexopathy.

15. On November 9, 2009 Dr. Patari once again recommended surgery consisting of a right muscular ulnar nerve transposition as well as decompression of Guyon canal and the carpal tunnel.

16. On November 16, 2009 Petitioner underwent surgery. Dr. Patari noted that Petitioner developed neuropathy over the last one to two years in his right arm. The ulnar nerve was dissected and identified proximally. This was severely scarred and the scar tissue was excised from around the ulnar nerve. It was apparently a partial submuscular transposition that was performed at the age of 3 to 4 as the ulnar nerve passed only under the FCU fascia and did not pass superficial to pronator teres and flexor digitorum. The post-operative diagnosis was right carpal tunnel syndrome, right cubital tunnel syndrome, right ulnar neuropathy with entrapment in Guyon's canal.

17. On December 1, 2009 Dr. Patari authored a medical report which was addressed to Petitioner's attorney. Dr. Patari noted that on September 2, 2009 Petitioner reported that his right hand had been shrinking over the last three years and he has had numbness in the last digits over the last three years. On June 23, 2009 he hit his hand dorsum with a 46-48 pound weight and as a result he developed pain in the dorsum of the right hand.

    Dr. Patari opined that he believed that the patient's job duties aggravated a pre-existing condition. The patient was already predisposed to further ulnar nerve injury due to the fact that he had a previous sub muscular transposition. As a result of his work, which may have caused ongoing muscle hypertrophy and strengthening of the flexor pronator origin, the muscle may have continued to hypertrophy. As a result this can cause increased compression across the ulnar nerve, which was finally noticed by the patient approximately three years ago. He believes that the patient's underlying diagnosis of carpal tunnel syndrome, which was noted in the August 2009 and October 2009 EMGs, was also due to the patient's line of work due to the fact that he has a high force, highly repetitive type of work which can predispose patients to carpal tunnel syndrome. He further feels that the aggravation was a continuing aggravation of his pre-existing condition of the right ulnar nerve entrapment.

    He opined that the June 23, 2009 new injury did not aggravate or exacerbate the patient's entrapment of the ulnar nerve/ulnar neuropathy either at the hand or elbow level. It simply caused a contusion of the patient's right hand, which has not completely resolved.

    At this time the patient is able to return to work at a restricted duty of no lifting more than 15 pounds due to the fact that he continues to recover from the ulnar nerve release and carpal tunnel release. His prognosis is guarded. It is unlikely that the patient will have a complete 100% recovery of the condition in his right hand due to the fact that it is chronic and ongoing in nature for the last three years. Specifically, the muscle atrophy most likely will not recover completely.

18. At the April 7, 2010 follow up visit with Dr. Patari, Petitioner reported minimal improvement in strength since the last visit. The doctor noted that the diagnosis is "non-

work" related and he returned Petitioner to full employment with an indication to return only as needed.

19. It appears that Petitioner returned to Dr. Patrai on July 28, 2010. No medical records were submitted into evidence for this visit. All that was submitted was a work status report from Dr. Patari with now indicated Petitioner had permanent restrictions of maximum lifting of ten pounds and limited strong grip, grasp and pinch.

20. On August 26, 2010 a medical report was generated by Dr. Nagle who evaluated Petitioner on the same day. He noted that the patient suffered a crush injury to the right hand, which was not sufficiently severe to cause a fracture or dislocation. The patient was noted to have signs and symptoms suggestive of a long-standing ulnar neuropathy. Nerve studies demonstrated no signs of compression of the ulnar nerve at the wrist or the elbow. Dr. Patari ordered another nerve study to evaluate the right ulnar neuropathy but it was not authorized. There was no evidence of carpal tunnel syndrome. In spite of the tests, the patient underwent a decompression of the ulnar nerve at the wrist and elbow and a carpal tunnel release.

Dr. Nagel stated he was unable to attribute the patient's ulnar nerve symptoms to the crush injury of the right hand. He suspected this is a long-standing problem as was suggested by the electromyographer. It is not evident from the records provided the patient actually presented with symptoms suggestive of carpal tunnel syndrome. Dr. Nagel opined that Petitioner is at maximum medical improvement in regard to the crush injury. As such no further treatment is needed.

The Petitioner continues to have problems particularly in regard to hypersensitivity along the medial side of his elbow. Hopefully with the passage of time, this will improve, though if it does not he might require a submuscular transposition. This assumes that the most recent ulnar nerve surgery consisted of a subcutaneous anterior ulnar nerve transposition. On November 8, 2010 Dr. Nagle issued a second report. He noted that Petitioner said he had had paresthesias in the ulnar nerve distribution for quite some time prior to his injury. In fact he had undergone surgery at the age of five in Mexico that may have involved the ulnar nerve. The August 28, 2009 nerve studies were consistent with a lesion of the ulnar nerve at the level of a decompression of the right brachial plexus. This patient underwent a decompression of the ulnar nerve at the elbow and wrist in the face of nerve studies which demonstrated no sign of compression at those levels. Dr. Nagle stated he had no information regarding symptoms related to repetitive activities and the medical records contained no suggestion of exposure to repetitive trauma. The patient presented with weakness in the deep flexors of the ring and small fingers as well as weakness of the flexor carpi ulnaris. These findings clearly indicate a problem with the ulnar nerve or its roots proximal to the wrist. The patient's injury involved his hand. There is no notion of a more proximal injury at the time of the June

23, 2009 injury. In summary, he had no data to suggest this patient's symptoms were in any way related to repetitive activity.

21. At the June 16, 2011 Arbitration hearing, Petitioner testified he was fired on September 29, 2009. Since then he has not looked for work because he cannot use his arm. He reported he has constant right arm pain. His arm is stiff and it cramps. He sleeps on his back. He writes a little with his right and then when it hurts he switches to his left hand. His wife helps him get dressed and helps him with the buttons on his shirt. He notices pain with bathing of his right hand. He starts the car and drives with his left hand only. He speaks very little English. He was told that he had surgery in Mexico on his right arm when he was 3-1/2 years old. He has a scar from that surgery. He told the doctors at Advocate Occupational that his right arm was hurting on June 23, 2009. In September of 2009 he gave Dr. Patari a history of his hand shrinking for three years. In July of 2010 Dr. Patari released him from care and gave him some lifting restrictions. He has not looked for work since he stopped treating with Dr. Patari.

The Commission finds that Petitioner is attempting to advance a repetitive trauma claim with a manifestation date of September 1, 2009 along with the specific June 23, 2009 accident resulting from a hand crush. The Commission finds that the Arbitrator is correct in pointing out the deficiencies of Petitioner's claim namely while Petitioner claims to have a repetitive job, Petitioner did not put specifics into evidence in regard to his repetitive trauma claim. At most, Petitioner reports on August 18, 2009 that has uses both his upper extremities, not just his right upper extremity, to perform winding duties for the last 22 years. Petitioner provides a history of an early childhood surgery to his right elbow, which is documented on physical examination. Yet, Petitioner only complains of right hand pain, which is supported by his physical examination. Given his history and the physical findings Petitioner is deemed to have chronic ulnar neuropathies. On September 1, 2009, the proposed manifestation date, the Petitioner's symptoms clinically are once again limited to his right hand. The EMG/NCV taken a few days earlier at most shows a lesion of the ulnar nerve at the right brachial plexus with no electrophysiologic evidence of right ulnar neuropathy at the elbow or wrist. As such the occupational doctor does not label the same as a worker compensation claim and instead discharges Petitioner from his care and refers Petitioner to his private doctor in regard to the chronic neuropathy. Upon seeking additional treatment from Dr. Patari the next day, Petitioner reports a similar history to that of the past. Specially, he complains of his right hand shrinking and experiencing numbness in the hand for the last three years. He reports the specific June 23, 2009 accident in which he hit his hand, but again, he does not indicate he has neurological problems for his wrist or arm. At this juncture he is clinically diagnosed with right ulnar neuropathy and a repeat EMG is ordered. The October 12, 2009 repeat EMG/NCV studies demonstrated ulnar mononeuropathy at the cubital tunnel on the right side. Yet the doctor who conducts the EMG/NCV studies notes that the findings again appear to reflect predominantly chronic changes. Although Petitioner's condition is labeled as chronic in nature, Dr. Patari claims in his follow up visit

that Petitioner has acute right cubital tunnel and carpal tunnel syndrome and he recommends surgery. The November 16, 2009 surgery report indicates that there was severe scarring excised from around the ulnar nerve, which is usually indicative of a chronic, longstanding problem. The Arbitrator further correctly points out the fact that no causation opinion was provided until after Petitioner's attorney elicited the same from the Dr. Patari in a report authored for litigation purposes. While addressing Petitioner's prognosis, Dr. Patari indicates it is unlikely that the Petitioner will have a complete 100% recovery of his right hand due to the fact that his condition is chronic and ongoing in nature for the last three years. Given this statement, Dr. Patari's opinion is in line with the other doctors who found Petitioner's condition to be chronic and dating back to a period three years prior to his treatment. When asked specifically about Petitioner's condition and its relationship to work Dr. Patari couches his opinion using the words may and can and he again acknowledges that the complaints date back to a period three years prior to his treatment. Specifically he indicates that Petitioner's work may have caused muscle hypertrophy that can cause compression across the ulnar nerve which Petitioner noticed approximately three years ago. While Dr. Patari comments that Petitioner had a high force, highly repetitive job that can predispose patients to carpal tunnel syndrome, he marks in his follow April 7, 2010 work status report that the condition is non-work related. Contrary to Petitioner's attorney's position in his brief, Respondent did provide evidence to rebut the repetitive trauma theory by submitting reports from Dr. Nagle. Dr. Nagle questioned both the need for the surgery given the result of the August 28, 2009 EMG/NCV studies along with commenting on the fact that there is no evidence of repetitive activities found within the medical records. He notes that Dr. Patari ordered another nerve study, but at most he comments that the nerve study was not authorized.

Based on the above, the Commission finds that Petitioner had a chronic neurological ulnar condition that predates the alleged manifestation date by a period of three years. The Commission finds that while Petitioner claims his job is repetitive in nature, the medical reports do not indicate that Petitioner is attributing his ulnar/elbow conditions to work. Petitioner claims a manifestation date of September 1, 2009, which is a date the occupational doctor label his condition as chronic and he discharges Petitioner from his care and releases Petitioner to a private doctor. While Dr. Patari labels Petitioner's condition as acute leading up to his surgery, it appears from the surgical records that Petitioner had evidence of a chronic condition which Dr. Patari subsequently acknowledges and which is in line with the occupational doctor and the electromyograher's opinions. At no time during the treatment of Petitioner does Dr. Patari express a causation opinion. It is only when he is asked to generate a report for the purposes of litigation that Dr. Patari expresses a positive causation opinion. Even then Dr. Patari's acknowledges that the condition is chronic in nature and was known to the Petitioner at least three years prior. Upon giving his causation opinion, Dr. Patari couches the same is words such as may and could while providing a generic opinion that Petitioner's job is the type that predisposes patients to carpal tunnel syndrome. With the exception of classifying his condition as acute leading up to the surgery, Dr. Patari does not express an opinion subsequent to that point that his condition is acute or that Petitioner's work aggravated Petitioner's pre-existing chronic condition to a point that he was in need of

14IWCC0768

treatment. Even after expressing a positive causation opinion, Dr. Patari marks that Petitioner's condition is not work related. Given the totality of the evidence, the Commission finds that Dr. Patari's records do not support the Petitioner's position that Petitioner sustained repetitive work related traumas that manifested themselves on September 1, 2009 and as such the Commission assigns little weight to his causation opinion. Contrary to the Petitioner's attorney's position, Respondent does provide rebuttal evidence in the form of Dr. Nagel's reports. While, the Commission acknowledges that Dr. Nagel may not have been privy to the October 12, 2009 EMG/NCV studies, it finds that his opinion that Petitioner's condition is long standing in nature and Petitioner provided no information regarding symptoms related to repetitive activities is in line with the remaining evidence in the record. As such the Commission assigns more weight to Dr. Nagel's opinions. The Commission finds as always Petitioner need prove up each and every element of his claim and having reviewed the evidence in the record, the Commission agrees with the Arbitrator that Petitioner failed to prove he sustained an accidental injury that manifested itself on September 1, 2009 and that Petitioner's current condition is causally related to the alleged September 1, 2009 accident.

IT IS THEREFORE ORDERED BY THE COMMISSION that the decision of the Arbitrator filed July 23, 2012 is herby affirmed and adopted.

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

DATED: SEP 10 2014

MB/jm

O: 9/4 /14

43

Mario Basurto

David L. Gore

Stephen Mathis

STATE OF ILLINOIS)
) SS.
COUNTY OF SANGAMON)

☐ 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

George Andrasko,

Petitioner,

vs.

NO: 09 WC 42536

14IWCC0769

Freeman United Coal Mining Co.,

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 occupational disease, causal connection, nature and extent of permanent disability and §1(d) through (f) of the Occupational Diseases Act 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 Petitioner is permanently disabled to the extent of 10% person as a whole. Petitioner did not leave his job at Respondent because he could not physically perform his job. He was laid off because the mine closed. Petitioner chose to take retirement, which severed his rights to recall to another mine. Petitioner was ready, willing and able to work, but for the lay off. He was performing his full duties up until the time the mine closed and he was laid off. The pulmonary function tests revealed no evidence of an obstruction or restriction. His lung volumes and diffusion capacity were normal. The Commission affirms all else.

14IWCC0769

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $636.15 per week for a period of 50 weeks, as provided in §8(d)2 of the Act, for the reason that the injuries sustained caused the permanent disability of the person as a whole to the extent of 10%.

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

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

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $31,900.00. 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: SEP 10 2014
MB/maw
o07/31/14
43

Mario Basurto

Stephen J. Mathis

David L. Gore

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

ANDRASKO, GEORGE
Employee/Petitioner

Case# **09WC042536**

14IWCC0769

FREEMAN UNITED COAL MINING CO
Employer/Respondent

On 11/21/2013, 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 0.10% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

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BRUCE R WISSORE
300 SMALL ST SUITE 3
HARRISBURG, IL 62946

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

14IWCC0769

STATE OF ILLINOIS)
)SS.
COUNTY OF SANGAMON)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

GEORGE ANDRASKO
Employee/Petitioner

v.

FREEMAN UNITED COAL MINING CO.
Employer/Respondent

Case # 09 WC 42536

An *Application for Adjustment 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 **September 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 a disease occur that arose out of and in the course of 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: Disease/Exposure, Causation, Sections 1(d)-(f).

FINDINGS

On **August 30, 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 exposure and disease 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 **$91,907.12**; the average weekly wage was **$1,767.46**.

On the date of accident, Petitioner was **60** years of age, ***married*** with **0** dependent children.

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

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

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

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

ORDER

Respondent shall pay Petitioner permanent partial disability benefits of $636.15/week for 75 weeks, because the injuries sustained caused the 15% loss of the person as a whole, as provided in Section 8(d)(2) of the Act.

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

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

Signature of Arbitrator

11/14/2013
Date

NOV 21 2013

14IWCC0769

STATE OF ILLINOIS)
) SS
COUNTY OF SANGAMON)

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

GEORGE ANDRASKO
Employee/Petitioner

v. Case # 09 WC 42536

FREEMAN UNITED COAL MINING CO.
Employer/Respondent

MEMORANDUM OF DECISION OF ARBITRATOR

FINDINGS OF FACT

Petitioner, George Andrasko, was born on May 11, 1947, and was sixty-six years old on the day of trial. Petitioner coal mined for thirty-two years with Respondent, Freeman United Coal Mining Company at its Crown II Mine, spending half of his career underground. While mining Petitioner regularly was exposed to coal mine and silica dust, as well as glue and diesel fumes.

Petitioner's last occupational exposure with Respondent occurred on August 30, 2007. Petitioner was sixty-years old and working as a service mechanic when the mine closed. Petitioner went on a recall panel for the nearby Freeman Crown III mine. Petitioner eventually took his name off the panel. Petitioner explained that he had survived for thirty-two years in the mines and did not want to "go back to the dangers of underground mining and the dust and dirt and everything to put up with so I decided I'd just retire." Petitioner unsuccessfully looked for work outside the mine. His retirement from Respondent became official in November 2007. By accepting his pension, Petitioner severed all rights to work at Respondent's mine.

Petitioner began to have problems breathing about three to four years before he retired. He noticed these problems when climbing the steps in the plant, ascending to the top of the silo, or shoveling. Petitioner bid into above ground jobs while in the mines to lessen his dust exposure, but was always sent back underground when there was a re-alignment. Currently, Petitioner feels able to walk approximately a quarter of a mile before becoming breathless; he can climb two flights of stairs before having to stop and rest. His breathing problems have worsened since their onset. Petitioner must take breaks when gardening and uses a rider mower to take care of his lawn. Shoveling snow is difficult. He does not think he has the lung capacity to perform his former mining jobs. He would not take a mining job today if offered because of the dangers and the dust. He has never held a non-manual labor type job. He has never smoked cigarettes. Petitioner does not go to the doctor very often. He does not like seeing doctors and stated that he would have to be in fairly bad condition to necessitate a doctor visit. About a year ago, his wife talked him into going to see Dr. Epplin because she felt he was having issues with his breathing.

At his attorney's request, Petitioner's chest x-ray of September 11, 2009 was interpreted that same month by B-reader/Radiologist, Dr. Henry Smith, as positive for coal workers' pneumoconiosis (CWP) category 1/0. Dr. Smith found interstitial fibrosis with p and s opacities in all lung zones. (Petitioner's Exhibit (PX) 2). Petitioner was then examined by Dr. Glennon Paul on May 24, 2010 at his attorney's request. Petitioner's chest exam and pulmonary function tests were normal. However, Dr. Paul agreed that Petitioner's chest film demonstrated fibro-nodular lesions throughout both lung fields indicative of CWP. (PX 1, pp. 9-10; Dep. Exh. 2, p. 2). Dr. Paul stated that a person with CWP cannot have further coal dust exposure without endangering his health, and that additional dust exposure can increase the progression of the disease. (PX 1, pp. 16-17). Dr. Paul provided that the lung tissue-affected CWP is scarred and associated with a halo of focal emphysema. The damaged tissue cannot function. Pulmonary function testing may not measure this localized damage, but one can lose a lung lobe and still generate normal testing. (PX 1, pp. 11-12).

At Respondent's request, Petitioner's September 11, 2009 chest x-ray was interpreted as normal on July 3, 2010 by B-reader/Radiologist, Dr. Jerome Wiot. Dr. Wiot also reported his disagreement with Dr. Smith. (RX 2). Respondent then asked Dr. David Rosenberg to review medical records, including the reports of Dr. Paul, Dr. Smith, and Dr. Wiot. Dr. Rosenberg also was given the September 11, 2009 chest film, which he interpreted negatively for CWP. Dr. Rosenberg's report of October 13, 2010 concluded that no respiratory complaints were voiced to any physician except Dr. Paul. He felt Petitioner had no respiratory disorder. (RX 1, Dep. Exh. B).

Respondent also offered an exhibit containing negative x-ray interpretations on file at NIOSH, for films taken in 1979, 1993, and 2007. (RX 3). The identity of the x-ray readers was supplied by someone who wrote their names on bottom of the documents. The films were taken during different decades, but the handwriting is the same on these documents. It is very similar to the person who signed the record certification. The miner's social security number is not crossed out on the reports, but the social security number of the x-ray reader is blacked out; the form indicates that if the film reader's social security number is not furnished, then the reader must supply his name and address. This was not done, but the aforementioned names appear to have been written in later. In addition, the record certification pertains to seven pages of records, when in fact nine pages are included, including the chart preceding the readings.

Respondent offered a series of Petitioner's medical records into evidence. The Veteran's Administration (VA) Medical records show a consult on November 18, 2009 regarding a prostate biopsy. (RX 4, p. 18). On January 6, 2009, and November 24, 2008, there were check-up appointments. (RX 4, pp. 21, 23). The rest of the records are mostly lab reports. (RX 4).

The sixteen pages of the Litchfield Family Practice records span June 23, 1982 to November 30, 2012. There few visits, and the remaining records deal with unrelated testing and labs. On November 30, 2012, Petitioner complained to Dr. Epplin that he had dyspnea, cough and wheezing of a sudden onset about a month prior. The symptoms were reported as occurring occasionally when Petitioner had to bend over or get up and do something. (RX 5, p. 2). The records of St. Francis Hospital concern an October 2008 colonoscopy. The review of systems on October 20, 2008 showed no cough or shortness of breath. (RX 6, p. 10).

CONCLUSIONS OF LAW

Issue (C): Did Petitioner suffer disease which arose out of and in the course of his employment by Respondent?

In view of the aforementioned irregularities of the NIOSH documents, the Arbitrator gives the NIOSH exhibit little weight. The readings of films from 1993 and 1979 also are of little relevance in determining whether Petitioner had CWP when he left the mines.

The Arbitrator concludes that Petitioner had CWP caused by his employment with Respondent. The treatment records Dr. Rosenberg reviewed contained nothing pertaining to the question of radiographic CWP. What remained were the diagnoses of Dr. Paul, Dr. Smith and Dr. Wiot, along with Dr. Rosenberg's own review of the x-ray at issue. Dr. Rosenberg agreed that a person can have radiographically significant CWP and no shortness of breath, normal testing, and normal physical exams. (RX 1, pp. 21, 27). Dr. Paul stated that same. (PX 1, p. 15). The Commission has noted that while medical records warrant consideration as trustworthy evidence, they can be of little value when it comes to radiographic CWP. *Sims v. Freeman United Coal Mining*, 12 IWCC 413 (April 20, 2012). The *Sims* case was recently affirmed by the Appellate Court of Illinois. *See Freeman United Coal Mining Co. v. Ill. Workers' Comp. Comm'n*, 2013 IL App (5th) 120564WC (5th Dist. 2013).

Dr. Rosenberg agreed that those parts of the lung damaged by CWP cannot work properly, though he attempted to downplay the related functional loss as occurring on a microscopic, theoretical basis. However, if the opacities of CWP are evident on x-ray, the damage is not microscopic or theoretical. Dr. Rosenberg agreed that one can have a loss of lung function and still test normally. (RX 1, p. 23). Dr. Rosenberg and Dr. Paul stated that a person can lose an entire lung lobe and test normally. They agreed that testing within the range of normal does not mean the lungs are free from injury or disease. (RX 1, p. 28; PX 1, p. 12).

The competing x-ray interpretations are resolved in Petitioner's favor. Dr. Wiot is qualified, but for over 50 years he "could not remember examining a set of x-rays for petitioners' or plaintiffs' attorneys. The overwhelming majority of his work is for insurance companies, respondents and employers." *Lefler v. Freeman Coal Co.*, 08 IWCC 1097 (Sept. 25, 2008). *See also Cross v. Liberty Coal Co.*, 08 IWCC 1260 (Nov. 5, 2008). Dr. Rosenberg's black lung exams are performed on behalf of insurance companies or attorneys for the mine. Ninety-five percent of all his exams have been for industry. (RX 1, pp. 7-8). Dr. Rosenberg's attempt to diminish CWP damage has already been noted. Dr. Rosenberg also downplayed the danger of further mine dust exposure for CWP victims. (RX 1, p. 26).

While Dr. Paul is not a B-reader, he reads fifteen to twenty chest films per day, and he has testified for both coal companies and coal miners. He has examined coal miners for coal mine-induced lung disease since the 1970s. (PX 1, pp. 7-9). The majority of the chest films he has read for CWP for Petitioner's counsel have been negative. (PX 1, p. 28). Dr. Paul's opinion was bolstered by B-reader/radiologist Dr. Smith, who has been a board certified radiologist since 1973. (PX 2, CV, p. 2). Dr. Smith has been a B-reader since 1987 and is a consultant to multiple occupational medical clinics. (PX 2, CV, pp. 2, 5). He is well-qualified, and the Arbitrator adopts his opinions.

The Arbitrator further notes that Petitioner was a credible witness at trial. He testified in an open and forthcoming manner, and appeared to be endeavoring to give the full truth, including on cross-examination.

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

Dr. Paul stated that the lung tissue scarred by CWP cannot function and that by definition there necessarily is impairment of function at the damage site. (PX 1, p. 12). The Commission has recognized that even in the absence of measurable impairment, CWP causes equates to disability under the Act. *See Eubanks v. Consolidation Coal Co.*, 08 IWCC 1515 (Dec. 29, 2008); *Samuel v. F W Electric*, 08 IWCC 1296 (Nov. 10, 2008); *Cross v. Liberty Coal Co.*, 08 IWCC 1260 (Nov. 5, 2008); *Brooks v. Consolidation Coal Co.*, 07 IWCC 1693 (Dec. 28, 2007); and *Chrostoski v. Freeman United Coal Mining Co.*, 07 IWWC 226 (2007). Furthermore, Petitioner cannot return to mining without risking progression of his CWP. He has proven disablement. *See Freeman United Coal Mining Co. v. Ill. Workers' Comp. Comm'n*, 2013 IL App (5th) 120564WC (5th Dist. 2013).

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

Based on the above findings, Petitioner is permanently and partially disabled under Section 8(d)(2) of the Act. It is possible that his disease will progress to a very serious level, although it is not possible to determine progression either way at this point. Based on the foregoing, the Arbitrator finds that Petitioner is disabled to the extent of 15% of the person as a whole.

Issue (O): Was Petitioner's disability timely under Section 1(f) of the Act?; Was there exposure?

Petitioner's last injurious exposure to coal mine dust was August 30, 2007. Petitioner's chest x-ray of September 11, 2009 was read as positive. This brief eleven day period after the expiration of Section 1(f) of the Act is immaterial. Dr. Rosenberg indicated that if Petitioner has CWP, then he had it when he left the mines. (RX 1, p. 25). Dr. Paul stated that CWP is a slowly developing disease which usually does not progress with exposure cessation. (PX 1, pp. 17, 32). *See Freeman United Coal Mining Co. v. Ill. Workers' Comp. Comm'n*, 2013 IL App (5th) 120564WC (5th Dist. 2013); and *Freeman United Coal Mining Co. v. Industrial Comm'n*, 308 Ill. App. 3d 578, 585-586, 720 N.E. 2d 309, 314 (5th Dist. 1999) (CWP on a 1990 autopsy, coupled with testimony that it would have been present on date of last exposure in 1976, was sufficient to satisfy Section 1(f) of the Act). The Arbitrator finds that Petitioner's disability was timely under Section 1(f) of the Act.

STATE OF ILLINOIS)
) SS.
COUNTY OF WILL)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Jose De Leon,

Petitioner,

vs.

NO: 11 WC 12568

14IWCC0770

Senior Star at Weber,

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, penalties and attorneys' 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 modifies the Decision of the Arbitrator finding that Petitioner was temporarily totally disabled from March 17, 2011 through May 2, 2011. The Commission notes that the Arbitrator gave Respondent credit for TTD benefits of $4,209.82, but did not make an award of TTD. The Arbitrator indicated Respondent paid TTD benefits through June 10, 2011. The Commission finds that the Arbitrator should have awarded TTD from March 17, 2011, when Dr. Gattas authorized Petitioner off work, through May 2, 2011, the day Dr. Engel released Petitioner to return to work at light duty. Petitioner saw §12 Dr. Heller on May 17, 2011 and reported he had been back to work for 2 weeks. Therefore, the Commission awards TTD benefits from March 17, 2011 through May 2, 2011, a period of 6-5/7 weeks. The Commission affirms all else.

14IWCC0770

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $342.66 per week for a period of 6-5/7 weeks, that being the period of temporary total incapacity for work under §8(b) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $319.00 per week for a period of 25 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 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. The Commission notes that Respondent paid $4,209.82 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 $6,200.00. 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: SEP 10 2014
MB/maw
o08/07/14
43

Mario Basurto

Stephen J. Mathis

David L. Gore

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

DE LEON, JOSE
Employee/Petitioner

Case# **11WC012568**

14IWCC0770

SENIOR STAR AT WEBER
Employer/Respondent

On 12/30/2013, 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 0.09% 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:

1922 SALK, STEVEN B & ASSOC LTD
FRANK I GAUGHAN
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2284 LAW OFFICE OF LAWRENCE COZZI
MAUREEN DUNSING
27201 BELLA VISTA PKWY #410
WARRENVILLE, IL 60555

STATE OF ILLINOIS)
)SS.
COUNTY OF WILL)

14IWCC0770

☐ 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

JOSE DELEON
Employee/Petitioner

v.

SENIOR STAR AT WEBER
Employer/Respondent

Case # **11** WC **12568**

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 **9/17/13**. 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. ☒ 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 14IWCC0770

On **March 16, 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 **$26727.48**; the average weekly wage was **$513.99**.

On the date of accident, Petitioner was **30** 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 **$4209.82** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$4209.82**.

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

ORDER

Respondent shall pay Petitioner the sum of $319.00/week for a further period of 25 weeks, as provided in Section 8(d)(2) of the Act, because the injuries sustained caused permanent partial disability to the person as a whole to the extent of 5% thereof.

The medical services that were provided to Petitioner, subsequent to May 17, 2011, were not reasonable or necessary. No further benefits are awarded.

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

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

Signature of Arbitrator

12/26/13
Date

ICArbDec p. 2

DEC 30 2013

Attachment to Arbitrator Decision
(11 WC 12568)

14IWCC0770

Statement of Facts

Petitioner, Jose DeLeon testified that, on March 16, 2011, he was working for Respondent, Senior Star at Weber, performing housekeeping and maintenance at a nursing home in Romeoville, IL. He was cleaning an office with a vacuum and attempted to move a paper shredder when he twisted his back, and felt pain in his right lower back. He also felt a cramp in both legs. Petitioner testified that he contacted his supervisor on his radio to report his injury, and was immediately sent to Adventist Bolingbrook Hospital. Petitioner also testified that he had no prior back problems, no comparable pain and no prior back treatment.

The records of Adventist Bolingbrook Hospital show that, on March 16, 2011, Petitioner presented with severe, dull, lumbar pain, with a history of the work accident. The records indicate that the pain was not radiating, and Petitioner had no complaints of numbness or tingling. (PX 1, p 3) His lumbosacral spine x-ray showed normal alignment, no fractures, and mild narrowing of the L5-S1 disc space. The radiologist noted that if clinically indicated, a MRI would be more sensitive in further evaluation. (PX 1 pgs 4, 29) Petitioner was assessed with back pain. The discharge instructions were to follow up with Dr. Pranjal Shah in two days, and to return to the emergency department if pain was worse the next day. (PX 1, p 6)

The following day, he began treating with Marque Medicos in Aurora, IL. He testified he learned of the facility from television. The records of Marque Medicos LLC show that Petitioner initially presented for complaints of back pain the day following the work accident, on March 17, 2011. Dr. Gattas, a chiropractor, saw the Petitioner. The initial history states that Petitioner's pain kept increasing and he was seeking a second opinion. He was tender to palpation at L1 though L5 on the right, and his ranges of motion were reduced in the thoracolumbar spine. The diagnosis was low back pain, with a plan for physical therapy 3 times per week for two weeks, and he was taken off work until March 31, 2011. Dr. Gattas also referred Petitioner for an MRI. (PX 2)

Petitioner underwent the prescribed MRI on March 18, 2011 at American Diagnostic MRI. According to the report, it showed diffuse lumbar spondylosis with multilevel annular disc bulging and hypertrophy of posterior elements. At L3-4, there was a 3 mm diffuse disc bulging and hypertrophy of facet points. There was also mild spinal and bilateral neural foraminal stenosis. At L4-5 there was 2.5 mm diffuse disc bulging flattening the thecal sac. At L5-S1 there was a 3 mm diffuse disc bulging with a 3.5 mm central herniation and hypertrophy of facet points. The 3.5 mm herniation was causing mild spinal stenosis. (PX 2)

Subsequent to the MRI, Dr. Gatta referred Petitioner to Dr. Engel, with Medicos Pain & Surgical Associates. Records show Dr. Engel first saw Petitioner on March 22, 2011. At that time, Petitioner provided a consistent history of the accident. Petitioner reported low back pain with numbness in his right hip. Petitioner described his pain as aching, throbbing, and cramping. He rated same as 5 out of 10 and was aggravated by activity. Dr. Engel's review of the lumbar MRI found mild spinal and bilateral neural foraminal stenosis, a 2.4-mm diffuse disc bulge at L4-5, and a 3-mm herniation at L5-S1. He felt there was mild stenosis and that the disc herniation appeared to be more right-sided than left. On physical exam, Petitioner had negative bilateral straight leg raise testing, 5/5 bilateral lower extremity strength, and decreased range of motion in his lumbar spine extension, but full flexion. Petitioner had full lateral rotation, no pain to palpation, no SI tenderness, no superior cluneal tenderness, no superior gluteal tenderness, and no greater trochanteric bursa tenderness. Dr. Engel diagnosed lumbar herniated disc; prescribed Ibuprofen, Flexeril and physical therapy. Dr. Engel kept

Petitioner off work and recommended an EMG. The doctor noted same was recommended to define the radicular component of Petitioner's pain associated with his central stenosis. (PX 3, pgs 53-54 of 169)

At Respondent's request, a Utilization Review was conducted by Dr. Antonelli of the Medical Review Institute of America to review the medical necessity of an EMG, as well as 9 additional physical therapy visits that were being recommended by Dr. Engel. In her report dated April 18, 2011, Dr. Antonelli reported that based on the Official Disability Guidelines an EMG may be recommended to obtain unequivocal evidence of radiculopathy after 1-month of conservative therapy, but not if radiculopathy is clinically obvious. Based on the records provided, Dr. Antonelli found no evidence of radiculopathy on exam, nor any evidence of potential neurologic dysfunction. Further, Dr. Antonelli found there was no evidence of potential radiculopathy, based on the MRI findings of neuroforaminal narrowing without nerve root compression. As such, Dr. Antonelli found that the recommendation for an EMG was not medically necessary. (RX 1)

With regards to the 9 additional sessions of physical therapy recommended by Dr. Engel, Dr. Antonelli reported that the Official Disability Guidelines recommend 10 visits of physical therapy (Petitioner had already had 12 visits by that time). The doctor noted that Petitioner had essentially normal exam findings on March 22, 2011, and there was no evidence of significant impairment at that time. Dr. Antonelli opined that the additional 9 visits of physical therapy were not medically necessary. She further opined that there was no evidence that Petitioner would be unable to continue and complete rehabilitation efforts with a home exercise program (RX 1)

At Respondent's request, a Utilization Review was conducted by Dr. Horne of the Medical Review Institute of America. The appraisal was a retrospective review of the medical necessity of the MRI which was performed on March 18, 2011. In his report dated April 19, 2011, Dr. Horne reported that based on the Official Disability Guidelines, a MRI is indicated where there is low back pain with radiculopathy after at least one month of conservative therapy, sooner if severe or progressive neurological deficit is noted. Based on the records submitted Dr. Horne reported that the lumbar MRI was not medically necessary. Dr. Horne based his opinion on the fact that given the MRI was done at two (2) days post injury with no red flags noted as well as the guideline recommendation. (RX 2)

Petitioner returned to Dr. Engel on April 19, 2011, complaining of the same pain level. Petitioner complained of low back pain with a "pins and needles" feeling in his right hip. Petitioner also reported having difficulty sleeping due to pain. Dr. Engel's exam revealed a continued decrease in the range of motion of the lumbar spine due to pain. There was pain to palpation on the right lumbar paraspinus musculature. Dr. Engel again recommended the EMG to define the potential radiculopathy in Petitioner's right hip. He prescribed continued physical therapy, medication, and kept Petitioner off work. (PX 3, p. 51 of 169)

The EMG/NCV was administrated on April 22, 2011 and was interpreted as a normal study (PX 3, p 9 of 169)

On May 3, 2011, Petitioner returned to Dr. Engel. The doctor noted that Petitioner was substantially better than the previous visit. Petitioner reported his pain was 1 out of 10. Petitioner provided he had an aching pain on the right side of his low back without radiation to the hip. The examination showed full range of motion in the lumbar spine. He had pain with full lumbar extension. There was no pain to palpation. Dr. Engel released Petitioner to return to light duty work with a 20 lb. lifting restriction. Petitioner was to continue with his medication and physical therapy. (PX 3, pg 49 of 169)

At Respondent's request, Petitioner underwent a Section 12 examination with Dr. Heller on May 17, 2011. Petitioner reported that he been back working for two weeks, and that he felt 80% to 90% better. Dr.

Heller reviewed the March 18th MRI indicating same demonstrated very mild degenerative change, very mild with very small disc bulging centrally at L3-4, L4-5 and L5-S1. She noted there was a very small central disc herniation at L5-S1. She stated there was no stenosis whatsoever and no impingement of any nerves. Upon examination, Petitioner had a full range of motion in his lumbosacral spine, with mild discomfort upon full extension. She found no palpable lumbar paraspinal spasm. Petitioner had normal strength, sensation, and reflexes in both legs. Dr. Heller opined Petitioner sustained a lumbar strain, most likely muscles and/or ligamentous strain. The doctor further opined that same was causally related to March 16, 2011 work accident. (RX 3)

In her report Dr. Heller provided that she agreed with the prior Utilization Review Reports that neither the MRI nor the EMG had been clinically indicated, or medically necessary. She opines that while Petitioner's physical therapy treatment was appropriate, two to three months of physical therapy was "quite excessive." Dr. Heller also reported that Petitioner's physical exam was completely normal, his complaints were subjective, and that his lumbar strain was resolved at that time. Dr. Heller found that Petitioner was able to return to full-duty work and should have been able to go back to work full-duty four weeks after the accident (RX 3)

On May 17, 2011, Petitioner also had a visit with Dr. Engel. Petitioner reported his pain was at 4/10. Upon examination, Petitioner had full range of motion in his lumbar spine. He reported pain to palpation in his right lumbar paraspinous musculature. Petitioner reported that bending over to mop at work aggravated the pain. At that time, Dr. Engel added lumbar facet syndrome to his assessment. He recommended diagnostic L3, 4, 5, and S1 medial branch blocks, prescribed Soma, and reduced Petitioner's lifting restrictions to 10 pounds (PX 3, p. 82 of 169).

On June 6, 2011, Dr. Engel noted Petitioner's pain complaints were 4/10 but the medication and sitting made the pain better. Petitioner reported essentially the same physical exam as the May 17, 2011 visit with limited extension in his lumbar spine. Dr. Engel reported Petitioner had undergone the medial branch nerve blocks noting he was pain free in the recovery room. Dr. Engel recommended second confirmatory branch block injections, prescribed Mobic and Omeprazole and continued Petitioner on 10 lb. lifting restrictions. (PX 3, p. 43 of 169)

On June 15, 2011, Dr. Gattas authored a letter in response to the April 19, 2011 utilization review report from Dr. Horne. Dr. Gattas provided that he was not in agreement with the determination indicating Dr. Horne's opinion was totally invalid and not based on facts. Dr. Gattas objected to Dr. Horne's reliance on the ODG guidelines stating that the medical necessity should be based on high-quality peer-reviewed medical literature. Dr. Gattas further provided the reviewer cut off the conversation not allowing him to fully explain his reasoning for the MRI and physical therapy (PX 2)

On June 28, 2011, Petitioner returned Dr. Engel who noted Petitioner underwent the confirmatory medial branch blocks. The doctor provided the blocks demonstrated the facet joint was not the root cause of the pain. The doctor no longer indicated lumbar facet syndrome in his assessment and recommended epidural steroid injections at L5 and S1. In his notes Dr. Engel commented on Dr. Heller's Section 12 examination. Dr. Engel wrote, "...Dr. Heller under reads the MRI. The patient has central stenosis and a central disc herniation at L5-S1. In addition, Dr. Heller says the patient MRI was not medically necessary. The MRI was obviously necessary since it is the only way to diagnose the patient's L5-S1 disc herniation. Dr. Heller's opinion that MRIs are only medically necessary to diagnose radiculopathy or other red flags is not based on high quality peer-review medical literature. Since Dr. Heller under reads the MRI and fails to use high quality peer-reviewed medical literature, her IME is void." (PX 3, p39 of 169)

On July 12, 2011, Dr. Engel reported Petitioner had undergone the epidural steroid injection and same did not decrease his pain. Dr. Engel discontinued physical therapy and referred Petitioner to Dr. Robert Erickson, a neurosurgeon, for a consultation. (PX 3, p.35 of 169)

The records contain notes from 40 physical therapy visits dated March 17 through July 11, 2011. (PX 2)

Petitioner saw Dr. Erickson on July 22, 2011. Dr. Erickson reviewed the MRI films and stated they showed a midline disc herniation at L5-S1 and bilateral recess stenosis at L4-5. Dr. Erickson recommended an evoked potential test of the legs to check for nerve compression. That test was performed by Dr. Chhabria, M.D. on July 22, 2011 who found significant evidence of L5 right and S2 right dermatomal conduction delay. (PX 4)

On August 5, 2011, Dr. Erickson recommended a decompression surgery at L4-5 and L5-S1. Dr. Erickson believed that the need for surgery was a direct result of the 3/16/2011 work accident. (PX 4)

Petitioner returned to Dr. Engel on August 16, 2011 with pain at 3/10. Bending over made the pain worse. Dr. Engel recommended that Petitioner follow-up with Dr. Erickson (PX 3, p.33 of 169) On August 23, 2011, Dr. Engel indicated a Functional Capacity Evaluation was necessary before considering surgery. (PX 3, p31 of 169)

On August 31, 2011, Dr. Engel noted that Petitioner requested a full duty release to return to work. Dr. Engel released Petitioner to full duty work, but continued to recommend the Functional Capacity Evaluation, as well as a home exercise program. (PX 3, p29 of 169) The FCE was never performed.

On November 1, 2011, Dr. Engel authored a letter to Respondent's worker's compensation carrier requesting a copy of the utilization review completed on April 19, 2011. Dr. Engel provided that he initially requested a copy of reviewers' findings on May 10, 2011. (PX 3, p12 of 169)

Petitioner testified that he requested the full duty release because he had not worked since May 17, 2011, had not received temporary total disability benefits and had to support his family. Petitioner testified that he continued to work full duty for Respondent until October 2011, when he left for other employment. Shortly thereafter, he became employed with Auto Team Repair in Joliet, Il, performing basic car maintenance, including performing oil changes, changing brakes, working on alternators, and rotating tires. He has continued in that line of work until the present day, and currently works for Meineke. He testified that he changes tires at least once per day. He testifies that he is careful while doing so, and wears a support brace. He testified that he believed he reinjured his back once while working at Auto Team Repair, but could not recall when, and has not reported any further injuries. Petitioner still has pain in his back with radiation into his right hip. It worsens as the day goes on. If he lifts a tire and twists or bends while holding hit, he feels immediate pain in his low back. He has to lower the tire directly from the car to the ground and then roll it out of the way.

Petitioner testified that he has not sought any treatment for his work injury since August 31, 2011. He testified he does not utilize a home exercise program, nor ice packs. If his back hurts, he takes over-the-counter medication. He testified that he no longer plays soccer due to his back pain.

In support of the Arbitrator's decision relating to the issue of (F), whether Petitioner's current condition is causally related to the injury, the Arbitrator makes the following finding:

Relying on the Independent Medical Examination of Dr. Heller, the Arbitrator finds Petitioner's current condition of ill-being is not causally related to the work accident sustained. In her report dated May 17, 2011, Dr. Heller opined that Petitioner was in need of no further treatment as of her examination on May 17, 2011. Dr. Heller notes that Petitioner had only subjective complaints of mild pain without any significant objective findings. Dr. Heller's examination revealed a full range of motion, no palpable lumbar paraspinal spasm, and normal strength, sensation and reflexes.

The Arbitrator notes Petitioner saw Dr. Engel of Medicos Pain & Surgical Specialists, S.C. on the same day as the IME with Dr. Heller. In contrast to his reports to Dr. Heller that he was 80 to 90% better at the time, he told Dr. Engel that his pain was 4/10 on the visual analog scale, and worse than his previous visit. Dr. Engel notes that Petitioner's pain has increased with work, though no such complaints were documented by Dr. Heller. In fact, Dr. Heller expressly notes that the Petitioner had requested to be released back to work. Dr. Engel noted that Petitioner reported pain to palpation in his right lumbar paraspinous musculature, whereas Dr. Heller found none.

Finally, the Arbitrator notes that Petitioner went back to full-duty work as of September 1, 2011, despite the fact that Dr. Engel recommended continued restrictions of 10-pound lifting, and further opined that a Functional Capacity Evaluation was necessary. Despite Dr. Engel's recommendations, Petitioner was able to return to full-duty work with Respondent, and auto mechanic work elsewhere shortly thereafter, continuing through present day basically without issue. This undermines the opinions of Dr. Engel.

Based on the foregoing, the Arbitrator finds that Petitioner's current condition is unrelated to his work accident. The Arbitrator further finds that Petitioner's physical injuries from the work accident had reached maximum medical improvement as of May 17, 2011, and that his current physical condition is unrelated to the work accident of March 16, 2011.

In support of the Arbitrator's decision relating to the issue of (J) whether the medical services provided to Petitioner were reasonable and necessary, and whether Respondent is liable for Petitioner's ongoing treatment, the Arbitrator makes the following finding:

Based on the Arbitrator's finding that Petitioner's work injury had reached maximum medical improvement as of May 17, 2011, the Arbitrator finds that medical services provided by Marque Medicos, Medicos Pain & Surgical Specialists, S.C., and Dr. Robert Erickson, dated May 17 through August 31, 2011 were neither reasonable nor necessary.

Petitioner's subjective complaints fluctuated from 1/10 to 3/10 or 4/10, at worst. Further, Petitioner had no radicular complaints, and negative diagnostics, and yet Dr. Engel continued to prescribe injections, recommend further treatment, and finally gave a referral to a neurosurgeon. The Arbitrator finds that Marque Medicos, LLC and Medicos Pain & Surgical Specialists ongoing treatment after May 17, 2011 was excessive, and not supported by Petitioner's condition.

Specifically with regards to the MRI performed on March 18, 2011, and the EMG performed on April 22, 2011, the Arbitrator relies on the Utilization Review Reports dated April 18, 2011 and April 19, 2011, submitted by Respondent. These reports also support the Arbitrator's findings with regards to determining

whether the extensive ongoing physical therapy was reasonable or necessary. Utilization Review is addressed in the Act under section 8.7(i)(5):

> "An admissible utilization review shall be considered by the Commission, [...], and must be addressed along with all other evidence in the determination of the reasonableness and necessity of the medical bills or treatment. [...] When 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

The Utilization Review (UR) Report by Dr. Horne, dated April 19, 2011, was a retrospective review of the lumbar MRI performed on March 18, 2011. That report found that, under the Official Disability Guidelines (ODG), the MRI was not medically necessary as Petitioner was only 2 days post-injury. A lumbar MRI would be indicated if Petitioner had continuing low back pain with radiculopathy after at least one month of conservative treatment. As such, the lumbar MRI performed on March 18, 2011, only 2 days after the work injury, was done prematurely, and was not reasonable or necessary. The IME report of Dr. Heller also finds that the MRI was not indicated at that time, as Petitioner had no radiating pain, or neurological deficits at that time.

The UR Report by Dr. Antonelli dated April 18, 2011 addresses the EMG which was performed on April 22, 2011, along with physical therapy which was performed thereafter. That report finds that Petitioner had no evidence of radiculopathy on exam, therefore, the EMG was not medically necessary. Under the ODG, an EMG may be used to obtain unequivocal evidence of radiculopathy after 1-month of conservative therapy, and are not necessary if the radiculopathy is clinically obvious. The Arbitrator also notes that Dr. Heller, Respondent's IME, agrees with the UR Report that the EMG was unnecessary, as Petitioner had no evidence of radicular pain at any point and the MRI did not demonstrate any nerve impingement.

The April 18, 2011 report further indicates that the ODG would allow for the initial 10 visits of physical therapy, and as the claimant had essentially normal exam findings on March 22, 2011, the additional physical therapy visits exceeds the ODG. As such, the physical therapy performed at Marque Medicos, LLC from April 26, 2011 through July 19, 2011, totaling 32 visits, were not reasonable or necessary.

With regards to the June 15, 2011 letter of Dr. Gattas indicating that he was unable to respond to Dr. Horne's UR Report, it is uncontroverted that Dr. Horne did, in fact, call and speak with Dr. Gattas. Clearly, the two have differing opinions as to what occurred during that conversation, and the Arbitrator chooses not to make a credibility decision between the two chiropractors based on the evidence in the record. Nevertheless, Dr. Horne did make an attempt to discuss the treatment with Dr. Gattas, despite there being no mandate under the Workers' Compensation Act.

With regards to the November 1, 2011 letter from Dr. Engel regarding requesting of the UR Report, Dr. Engel indicates in the letter that a request for the report was sent via certified mail on May 10, 2011; however, there is no copy of the original request, or the certified mail receipt in the evidence in the record.

The UR reports create a rebuttable presumption that Respondent is not responsible for payment of the MRI, EMG, or physical therapy past 10 visits. The Arbitrator finds that Petitioner did not present sufficient evidence that the ODG should not have applied in this case, or should have been disregarded for special circumstances. Therefore, Petitioner did not rebut the presumption as required by the Workers' Compensation Act.

Finally, Petitioner's medical bills include $3825.00 in transportation charges to Medicos Pain & Surgical Specialists ($2907.00 per the fee schedule)(PX8), and $850.00 in transportation charges to Ambulatory Surgical Care Facility, LLC ($646.00 per the fee schedule)(PX10). The non-emergency transportation was charged at $425.00 per trip. The Arbitrator finds this case to be similar to those of Xique v. Wendy's, 09 IL.W.C. 37812 (Ill.Indus.Com'n Dec. 10, 2012), and Avalos v. Spizzico, Inc., 10 IL.W.C. 18425 (Ill. Indus. Com'n Nov. 16, 2012). In those cases, similar transportation charges were found to be unreasonable and unnecessary. Petitioner provided no evidence as to why such non-emergency transportation charges were reasonable and necessary.

In support of the Arbitrator's decision relating to the issue of (K) what temporary benefits are in dispute, the Arbitrator makes the following finding:

The Arbitrator finds that Petitioner is not entitled to nor awarded any additional benefits. Petitioner was placed at maximum medical improvement by Dr. Heller on May 17, 2011. Respondent paid TTD to Petitioner for his lost time through June 10, 2011. Petitioner is not entitled to, and Respondent is not responsible for any further temporary benefits.

In support of the Arbitrator's decision relating to the issue of (L) the nature and extent of Petitioner's injury, the Arbitrator makes the following finding:

The Arbitrator finds that Petitioner sustained a lumbar sprain as a result of the work accident of March 16, 2011. The sprain resolved within weeks of the injury with conservative treatment. This is based on both the findings of Petitioner's own treating physicians, as well as the IME report of Dr. Barbara Heller.

Based on the foregoing, the Arbitrator finds that Petitioner is entitled to an award of 5% of a person to compensate him for his injuries sustained on March 16, 2011.

In support of the Arbitrator's decision relating to the issue of (M) should penalties or fees be imposed upon Respondent, the Arbitrator makes the following finding:

Based on the Arbitrator's findings regarding Petitioner's medical treatment, and in light of Respondent's reasonable reliance on the UR Reports and IME Report of Dr. Heller, the Arbitrator finds that no penalties or fees shall be imposed.

STATE OF ILLINOIS)
) SS.
COUNTY OF WILL)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Robert DeAngelo,

Petitioner,

vs.

NO: 05 WC 27590

14IWCC0771

Peotone School District,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of accident, causal connection, temporary total disability, permanent partial disability, and 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 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.

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.

14IWCC0771

The party commencing the 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
TJT:yl
o 9/8/14
51

Thomas J. Tyrrell

Michael J. Brennan

Kevin W. Lamborn

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

DeANGELO, ROBERT
Employee/Petitioner

Case# **05WC027590**

07WC052955

PEOTONE SCHOOL DISTRICT
Employer/Respondent

14IWCC0771

On 4/11/2013, 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 0.09% 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:

0293 KATZ FRIEDMAN EAGLE ET AL
DAVID M BARISH
77 W WASHINGTON ST 20TH FL
CHICAGO, IL 60602

1120 BRADY CONNOLLY & MASUDA PC
NICOLE RUSSO WEISBRODT
ONE N LASALLE ST SUITE 1000
CHICAGO, IL 60602

STATE OF ILLINOIS)
)SS.
COUNTY OF Will)

14IWCC0771

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Robert DeAngelo
Employee/Petitioner

v.

Peotone School District
Employer/Respondent

Case # **05** WC **27590**

Consolidated cases: **07 WC 52955**

An *Application for Adjustment 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 Lennox**, on **December 13, 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 **4-29-2005**, 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.

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

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

In the year preceding the injury, Petitioner earned **$18,930.08**; the average weekly wage was **$364.04**.

On the date of accident, Petitioner was **53** 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 $ for TTD, $ for TPD, $ for maintenance, and $ for other benefits, for a total credit of $.

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

ORDER

Having failed to prove that he sustained an accident that arose out of and in the course of his employment with Respondent on April 29, 2005, 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

4/10/13
Date

ICArbDec p. 2

APR 11 2013

14IWCC0771

Statement of Facts

Petitioner, Robert DeAngelo, was a custodian and maintenance worker for Respondent Peotone School District in 2005. He began working for Respondent in October, 2004. Prior to working for Respondent, Petitioner had a significant medical history. Petitioner provided that he had a prior injury to his neck and back for which he had filed a Workers' Compensation claim. He underwent a cervical fusion in 2003 and had undergone two prior surgeries (2003 and 2004) to his lumbar spine. Petitioner testified that he had just been released from his prior back surgery in August 2004, right before he began his employment with Respondent.

Petitioner testified that prior to being employed by Respondent, he was working for Aramark Management Services. Petitioner stated that his prior employment with Aramark was a physically strenuous job and that he worked as a custodian. He provided that his duties for Aramark was more physically demanding than the work he was doing for the current Respondent. Petitioner also provided that prior to being employed by Respondent, he had experienced problems with numbness in his right hand and had pre-existing leg pain.

Petitioner recalled having carpal tunnel syndrome in his right hand but was unclear about the left. He recalled a settlement in 1991 for his left arm but could not recall exactly what was injured. He settled a workers' compensation case for a 20% loss of use of the left arm. The parties did not provide any details as to what injury was sustained. Petitioner was able to recall fracturing his left elbow in a motor vehicle accident many years ago where there was no litigation.

Petitioner testified that he was feeling "allright" in the Fall of 2004. He had no left hand or elbow problems. Petitioner stated that he did a variety of custodial duties including sweeping, mopping, general cleaning, changing bulbs and some minor maintenance like fixing pencil sharpeners and hanging banners.

Petitioner testified that on January 25, 2005 he felt "ok" before he began work. Petitioner testified that on January 26, 2005, he was called into work early at approximately 2:00 a.m., due to a big snowfall. Petitioner testified that when he arrived to work there was a lot of snow, and that it was wet snow with ice underneath. He estimated 5 to 6 inches of snow had come down and was still blowing. Petitioner testified that he was assigned to take an industrial snow blower and clear all the sidewalks and entrance areas. Petitioner testified that he used the snow blower for 1 to 2 hours and that he subsequently had to clean the ice off the sidewalk. Petitioner testified that he used a shovel to remove ice and it took him an additional 1 to 1-1/2 hours to complete the task. Petitioner provided that while removing the ice from the sidewalk, he noticed a sharp pain in his lower back and legs.

Petitioner testified that that after the ice removal was completed, he had to push the big snow blower to a second school that was "about ¼ mile away." He then used the snowblower at the other school until the boss sent others to help. Petitioner testified that his lower back hurt and that he was having difficulty walking between the schools. Petitioner indicated that after clearing the snow at the second school, he walked the snow blower back to the maintenance garage, and completed his workday. Petitioner provided that during his workday he was having pain in his lower back and experienced significant pain when he went home that evening. The following day he set an appointment with his doctor, Dr. Mekhail, via his HMO and the first appointment was February 10. Dr. Mekhail had previously treated Petitioner for his back and neck. Prior to his visit with Dr. Mekhail, Petitioner attended a previous scheduled independent medical examination with Dr. Cronin, on February 5, 2005, which pertained to his prior workers' compensation claim with a different Respondent. Petitioner also underwent a previous scheduled MRI on February 9th.

Petitioner testified that he saw Dr. Mekhail on February 10, 2005 and provided a history of injury. Petitioner indicated the doctor issued a work status note which prohibited snow shoveling. Petitioner stated that he gave the note to his supervisor, Don Palmer. Petitioner testified that he did not shovel again and continued to work through the late Winter and Spring. Petitioner provided that although he continued with a nagging pain, his lower back pain seemed to subside a little bit, and that he was feeling a little better.

Petitioner testified that when he reported to work on April 29, 2005 his low back was "o.k.; not as good as how it felt before" he commenced employment with Respondent. He also provided that his left hand and arm felt "pretty good" that day. Petitioner stated that on April 29th he was assigned to use a weed whacker to clear high grass around the fence posts and backstops of baseball and football fields. Petitioner estimated the area to be between 900 to 1000 feet. He stated that he was using a gas operated weed whacker, and that he held the main part in his left hand and tucked the other part with the motor under his arm. Petitioner estimated that the weed whacker weighed approximately 6 to 8 pounds. He testified that it took him approximately 7 ½ hours to complete his weed whacking duties. Petitioner reported that as the day progressed, his left arm was getting weaker, and he began developing pain in the left elbow and wrist. Petitioner reported that at the end of his shift, his whole left arm was numb and he couldn't grip the handle. Petitioner reported that when he completed the assignment no other employees were around that day. Petitioner testified that his left arm symptoms persisted over the weekend, and that he called in sick on Monday. Petitioner stated that he went to work the following day, on Tuesday, but that he did not work. Petitioner testified that he reported an injury with a weed whacker, and that Mr. Palmer kind of snickered. Petitioner reported that he was directed to the main office to get paperwork for handling a workers' compensation matter.

Petitioner first sought treatment for his left arm complaints on May 10, 2005, utilizing his group health insurance for his initial visit with Dr. Mejia. Petitioner testified that Dr. Mejia recommended an EMG test and subsequently diagnosed left carpal tunnel and cubital tunnel syndromes. Thereafter, Petitioner underwent left cubital tunnel release and carpal tunnel release on July 15, 2005. Petitioner stated that the medical treatment was paid by his group medical insurance. Petitioner testified that he was released to return to work following his left arm surgery in September 2005, but he did not return to work for the school district.

Petitioner testified that he began a tax and financial service working out of his home in the Fall of 2005. He did desk work with no physical activities. Petitioner testified that in the fall of 2005 he noticed continuing low back pain that was increased when he bent, squatted or walked. His left hand and arm were improved but he still had residual numbness in his fingers and had difficulty lifting and gripping things.

Petitioner testified that his low back condition deteriorated. He saw Dr. Mekhail in May, 2006. Dr. Mekhail performed a redo of the previous L3/4 and L4/5 bilateral laminectomies and also did a posterior spinal fusion on July 25, 2007. He did another procedure at L3/4 on November 14, 2007. Petitioner provided that he saw Dr. Mekhail in January 2008 but was never formally released to return to work. Petitioner testified that he began working again "with taxes" in January, 2008. He did return to Dr. Mekhail in 2009 and was prescribed a spinal stimulator. He declined.

Petitioner testified that he still has residual numbness in the fingers of his left hand. His low back has a constant pain level of about 3-4/10 with medication but will go to 7-8/10 if he does not take medication or tries to do yard work. He has had no new injuries and continues to work from home.

On cross-examination, Petitioner testified that he was a current smoker and that he had been smoking for approximately 38 years. Petitioner stated that he was not advised that smoking would effect his spinal surgeries. He has never quit, but has cut back.

Petitioner testified that he "didn't say anything about an accident or seek medical attention" on January 26, 2005. Petitioner further admitted that he came back to work after that time and was doing his normal job duties. Petitioner further acknowledged that when he first saw Dr. Mekhail on February 10, 2005, Dr. Mekhail merely restricted him from shoveling snow.

On cross-examination, Petitioner initially denied that he ever applied for unemployment benefits. However, on further questioning, Respondent's attorney presented Petitioner with an Application for Unemployment Benefits filed on October 15, 2005. After being confronted with the exhibit, Petitioner recalled applying for unemployment benefits in October 2005. Respondent's Exhibit #1, the Application for Unemployment Benefits, identified Petitioner's reason for separation was a voluntary leave/quit. Petitioner could not testify for sure whether or not he had ever received unemployment benefits.

Petitioner testified that he continued to have leg pain after the June 2004 back surgery which predated his alleged accident, and further, that the leg pain did not improve or resolve. Petitioner also admitted that when he applied for unemployment in October of 2005, he had already been released to return back to work, and that he was not on any restrictions regarding his back or left arm.

Regarding the left arm, Petitioner was questions on cross-examination regarding the prior workers' compensation claim involving the same body part. Petitioner initially testified that he had a traffic accident in 1985 that results in a fracture of his left elbow, but denied surgery. He also denied filing a workers' compensation claim involving his left arm in 1991. Presented with a prior filing history from the Illinois Workers' Compensation Commission, reflecting a prior settlement for 20% loss of use of the left arm in 1992, Petitioner stated that he did not recall. He admitted that the document reflected his proper date of birth, and also confirmed that he worked for Shannon Construction Services in 1990. Petitioner testified that his prior injury while working for Shannon Construction involved left carpal tunnel. He denied any injury to his left elbow.

Respondent presented the testimony of Donald Palmer, the director of building and grounds for Respondent. Mr. Palmer testified that he had been employed by the school district for 51 years, and had been previously employed there as a custodian. Mr. Palmer testified he had been in a supervisory position for the last 30 years, and that his duties included supervision of custodians and maintenance personnel. Mr. Palmer testified that he was supervisor of the custodians in 2005, when Petitioner was an employee. Mr. Palmer testified that although he could not specifically remember what if anything occurred on January 26, 2005, an injury report would have been completed if an injury had been reported. Mr. Palmer also testified that he could not remember if an injury was reported nor could he remember if it snowed on January 26, 2005. Mr. Palmer further stated that there was no paperwork or injury reports pertaining to a January 26, 2005, date of accident claimed by Petitioner.

Dr. Anis Mekhail

Records submitted show Petitioner had been treating with Dr. Mekhail for a history of cervical stenosis as well as lumbar stenosis that had not responded to nonoperative treatment. On January 26, 2004, Dr. Mekhail performed a procedure consisting of a cervical spine laminaplasty (PX 3) On June 4, 2004, Dr. Mekhail performed a decompression laminectomy at L3-4 and L4-5 with foraminotomy and pressure diskectomy. (81)

Petitioner follow-up with Dr. Mekhail on June 14, 2004. At that time, Petitioner reported that he was happy with the outcome. Petitioner reported that he no longer had pain in his legs and that the numbness he had was completely gone. Petitioner also reported very occasional numbness or tingling at the end of the day in his foot. On July 12, 2004, Petitioner reported that his lower leg symptoms had completely subsided. He however noted that two weeks prior he started complaining of numbness in the right thigh upon extended standing. Petitioner also reported back pain when he walked, more "like a backache to both thighs." Dr. Mekhail ordered

a MRI to see if there was some kind of nerve compression leading to the numbness in the right thigh. Physical therapy was also ordered. On August 23, 2004, Dr. Mekhail noted Petitioner was having some persistent mild back pain and discomfort. He noted the pain got better at times, especially activity-related. Petitioner provided that he experienced numbness at the anterior thigh when he stood for over 20-25 minutes, in both thighs. Dr. Mekhail noted the MRI had been obtained which only showed epidural scarring and no stenosis with adequate decompression. Dr. Mekhail released Petitioner to restricted work for three weeks and return to regular duty afterwards. Petitioner was instructed to return in four months at which time AP and lateral x-rays of the lumbosacral spine would be obtained.(RX 10)

On February 10, 2005, Petitioner presented to Dr. Mekhail with a history of worsening low back pain after shoveling snow at his job about a month prior. Petitioner reported that his pain was primarily with activity but had been increasing to more constant. Petitioner reported the pain radiated to his right thigh and that he also experienced some numbness and tingling in his toes. The doctor felt Petitioner presented with lumbar spine disease. He indicated that Petitioner's numbness and right side tingling in the L4 distribution was consistent with musculoskeleton or with muscular injury secondary to physical exertion when Petitioner was shoveling snow. Petitioner was provided with a prescription for medication and physical therapy. Petitioner was advised to return in 6 weeks or sooner if further symptoms developed.

On May 25, 2006, Petitioner returned to Dr. Mekhail complaining of back pain that radiated down to the buttocks. The doctor notes indicate Petitioner's back pain started about six months previous and there was no precipitating event. The doctor wrote that Petitioner believed shoveling the snow could have aggravated it. X-rays taken showed degenerative changes, very mild anterolisthesis with flexion and evidence of decompression in the back. (RX 10)

On January 25, 2007, Petitioner returned to Dr. Mekhail. The doctor noted that the last time he saw Petitioner he only had some back pain. At this visit Petitioner complained of arm pain. Petitioner reported he had been doing well with neck pain until a couple of weeks prior when he picked up his coat and felt numbness shooting down the left arm. Petitioner also reported back pain that radiated down the right leg. The doctor noted that Petitioner did not have much leg pain before. In addition to ordering a MRI of the cervical spine, the doctor also ordered a MRI of the lumbar spine. (RX 10)

On February 8, 2007, Dr. Mekhail noted the MRI of the lumbar spine show lumbar stenosis, more pronounced at L4-L5. A stroid injection was recommended. (RX 10)

On June 25, 2007, Petitioner presented to Dr. Mekhail for follow-up. Dr. Mekhail noted that Petitioner's left central cervical radiculopathy had completely resolved. The doctor noted Petitioner had a C6-C7 herniated disc which Petitioner had no complaints regarding same. However, Petitioner had significant low back and right lower extremity pain. At that time, the doctor recommended a redo L4-L5 decompression, possible fusion with instrumentation. (98)

On July 25, 2007, Dr. Mekhail performed a redo L3-4 and L4-5 bilateral laminotomy, foraninotomy, partial facetectomy, and posterior spinal fusion. The post-operative diagnosis was recurrent L3-4 and L4-5 spinal stenosis with radiculopathy, more on the right. (139)

Due to complaints of recurrent radicular symptoms to the right side and some back pain, Dr. Mekhail performed additional surgery on November 14, 2007 in the form of an exploration with arthrodesis as well as redo of right L3-4 decompression, laminotomy, facetectomy, foraminotomy as well as right L3-4 transforaminal lumbar interverebral fusion. The post operative diagnosis was right L3-4 stenosis with lumbar spondylosis. (228)

Post surgery, Petitioner continued with Dr. Mekhail. On January 24, 2008, it was noted that Petitioner had some residual numbness in the anterior thigh, both sides. He did not have any of the leg pain going down all the way below the knee. He also had some right posterior back pain. Petitioner was urged to quit smoking and advised to wean off Lyrica. On April 27, 2009, Petitioner reported that he still had pain that goes down the right groin and sometimes the right leg. He had numbness in the right anterior thigh and reported the pain could be really severe in the right buttocks. On June 8, 2009, Petitioner continued with complaints of back pain going down the right leg in the L2, L3, L4 distribution and occasionally at L5. The doctor noted Petitioner had anterolisthesis below the level of the L3 fusion but his symptoms were also in the upper lumbar. Continued strengthening exercises was recommended. A MRI was also recommended to evaluate neural compression. The MRI was performed on June 19, 2009 demonstarting mild acquired vertebral canal stenosis at the L2-L3 level. Mild foraminal stenosis was also identified due to bony hypertrophy. When compared to previous studies, it was determined surgical fusion had occurred. The previous narrowed thecal sac had been corrected. (RX 10)

The last visit recorded visit in the submitted evidence show Petitioner was seen on June 22, 2009. Petitioner was still complaining of pain, tingling and numbness in the right anterior thigh. Dr. Mekhail noted the MRI was positive for a L5-S1 disc protrusion. He felt there was no significant neural compression to explain Petitioner's symptoms. An EMG was ordered and consideration was made regarding a spinal cord stimulator.(RX 10)

Dr. Alfonso Mejia

On July 15, 2005, Dr. Mejia performed a medial nerve decompression at the carpal tunnel and ulnar nerve decompression around the elbow. The post operative diagnosis was left upper extremity carpal tunnel syndrome and cubital tunnel syndrome. (PX 3)

Dr. Robert Schenck

Dr. Schenck performed a Section 12 examination at Respondent's request on June 22, 2005. Dr. Schenck recorded a history that Petitioner reported "experiencing numbness in his left arm and hand initially at the end of January, 2005, after doing some heavy snow shoveling. This episode lasted for about two weeks before improving. After that, he had intermittent symptoms of numbness in his left hand with activities such as emptying garbage. He reported that his symptoms "never went away completely." On April 29, 2005, he reportedly "carried around" a 20-pound gas whacker for seven hours, and by the end of the shift, he had no strength in his left arm..." The doctor further recorded that "[Petitioner] explained he used a gas-powered weed whacker, that weighed between 15 and 20 pounds, continuously for seven hours on April 29, 2005. He estimated walking three miles around the school grounds while using the weed whacker, at baseball field, around diamond fences and around two sides of a fence in the football field. He also reported using the weed whacker along the edges of every tree, stump and hedges around the school..." Dr. Schenck performed an examination and reviewed medical documentation. A validity profile was performed which the doctor opined Petitioner did not put forth full effort. Dr. Schenck opined that Petitioner had electrdiagnostic evidence of multiple nerve involvement of both upper extremities which was consistent with peripheral polyneuropathy. The doctor indicated Petitioner had left carpal tunnel syndrome and cubital tunnel syndrome of moderate degree. He felt surgical release of the carpal tunnel syndrome and cubital tunnel syndrome was warranted. However, he opined that same was not related to one day of weed whacking but rather to degenerative or idiopathic causes. The doctor noted Petitioner had an extensive smoking history, obesity and possible trauma to the left elbow. He noted Petitioner had problems with his left hand, as well as a diagnosis of left carpal tunnel syndrome in January 2005. The doctor also noted Petitioner admitted that his symptoms had been intermittent at that time. (RX 7)

Dr. Steven Mather

At Respondent's request Dr. Steven Mather performed a Section 12 examination on November 29, 2010. In his report dated December 8, 2010, the doctor opined that after review of the history, physical examination and medical documentation, Petitioner had continued symptoms of back and legs starting in 2004. The doctor felt Petitioner's lumbar laminectomy led to instability and clearly had continued identical symptomatology through the date of examination. He felt Petitioner had developed spondylolisthesis from the natural degenerative process accelerated by a posterior laminectomy of June 4, 2004. Dr. Mather opined that Petitioner had degenerative spondylolisthesis and spinal stenosis at L3, L4, L5 that had been partially treated with lumbar laminectomy and fusion at L3-L4. He felt Petitioner requires a fusion at L4-L5 though not work related. Lastly, Dr. Mather opined that Petitioner's treatment and care was appropriate but not work related. (RX 8)

Dr. Mather testified by way of evidence deposition. Dr. Mather testified that he is a Board certified orthopaedic surgeon. Dr. Mather testified that after reviewing medical records and performing an examination, he diagnosed Petitioner with spondylolisthesis which gave him his back and leg symptoms. He felt that the diagnosis was not work related. The doctor felt Petitioner had the same symptoms before the January 2005 accident and "this is the natural history of what happens to an unstable spine following laminectomy." He opined that the medical care for the low back was appropriate but that Petitioner's condition was related to the prior surgery in 2004.

Dr. Thomas Cronin

At his request Petitioner saw Dr. Thomas Cronin for an independent medical examination on February 5, 2005 in connection with a prior case. In addition to providing information for the prior case Dr. Cronin documented that "In January 2005, [Petitioner] relates while shoveling snow while at work on his job, he aggravated his right leg problem. He developed pain, numbness and tingling on the front of his right thigh extending to his right knee, and he developed numbness in his whole foot, which has been increasingly symptomatic since this incident in January 2005. Additionally, he relates that he is now developing tingling in his left foot as well. He relates these present symptoms to his snow shoveling activities." Dr. Cronin noted that Petitioner's post surgical course was uneventful until the snow shoveling incident. The doctor also wrote, "rule out new herniated nucleus pulposus with radiculopathy." He felt "surgical intervention is anticipated following diagnostic imaging studies of the MRI."

Dr. Cronin saw Petitioner again on November 19, 2009. Dr. Cronin recorded the history of the snow shoveling incident on January 26, 2005 as well as the weed whacking of April 29, 2005. After reviewing medical documentation, a job description and performing an examination, Dr. Cronin's impression was chronic low back derangement with persistent radiculopthy; status post ulnar nerve transposition (left cubital tunnel syndrome) improved; and improved left carpal tunnel surgery. Dr. Cronin wrote that he disagreed with the opinion of Dr. Schenck stating "...the primary causation of this left upper extremity ulnar nerve neuropathy and carpal tunnel syndrome is based on over-use and aggravation that is directly connected and immediately related to using this unsupported weed whacker during eight-hour shift as described by the patient." The doctor concluded indicating Petitioner's condition of ill-being was due to "Over-use-syndrome and heavy demand work that resulted in dysfunction in his lower back and his left upper extremity."

On February 2, 2011, Dr. Cronin issued an Interim Report Review. The report was generated in response to Petitioner's request to review the IME report of Dr. Mather. Dr. Cronin commented that he disagreed with Dr. Mather's opinion regarding the status of Petitioner. Dr. Cronin wrote, "[Petitioner] performed heavy demand work shoveling snow, using a weed whacker that was the causation of his low back pain in particular. He had three lumbar surgeries and it is not surprising that he has had subsequent degenerative changes and "spondylolisthesis. In my opinion, his work activities were the primary causation of this disability..."

Dr. Cronin testified by way of evidence deposition. Dr. Cronin testified that he specialized in Occupational Medicine. He is not Board certified in any areas of medicine and does not specialize in orthopedics, neurosurgery or spinal surgery. He performed an independent medical examination of Petitioner on two separate occasions, February 5, 2005 and November 19, 2009. Dr. Cronin testified that he believed that Petitioner's job activities aggravated his previous lumbar spine pathology causing more lumbar spine pathology with radiculopathy and back pain. He further opined that Petitioner's left upper extremity problem with the cubital tunnel and carpal tunnel syndrome was directly related to his use of the weed whacker. The doctor believed the heavy demand activity resulted in Petitioner's injuries and subsequent disability. He further opined that Petitioner aggravated degenerative disc disease and spondylolisthesis with the snow shoveling and that the subsequent surgeries were causally related.

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 the petitioner's current condition of ill-being causally related to the injury, the Arbitrator finds as follows:

Petitioner testified that when he reported to work on April 29, 2005 his left hand and arm felt "pretty good" that day. Petitioner stated that on April 29th he was assigned to use a weed wacker to clear high grass around the fence posts and backstops of baseball and football fields. Petitioner estimated the area to be between 900 to 1000 feet. He stated that he was using a gas operated weed whacker, and that he held the main part in his left hand and tucked the other part with the motor under his arm. Petitioner estimated that the weed whacker weighed approximately 6 to 8 pounds. He testified that it took him approximately 7 ½ hours to complete his weed whacking duties. Petitioner reported that as the day progressed, his left arm was getting weaker, and he began developing pain in the left elbow and wrist. Petitioner reported that at the end of his shift, his whole left arm was numb and he couldn't grip the handle. Petitioner testified that his left arm symptoms persisted over the weekend, and that he called in sick on Monday. Petitioner stated that he went to work the following day, on Tuesday, but that he did not work. Petitioner testified that he reported an injury with a weed whacker.

Petitioner first sought treatment for his left arm complaints on May 10, 2005, utilizing his group health insurance for his initial visit with Dr. Mejia. Petitioner testified that Dr. Mejia recommended an EMG test and subsequently diagnosed left carpal tunnel and cubital tunnel syndromes.

On July 15, 2005, Dr. Mejia performed a medial nerve decompression at the carpal tunnel and ulnar nerve decompression around the elbow. The post operative diagnosis was left upper extremity carpal tunnel syndrome and cubital tunnel syndrome.

The only physicians to render an opinion with respect to whether Petitioner's left cubital tunnel syndrome and left carpal tunnel were related to the weed whacking occurrence are Dr. Schenck and Dr. Cronin. Dr. Schenck performed a Section 12 examination at Respondent's request on June 22, 2005. Dr. Schenck recorded a history that Petitioner reported "experiencing numbness in his left arm and hand initially at the end of January, 2005, after doing some heavy snow shoveling. This episode lasted for about two weeks before improving. After that, he had intermittent symptoms of numbness in his left hand with activities such as emptying garbage. He reported that his symptoms "never went away completely." On April 29, 2005, he reportedly "carried around" a 20-pound gas whacker for seven hours, and by the end of the shift, he had no strength in his left arm..." The doctor further recorded that "[Petitioner] explained he used a gas-powered weed wacker, that weighed between 15 and 20 pounds, continuously for seven hours on April 29, 2005. He estimated walking three miles around the school grounds while using the weed whacker, at baseball field, around diamond fences and around two sides of a fence in the football field. He also reported using the weed whacker along the edges of every tree, stump and hedges around the school..." Dr. Schenck performed an examination and reviewed medical documentation. A validity profile was performed which the doctor opined Petitioner did not

put forth full effort. Dr. Schenck opined that Petitioner had electrdiagnostic evidence of multiple nerve involvement of both upper extremities which was consistent with peripheral polyneuropathy. The doctor indicated Petitioner had left carpal tunnel syndrome and cubital tunnel syndrome of moderate degree. He felt surgical release of the carpal tunnel syndrome and cubital tunnel syndrome was warranted. However, he opined that same was not related to one day of weed whacking but rather to degenerative or idiopathic causes. The doctor noted Petitioner had an extensive smoking history, obesity and possible trauma to the left elbow. He noted Petitioner had problems with his left hand, as well as a diagnosis of left carpal tunnel syndrome in January 2005. The doctor also noted Petitioner admitted that his symptoms had been intermittent at that time.

Conversely, at his request, Petitioner saw Dr. Cronin for an IME on November 19, 2009. After reviewing medical documentation, a job description and performing an examination, Dr. Cronin's impression was status post ulnar nerve transposition (left cubital tunnel syndrome) improved; and improved left carpal tunnel surgery. Dr. Cronin wrote that he disagreed with the opinion of Dr. Schenck stating "...the primary causation of this left upper extremity ulnar nerve neuropathy and carpal tunnel syndrome is based on over-use and aggravation that is directly connected and immediately related to using this unsupported weed whacker during eight-hour shift as described by the patient."

After considering the entire record, the Arbitrator is persuaded by the opinion of Dr. Schenck who felt Petitioner left elbow and hand condition of ill-being was not related to one day of weed whacking but rather to degenerative or idiopathic causes. The doctor noted Petitioner had an extensive smoking history, obesity and possible trauma to the left elbow. He noted Petitioner had problems with his left hand as well as Petitioner's admission that his symptoms had been intermittent. The Arbitrator also finds significant that while Dr. Schenck specializes in hand surgery, Dr. Cronin specializes in occupational medicine, not orthopedic treatment of the hands and upper extremities.

Based on the above, the Arbitrator finds that Petitioner failed to prove that he sustained an accidental injury arising out of and in the course of his employment with Respondent on April 29, 2005. The Arbitrator further finds that Petitioner's left cubital tunnel syndrome and left carpal tunnel syndrome is not causally related to his employment with Respondent on April 29, 2005.

All remaining issues are moot.

STATE OF ILLINOIS)
) SS.
COUNTY OF WILL)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Robert DeAngelo,

Petitioner,

vs.

NO: 07 WC 52955

14IWCC0772

Peotone School District,

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 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 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.

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.

14IWCC0772

The party commencing the 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
TJT:yl
o 9/8/14
51

Thomas J. Tyrrell

Michael J. Brennan

Kevin W. Lamborn

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

DeANGELO, ROBERT
Employee/Petitioner

Case# **07WC052955**

05WC027590

PEOTONE SCHOOL DISTRICT
Employer/Respondent

14IWCC0772

On 4/11/2013, 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 0.09% 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:

0293 KATZ FRIEDMAN EAGLE ET AL
DAVID M BARISH
77 W WASHINGTON ST 20TH FL
CHICAGO, IL 60602

1120 BRADY CONNOLLY & MASUDA PC
NICOLE RUSSO WEISBRODT
ONE N LASALLE ST SUITE 1000
CHICAGO, IL 60602

STATE OF ILLINOIS)
)SS.
COUNTY OF Will)

14IWCC0772

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Robert DeAngelo
Employee/Petitioner

v.

Peotone School District
Employer/Respondent

Case # **07** WC **52955**

Consolidated cases: **05 wc 27590**

An *Application for Adjustment 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 Lennox, Illinois**, on **December 13, 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 **1-26-2005**, 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.

14IWCC0772

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

In the year preceding the injury, Petitioner earned **$18,930.08**; the average weekly wage was **$364.04**.

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

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

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

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

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

ORDER

Respondent shall pay Petitioner permanent partial disability benefits of $218.42/week for 15 weeks, because the injuries sustained caused the 3% disability 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.

Signature of Arbitrator

4/10/13
Date

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APR 11 2013

Statement of Facts

Petitioner, Robert DeAngelo, was a custodian and maintenance worker for Respondent Peotone School District in 2005. He began working for Respondent in October, 2004. Prior to working for Respondent, Petitioner had a significant medical history. Petitioner provided that he had a prior injury to his neck and back for which he had filed a Workers' Compensation claim. He underwent a cervical fusion in 2003 and had undergone two prior surgeries (2003 and 2004) to his lumbar spine. Petitioner testified that he had just been released from his prior back surgery in August 2004, right before he began his employment with Respondent.

Petitioner testified that prior to being employed by Respondent, he was working for Aramark Management Services. Petitioner stated that his prior employment with Aramark was a physically strenuous job and that he worked as a custodian. He provided that his duties for Aramark was more physically demanding than the work he was doing for the current Respondent. Petitioner also provided that prior to being employed by Respondent, he had experienced problems with numbness in his right hand and had pre-existing leg pain.

Petitioner recalled having carpal tunnel syndrome in his right hand but was unclear about the left. He recalled a settlement in 1991 for his left arm but could not recall exactly what was injured. He settled a workers' compensation case for a 20% loss of use of the left arm. The parties did not provide any details as to what injury was sustained. Petitioner was able to recall fracturing his left elbow in a motor vehicle accident many years ago where there was no litigation.

Petitioner testified that he was feeling "allright" in the Fall of 2004. He had no left hand or elbow problems. Petitioner stated that he did a variety of custodial duties including sweeping, mopping, general cleaning, changing bulbs and some minor maintenance like fixing pencil sharpeners and hanging banners.

Petitioner testified that on January 25, 2005 he felt "ok" before he began work. Petitioner testified that on January 26, 2005, he was called into work early at approximately 2:00 a.m., due to a big snowfall. Petitioner testified that when he arrived to work there was a lot of snow, and that it was wet snow with ice underneath. He estimated 5 to 6 inches of snow had come down and was still blowing. Petitioner testified that he was assigned to take an industrial snow blower and clear all the sidewalks and entrance areas. Petitioner testified that he used the snow blower for 1 to 2 hours and that he subsequently had to clean the ice off the sidewalk. Petitioner testified that he used a shovel to remove ice and it took him an additional 1 to 1-1/2 hours to complete the task. Petitioner provided that while removing the ice from the sidewalk, he noticed a sharp pain in his lower back and legs.

Petitioner testified that that after the ice removal was completed, he had to push the big snow blower to a second school that was "about ¼ mile away." He then used the snowblower at the other school until the boss sent others to help. Petitioner testified that his lower back hurt and that he was having difficulty walking between the schools. Petitioner indicated that after clearing the snow at the second school, he walked the snow blower back to the maintenance garage, and completed his workday. Petitioner provided that during his workday he was having pain in his lower back and experienced significant pain when he went home that evening. The following day he set an appointment with his doctor, Dr. Mekhail, via his HMO and the first appointment was February 10. Dr. Mekhail had previously treated Petitioner for his back and neck. Prior to his visit with Dr. Mekhail, Petitioner attended a previous scheduled independent medical examination with Dr. Cronin, on February 5, 2005, which pertained to his prior workers' compensation claim with a different Respondent. Petitioner also underwent a previous scheduled MRI on February 9th.

Petitioner testified that he saw Dr. Mekhail on February 10, 2005 and provided a history of injury. Petitioner indicated the doctor issued a work status note which prohibited snow shoveling. Petitioner stated that he gave the note to his supervisor, Don Palmer. Petitioner testified that he did not shovel again and continued to work through the late Winter and Spring. Petitioner provided that although he continued with a nagging pain, his lower back pain seemed to subside a little bit, and that he was feeling a little better.

Petitioner testified that when he reported to work on April 29, 2005 his low back was "o.k.; not as good as how it felt before" he commenced employment with Respondent. He also provided that his left hand and arm felt "pretty good" that day. Petitioner stated that on April 29th he was assigned to use a weed whacker to clear high grass around the fence posts and backstops of baseball and football fields. Petitioner estimated the area to be between 900 to 1000 feet. He stated that he was using a gas operated weed whacker, and that he held the main part in his left hand and tucked the other part with the motor under his arm. Petitioner estimated that the weed whacker weighed approximately 6 to 8 pounds. He testified that it took him approximately 7 ½ hours to complete his weed whacking duties. Petitioner reported that as the day progressed, his left arm was getting weaker, and he began developing pain in the left elbow and wrist. Petitioner reported that at the end of his shift, his whole left arm was numb and he couldn't grip the handle. Petitioner reported that when he completed the assignment no other employees were around that day. Petitioner testified that his left arm symptoms persisted over the weekend, and that he called in sick on Monday. Petitioner stated that he went to work the following day, on Tuesday, but that he did not work. Petitioner testified that he reported an injury with a weed whacker, and that Mr. Palmer kind of snickered. Petitioner reported that he was directed to the main office to get paperwork for handling a workers' compensation matter.

Petitioner first sought treatment for his left arm complaints on May 10, 2005, utilizing his group health insurance for his initial visit with Dr. Mejia. Petitioner testified that Dr. Mejia recommended an EMG test and subsequently diagnosed left carpal tunnel and cubital tunnel syndromes. Thereafter, Petitioner underwent left cubital tunnel release and carpal tunnel release on July 15, 2005. Petitioner stated that the medical treatment was paid by his group medical insurance. Petitioner testified that he was released to return to work following his left arm surgery in September 2005, but he did not return to work for the school district.

Petitioner testified that he began a tax and financial service working out of his home in the Fall of 2005. He did desk work with no physical activities. Petitioner testified that in the fall of 2005 he noticed continuing low back pain that was increased when he bent, squatted or walked. His left hand and arm were improved but he still had residual numbness in his fingers and had difficulty lifting and gripping things.

Petitioner testified that his low back condition deteriorated. He saw Dr. Mekhail in May, 2006. Dr. Mekhail performed a redo of the previous L3/4 and L4/5 bilateral laminectomies and also did a posterior spinal fusion on July 25, 2007. He did another procedure at L3/4 on November 14, 2007. Petitioner provided that he saw Dr. Mekhail in January 2008 but was never formally released to return to work. Petitioner testified that he began working again "with taxes" in January, 2008. He did return to Dr. Mekhail in 2009 and was prescribed a spinal stimulator. He declined.

Petitioner testified that he still has residual numbness in the fingers of his left hand. His low back has a constant pain level of about 3-4/10 with medication but will go to 7-8/10 if he does not take medication or tries to do yard work. He has had no new injuries and continues to work from home.

On cross-examination, Petitioner testified that he was a current smoker and that he had been smoking for approximately 38 years. Petitioner stated that he was not advised that smoking would effect his spinal surgeries. He has never quit, but has cut back.

Petitioner testified that he "didn't say anything about an accident or seek medical attention" on January 26, 2005. Petitioner further admitted that he came back to work after that time and was doing his normal job duties. Petitioner further acknowledged that when he first saw Dr. Mekhail on February 10, 2005, Dr. Mekhail merely restricted him from shoveling snow.

On cross-examination, Petitioner initially denied that he ever applied for unemployment benefits. However, on further questioning, Respondent's attorney presented Petitioner with an Application for Unemployment Benefits filed on October 15, 2005. After being confronted with the exhibit, Petitioner recalled applying for unemployment benefits in October 2005. Respondent's Exhibit #1, the Application for Unemployment Benefits, identified Petitioner's reason for separation was a voluntary leave/quit. Petitioner could not testify for sure whether or not he had ever received unemployment benefits.

Petitioner testified that he continued to have leg pain after the June 2004 back surgery which predated his alleged accident, and further, that the leg pain did not improve or resolve. Petitioner also admitted that when he applied for unemployment in October of 2005, he had already been released to return back to work, and that he was not on any restrictions regarding his back or left arm.

Regarding the left arm, Petitioner was questions on cross-examination regarding the prior workers' compensation claim involving the same body part. Petitioner initially testified that he had a traffic accident in 1985 that results in a fracture of his left elbow, but denied surgery. He also denied filing a workers' compensation claim involving his left arm in 1991. Presented with a prior filing history from the Illinois Workers' Compensation Commission, reflecting a prior settlement for 20% loss of use of the left arm in 1992, Petitioner stated that he did not recall. He admitted that the document reflected his proper date of birth, and also confirmed that he worked for Shannon Construction Services in 1990. Petitioner testified that his prior injury while working for Shannon Construction involved left carpal tunnel. He denied any injury to his left elbow.

Respondent presented the testimony of Donald Palmer, the director of building and grounds for Respondent. Mr. Palmer testified that he had been employed by the school district for 51 years, and had been previously employed there as a custodian. Mr. Palmer testified he had been in a supervisory position for the last 30 years, and that his duties included supervision of custodians and maintenance personnel. Mr. Palmer testified that he was supervisor of the custodians in 2005, when Petitioner was an employee. Mr. Palmer testified that although he could not specifically remember what if anything occurred on January 26, 2005, an injury report would have been completed if an injury had been reported. Mr. Palmer also testified that he could not remember if an injury was reported nor could he remember if it snowed on January 26, 2005. Mr. Palmer further stated that there was no paperwork or injury reports pertaining to a January 26, 2005, date of accident claimed by Petitioner.

Dr. Anis Mekhail

Records submitted show Petitioner had been treating with Dr. Mekhail for a history of cervical stenosis as well as lumbar stenosis that had not responded to nonoperative treatment. On January 26, 2004, Dr. Mekhail performed a procedure consisting of a cervical spine laminaplasty (PX 3) On June 4, 2004, Dr. Mekhail performed a decompression laminectomy at L3-4 and L4-5 with foraminotomy and pressure diskectomy. (81)

Petitioner follow-up with Dr. Mekhail on June 14, 2004. At that time, Petitioner reported that he was happy with the outcome. Petitioner reported that he no longer had pain in his legs and that the numbness he had was completely gone. Petitioner also reported very occasional numbness or tingling at the end of the day in his foot. On July 12, 2004, Petitioner reported that his lower leg symptoms had completely subsided. He however noted that two weeks prior he started complaining of numbness in the right thigh upon extended standing. Petitioner also reported back pain when he walked, more "like a backache to both thighs." Dr. Mekhail ordered

a MRI to see if there was some kind of nerve compression leading to the numbness in the right thigh. Physical therapy was also ordered. On August 23, 2004, Dr. Mekhail noted Petitioner was having some persistent mild back pain and discomfort. He noted the pain got better at times, especially activity-related. Petitioner provided that he experienced numbness at the anterior thigh when he stood for over 20-25 minutes, in both thighs. Dr. Mekhail noted the MRI had been obtained which only showed epidural scarring and no stenosis with adequate decompression. Dr. Mekhail released Petitioner to restricted work for three weeks and return to regular duty afterwards. Petitioner was instructed to return in four months at which time AP and lateral x-rays of the lumbosacral spine would be obtained.(RX 10)

On February 10, 2005, Petitioner presented to Dr. Mekhail with a history of worsening low back pain after shoveling snow at his job about a month prior. Petitioner reported that his pain was primarily with activity but had been increasing to more constant. Petitioner reported the pain radiated to his right thigh and that he also experienced some numbness and tingling in his toes. The doctor felt Petitioner presented with lumbar spine disease. He indicated that Petitioner's numbness and right side tingling in the L4 distribution was consistent with musculoskeleton or with muscular injury secondary to physical exertion when Petitioner was shoveling snow. Petitioner was provided with a prescription for medication and physical therapy. Petitioner was advised to return in 6 weeks or sooner if further symptoms developed.

On May 25, 2006, Petitioner returned to Dr. Mekhail complaining of back pain that radiated down to the buttocks. The doctor notes indicate Petitioner's back pain started about six months previous and there was no precipitating event. The doctor wrote that Petitioner believed shoveling the snow could have aggravated it. X-rays taken showed degenerative changes, very mild anterolisthesis with flexion and evidence of decompression in the back. (RX 10)

On January 25, 2007, Petitioner returned to Dr. Mekhail. The doctor noted that the last time he saw Petitioner he only had some back pain. At this visit Petitioner complained of arm pain. Petitioner reported he had been doing well with neck pain until a couple of weeks prior when he picked up his coat and felt numbness shooting down the left arm. Petitioner also reported back pain that radiated down the right leg. The doctor noted that Petitioner did not have much leg pain before. In addition to ordering a MRI of the cervical spine, the doctor also ordered a MRI of the lumbar spine. (RX 10)

On February 8, 2007, Dr. Mekhail noted the MRI of the lumbar spine show lumbar stenosis, more pronounced at L4-L5. A stroid injection was recommended. (RX 10)

On June 25, 2007, Petitioner presented to Dr. Mekhail for follow-up. Dr. Mekhail noted that Petitioner's left central cervical radiculopathy had completely resolved. The doctor noted Petitioner had a C6-C7 herniated disc which Petitioner had no complaints regarding same. However, Petitioner had significant low back and right lower extremity pain. At that time, the doctor recommended a redo L4-L5 decompression, possible fusion with instrumentation. (98)

On July 25, 2007, Dr. Mekhail performed a redo L3-4 and L4-5 bilateral laminotomy, foraninotomy, partial facetectomy, and posterior spinal fusion. The post-operative diagnosis was recurrent L3-4 and L4-5 spinal stenosis with radiculopathy, more on the right. (139)

Due to complaints of recurrent radicular symptoms to the right side and some back pain, Dr. Mekhail performed additional surgery on November 14, 2007 in the form of an exploration with arthrodesis as well as redo of right L3-4 decompression, laminotomy, facetectomy, foraminotomy as well as right L3-4 transforaminal lumbar interverebral fusion. The post operative diagnosis was right L3-4 stenosis with lumbar spondylosis. (228)

Post surgery, Petitioner continued with Dr. Mekhail. On January 24, 2008, it was noted that Petitioner had some residual numbness in the anterior thigh, both sides. He did not have any of the leg pain going down all the way below the knee. He also had some right posterior back pain. Petitioner was urged to quit smoking and advised to wean off Lyrica. On April 27, 2009, Petitioner reported that he still had pain that goes down the right groin and sometimes the right leg. He had numbness in the right anterior thigh and reported the pain could be really severe in the right buttocks. On June 8, 2009, Petitioner continued with complaints of back pain going down the right leg in the L2, L3, L4 distribution and occasionally at L5. The doctor noted Petitioner had anterolisthesis below the level of the L3 fusion but his symptoms were also in the upper lumbar. Continued strengthening exercises was recommended. A MRI was also recommended to evaluate neural compression. The MRI was performed on June 19, 2009 demonstarting mild acquired vertebral canal stenosis at the L2-L3 level. Mild foraminal stenosis was also identified due to bony hypertrophy. When compared to previous studies, it was determined surgical fusion had occurred. The previous narrowed thecal sac had been corrected. (RX 10)

The last visit recorded visit in the submitted evidence show Petitioner was seen on June 22, 2009. Petitioner was still complaining of pain, tingling and numbness in the right anterior thigh. Dr. Mekhail noted the MRI was positive for a L5-S1 disc protrusion. He felt there was no significant neural compression to explain Petitioner's symptoms. An EMG was ordered and consideration was made regarding a spinal cord stimulator.(RX 10)

Dr. Alfonso Mejia

On July 15, 2005, Dr. Mejia performed a medial nerve decompression at the carpal tunnel and ulnar nerve decompression around the elbow. The post operative diagnosis was left upper extremity carpal tunnel syndrome and cubital tunnel syndrome. (PX 3)

Dr. Robert Schenck

Dr. Schenck performed a Section 12 examination at Respondent's request on June 22, 2005. Dr. Schenck recorded a history that Petitioner reported "experiencing numbness in his left arm and hand initially at the end of January, 2005, after doing some heavy snow shoveling. This episode lasted for about two weeks before improving. After that, he had intermittent symptoms of numbness in his left hand with activities such as emptying garbage. He reported that his symptoms "never went away completely." On April 29, 2005, he reportedly "carried around" a 20-pound gas whacker for seven hours, and by the end of the shift, he had no strength in his left arm..." The doctor further recorded that "[Petitioner] explained he used a gas-powered weed whacker, that weighed between 15 and 20 pounds, continuously for seven hours on April 29, 2005. He estimated walking three miles around the school grounds while using the weed whacker, at baseball field, around diamond fences and around two sides of a fence in the football field. He also reported using the weed whacker along the edges of every tree, stump and hedges around the school..." Dr. Schenck performed an examination and reviewed medical documentation. A validity profile was performed which the doctor opined Petitioner did not put forth full effort. Dr. Schenck opined that Petitioner had electrdiagnostic evidence of multiple nerve involvement of both upper extremities which was consistent with peripheral polyneuropathy. The doctor indicated Petitioner had left carpal tunnel syndrome and cubital tunnel syndrome of moderate degree. He felt surgical release of the carpal tunnel syndrome and cubital tunnel syndrome was warranted. However, he opined that same was not related to one day of weed whacking but rather to degenerative or idiopathic causes. The doctor noted Petitioner had an extensive smoking history, obesity and possible trauma to the left elbow. He noted Petitioner had problems with his left hand, as well as a diagnosis of left carpal tunnel syndrome in January 2005. The doctor also noted Petitioner admitted that his symptoms had been intermittent at that time. (RX 7)

Dr. Steven Mather

At Respondent's request Dr. Steven Mather performed a Section 12 examination on November 29, 2010. In his report dated December 8, 2010, the doctor opined that after review of the history, physical examination and medical documentation, Petitioner had continued symptoms of back and legs starting in 2004. The doctor felt Petitioner's lumbar laminectomy led to instability and clearly had continued identical symptomatology through the date of examination. He felt Petitioner had developed spondylolisthesis from the natural degenerative process accelerated by a posterior laminectomy of June 4, 2004. Dr. Mather opined that Petitioner had degenerative spondylolisthesis and spinal stenosis at L3, L4, L5 that had been partially treated with lumbar laminectomy and fusion at L3-L4. He felt Petitioner requires a fusion at L4-L5 though not work related. Lastly, Dr. Mather opined that Petitioner's treatment and care was appropriate but not work related. (RX 8)

Dr. Mather testified by way of evidence deposition. Dr. Mather testified that he is a Board certified orthopaedic surgeon. Dr. Mather testified that after reviewing medical records and performing an examination, he diagnosed Petitioner with spondylolisthesis which gave him his back and leg symptoms. He felt that the diagnosis was not work related. The doctor felt Petitioner had the same symptoms before the January 2005 accident and "this is the natural history of what happens to an unstable spine following laminectomy." He opined that the medical care for the low back was appropriate but that Petitioner's condition was related to the prior surgery in 2004.

Dr. Thomas Cronin

At his request Petitioner saw Dr. Thomas Cronin for an independent medical examination on February 5, 2005 in connection with a prior case. In addition to providing information for the prior case Dr. Cronin documented that "In January 2005, [Petitioner] relates while shoveling snow while at work on his job, he aggravated his right leg problem. He developed pain, numbness and tingling on the front of his right thigh extending to his right knee, and he developed numbness in his whole foot, which has been increasingly symptomatic since this incident in January 2005. Additionally, he relates that he is now developing tingling in his left foot as well. He relates these present symptoms to his snow shoveling activities." Dr. Cronin noted that Petitioner's post surgical course was uneventful until the snow shoveling incident. The doctor also wrote, "rule out new herniated nucleus pulposus with radiculopathy." He felt "surgical intervention is anticipated following diagnostic imaging studies of the MRI."

Dr. Cronin saw Petitioner again on November 19, 2009. Dr. Cronin recorded the history of the snow shoveling incident on January 26, 2005 as well as the weed whacking of April 29, 2005. After reviewing medical documentation, a job description and performing an examination, Dr. Cronin's impression was chronic low back derangement with persistent radiculopthy; status post ulnar nerve transposition (left cubital tunnel syndrome) improved; and improved left carpal tunnel surgery. Dr. Cronin wrote that he disagreed with the opinion of Dr. Schenck stating "...the primary causation of this left upper extremity ulnar nerve neuropathy and carpal tunnel syndrome is based on over-use and aggravation that is directly connected and immediately related to using this unsupported weed whacker during eight-hour shift as described by the patient." The doctor concluded indicating Petitioner's condition of ill-being was due to "Over-use-syndrome and heavy demand work that resulted in dysfunction in his lower back and his left upper extremity."

On February 2, 2011, Dr. Cronin issued an Interim Report Review. The report was generated in response to Petitioner's request to review the IME report of Dr. Mather. Dr. Cronin commented that he disagreed with Dr. Mather's opinion regarding the status of Petitioner. Dr. Cronin wrote, "[Petitioner] performed heavy demand work shoveling snow, using a weed whacker that was the causation of his low back pain in particular. He had three lumbar surgeries and it is not surprising that he has had subsequent degenerative changes and "spondylolisthesis. In my opinion, his work activities were the primary causation of this disability..."

Dr. Cronin testified by way of evidence deposition. Dr. Cronin testified that he specialized in Occupational Medicine. He is not Board certified in any areas of medicine and does not specialize in orthopedics, neurosurgery or spinal surgery. He performed an independent medical examination of Petitioner on two separate occasions, February 5, 2005 and November 19, 2009. Dr. Cronin testified that he believed that Petitioner's job activities aggravated his previous lumbar spine pathology causing more lumbar spine pathology with radiculopathy and back pain. He further opined that Petitioner's left upper extremity problem with the cubital tunnel and carpal tunnel syndrome was directly related to his use of the weed whacker. The doctor believed the heavy demand activity resulted in Petitioner's injuries and subsequent disability. He further opined that Petitioner aggravated degenerative disc disease and spondylolisthesis with the snow shoveling and that the subsequent surgeries were causally related.

In support of the Arbitrator's decision relating to (C.) Did an accident occur that arose out of and in the course of petitioner's employment by respondent, the Arbitrator finds as follows:

Petitioner testified that injured himself shoveling snow on January 26, 2005. He testified that he pushed a snow blower for about an hour and a half in wet snow that was at least 6" deep and drifted deeper. He then took a shovel to remove the ice that was under the fresh snow. He pushed the snowblower about a quarter mile to another school and then used it to clear the other school. He worked from 2:00 a.m. until 7:30 a.m. performing these activities. Respondent's witness, Don Palmer testified that this type of work was not really done but he had scant recollection of anything much less the events described by Petitioner.

Petitioner's testimony is corroborated by the medical records. Dr. Cronin was performing an evaluation on a prior claim that had coincidentally been set for February 5, 2005. Petitioner told Dr. Cronin about the snow shoveling injuring his back. Petitioner saw Dr. Mekhail on February 10, 2010 and also mentioned injuring his low back shoveling snow.

Based on Petitioner's testimony and the consistent histories given, the Arbitrator finds that Petitioner sustained an accident that arose out of and in the course of his employment with Respondent on January 26, 2005.

In support of the Arbitrator's decision relating to (E.) Was timely notice of the accident given to respondent, the Arbitrator finds as follows:

Petitioner testified that after clearing the snow he completed his workday. Petitioner provided that during his workday he was having pain in his lower back and experienced significant pain when he went home that evening. The following day he set an appointment with his doctor, Dr. Mekhail, via his HMO. Petitioner testified that he saw Dr. Mekhail on February 10, 2005 and provided a history of injury. Petitioner indicated the doctor issued a work status note which prohibited snow shoveling. Petitioner stated that he gave the note to his supervisor, Don Palmer. He testified that this was met with a curse but was accommodated. Petitioner testified that he did not shovel again and continued to work through the late Winter and Spring. Mr. Palmer was unable to recall anything to either confirm or deny this.

Based on the preponderance of evidence, the Arbitrator finds that Petitioner provided timely notice of accident.

In support of the Arbitrator decision relating to (F.) Is the petitioner's current condition of ill-being causally related to the injury, the Arbitrator finds as follows:

The Arbitrator finds that Petitioner failed to prove that his current condition of ill-being is causally related to the accident sustained on January 26, 2005

On February 10, 2005, Petitioner presented to Dr. Mekhail with a history of worsening low back pain after shoveling snow at his job about a month prior. Petitioner reported that his pain was primarily with activity but had been increasing to more constant. Petitioner reported the pain radiated to his right thigh and that he also experienced some numbness and tingling in his toes. The doctor felt Petitioner presented with lumbar spine disease. He indicated that Petitioner's numbness and right side tingling in the L4 distribution was consistent with musculoskeleton or with muscular injury secondary to physical exertion when Petitioner was shoveling snow. Petitioner was provided with a prescription for medication and physical therapy. Petitioner was advised to return in 6 weeks or sooner if further symptoms developed. Petitioner did not treat again for the lumbar until fifteen months later on May 25, 2006, when he returned to Dr. Mekhail complaining of back pain that radiated down to the buttocks. The doctor notes indicate Petitioner's back pain started about six months previous and there was no precipitating event. The doctor wrote that Petitioner believed shoveling the snow could have aggravated it. X-rays taken showed degenerative changes, very mild anterolisthesis with flexion and evidence of decompression in the back. Records submitted show that no treatment was rendered until January 25, 2007. Petitioner returned to Dr. Mekhail. The doctor noted that the last time he saw Petitioner he only had some back pain. At this visit Petitioner complained of arm pain. Petitioner also reported back pain that radiated down the right leg. A MRI of the lumbar spine was ordered.

On February 8, 2007, Dr. Mekhail noted the MRI of the lumbar spine show lumbar stenosis, more pronounced at L4-L5. A stroid injection was recommended. On June 25, 2007, Dr. Mekhail noted Petitioner had significant low back and right lower extremity pain. At that time, the doctor recommended a redo L4-L5 decompression, possible fusion with instrumentation.

On July 25, 2007, Dr. Mekhail performed a redo L3-4 and L4-5 bilateral laminotomy, foraninotomy, partial facetectomy, and posterior spinal fusion. The post-operative diagnosis was recurrent L3-4 and L4-5 spinal stenosis with radiculopathy, more on the right. Due to complaints of recurrent radicular symptoms to the right side and some back pain, Dr. Mekhail performed additional surgery on November 14, 2007 in the form of an exploration with arthrodesis as well as redo of right L3-4 decompression, laminotomy, facetectomy, foraminotomy as well as right L3-4 transforaminal lumbar interverebral fusion. The post operative diagnosis was right L3-4 stenosis with lumbar spondylosis.

Post surgery, Petitioner continue with Dr. Mekhail. The last visit recorded visit in the submitted evidence show Petitioner was seen on June 22, 2009. Petitioner was still complaining pain, tingling and numbness in the right anterior thigh. Dr. Mekhail noted a MRI taken was positive for a L5-S1 disc protrusion. He felt there was no significant neural compression to explain Petitioner's symptoms.

The only causal relationship opinions tendered in this matter were offered by Dr. Cronin on behalf of Petitioner and Dr. Mather on behalf of Respondent. Dr. Cronin testified that he specialized in Occupational Medicine. He is not Board certified in any areas of medicine and does not specialize in orthopedics, neurosurgery or spinal surgery. Dr. Cronin testified that he believed that Petitioner's job activities aggravated his previous lumbar spine pathology causing more lumbar spine pathology with radiculopathy and back pain. The doctor believed the heavy demand activity resulted in Petitioner's injuries and subsequent disability. He further opined that Petitioner aggravated degenerative disc disease and spondylolisthesis with the snow shoveling and that the subsequent surgeries were causally related. Conversely, Dr. Mather testified that based on the fact that Petitioner continued to complain of back and leg symptoms subsequent to his June 4, 2004, surgery, this was suggestive of instability and was likely the cause of Petitioner's spinal stenosis. Dr. Mather testified that when comparing Petitioner's lumbar MRI from July 2004 with a lumbar MRI from February 9, 2005, there were no new findings. Dr. Mather also testified that the fact that Petitioner complained of leg pain prior to his alleged January 26, 2005, date of accident suggested that he already had pre-existing nerve root compression. Dr. Mather's diagnosed spondylolisthesis which he felt was not related to the January 26, 2005 date of accident.

The basis for Dr. Mather's opinion included the fact that Petitioner had the same symptoms before the alleged accident, and that his complaints were characteristic of the natural history of what happens to an unstable spine following a laminectomy. Dr. Mather went on to testify, "If you start with an unstable spine, make it more unstable, it's going to go on to gross spondylolisthesis even if has a desk job."

The Arbitrator finds the opinions of Dr. Mather are more persuasive than those of Dr. Cronin. Dr. Mather has been board-certified in orthopedic surgery since 1994 and, as part of his training, completed a residency in adult spinal surgery from 1991 to 1992. Dr. Mather is also a team physician for the Chicago White Sox. He has been practicing adult spinal surgery and spinal disorders at M&M Orthopaedics since 1999. By comparison, Dr. Cronin practices occupational medicine, does not specialize in spinal orthopedics, and does not perform any spinal surgeries.

In addition to relying on the persuasive opinion of Dr. Mather, the Arbitrator notes that at the initial visit with Dr. Mekhail on February 10, 2005, Dr. Mekhail felt Petitioner's presentation was consistent with musculoskeleton or with muscular injury secondary to physical exertion when Petitioner was shoveling snow. Petitioner did not treat again for the lumbar until fifteen months later on May 25, 2006, when he returned to Dr. Mekhail complaining of back pain that radiated down to the buttocks. The doctor noted Petitioner's back pain started about six months previous and there was no precipitating event. After that visit, records show that no treatment was rendered until January 25, 2007 when Petitioner returned to Dr. Mekhail.

Based on the significant gap in treatment and the causal relationship opinion of Dr. Mather, the Arbitrator finds that Petitioner failed to prove that his current condition of ill-being is causally related to the accident sustained on January 26, 2005. Relying on the on the opinion of Dr. Mekhail, the Arbitrator finds that Petitioner sustained a musculoskeleton or muscular injury secondary to physical exertion.

In support of the Arbitrator decision relating to (J.)Were the medical services that were provided to the petitioner reasonable and necessary? Has respondent paid all appropriate charges for all reasonable and necessary medical services, the Arbitrator finds as follows:

Based on the Arbitrator's findings in Sections C and F above, the Arbitrator finds that the medical services provided after Petitioner's visit with Dr. Mekhail on February 10, 2005 are not causally related to the January 26, 2005 accident. As such any claim for medical expenses subsequent thereto are denied.

In support of the Arbitrator decision relating to (K.) What temporary benefits are in dispute, the Arbitrator finds as follows:

For the reasons set forth in Section C, the Arbitrator finds that Petitioner is not entitled to any compensation for temporary total disability benefits. Furthermore, Petitioner acknowledged that he continued working after the snow removal incident performing his regular duties as a custodian until his alleged April 29, 2005, date of accident. Accordingly, temporary total disability benefits pertaining to the January 26, 2005 date of accident are denied.

In support of the Arbitrator decision relating to (L.) What is the nature and extent of the injury, the Arbitrator finds as follows:

Relying on the on the opinion of Dr. Mekhail, the Arbitrator finds that Petitioner sustained a musculoskeleton or muscular injury secondary to physical exertion. As such, the Arbitrator finds that Petitioner is entitled to 15 weeks of permanent partial disability benefits, under Section 8(d)(2) of the Act because the injuries sustained caused permanent partial disability to Petitioner's person as a whole to the extent of 3% thereof.

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

John Barclay,

14IWCC0773

Petitioner,

vs.

NO: 12 WC 14794

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, 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 February 19, 2013, is hereby affirmed and adopted.

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

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

DATED: SEP 14 2014
o8/27/14
RWW/rm
046

Ruth W. White

Charles J. DeVriendt

Daniel R. Donohoo

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

14IWCC0773

BARCLAY, JOHN Case# **12WC014794**
Employee/Petitioner

ILLINOIS DEPT OF CORRECTIONS
Employer/Respondent

On 2/19/2013, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.12% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

1337 KNELL & KELLY LLC
STEPHWN P KELLY ESQ
504 FAYETTE ST
PEORIA, IL 61603

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

4707 LAW OFFICE OF CHRIS DOSCOTCH
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

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

FEB 19 2013

KIMBERLY B. JANAS Secretary
Illinois Workers' Compensation Commission

14IWCC0773

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

JOHN BARCLAY,
Employee/Petitioner

v.

ILLINOIS DEPARTMENT OF CORRECTIONS,
Employer/Respondent

Case # 12 WC 14794

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 **1/29/13**. 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 **8/17/10**, Respondent *was* operating under and subject to the provisions of the Act.

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

On this date, Petitioner *did 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 $**56,110.66**; the average weekly wage was $**1,079.05**.

On the date of accident, Petitioner was **44** 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 $**20,553.94** for TTD, $**00.00** for TPD, $**00.00** for maintenance, and $**00.00** for other benefits, for a total credit of $**20,553.94**.

Respondent is entitled to a credit of $**00.00** under Section 8(j) of the Act.

ORDER

The arbitrator finds the petitioner has failed to prove by a preponderance of the credible evidence that he sustained an accidental injury due to repetitive work activities that arose out of and in the course of his employment by respondent on 8/17/10. The petitioner's claim for compensation is denied.

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

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

Signature of Arbitrator

2/13/12
Date

FEB 19 2013

THE ARBITRATOR HEREBY MAKES THE FOLLOWING FINDINGS OF FACT:

Petitioner, a 44-year-old corrections officer, alleges he sustained an accidental injury to his bilateral hands and elbows due to his alleged repetitive work activities that arose out of and in the course of his employment by respondent, and manifested itself on 8/17/10. Petitioner is employed at the Illinois River Correctional Center. His duties include supervising inmates, shaking down inmates, and letting inmates in and out of various doors. Petitioner has been a correctional officer for 21 years.

As a correctional officer at the Illinois River Correctional Center petitioner worked various assignments that included control officer, core officer, wing officer, segregation officer, and tower officer. Each day petitioner would be required to go through eight doors in order to get into the facility. Petitioner testified that the doors were heavy and he would have to push them open and pull to shut. In order to get to the housing assignment petitioner testified that he would need to go through six more doors. He testified that the doors weighed more than 25 pounds and were heavy.

When working as a control officer petitioner would work in the "control bubble". To get to the control bubble petitioner would go through two more doors. Petitioner used his hands and arms to go through these doors. While in the control bubble petitioner's duties included using two touch screen control panels to control all the doors in the housing unit and control the movement of the inmates in and out of the housing unit. To accomplish this petitioner would press the touch screen to open and secure the doors for line movement, day room, inmates with a call pass, and to control the wing and cell doors. While at the control panel in the control bubble petitioner would rest his right and left elbows on a hard surface. He would also utilize a handheld radio. To communicate using the radio petitioner would remove the radio from the clip holder on his belt, bring the radio to his mouth and squeeze the radio button with his thumb to talk.

In the control bubble petitioner was also required to keep four log books to record inmate movement. Petitioner would log 1-40 moves a day, or on average 15 a day. Each entry took less than a minute. He also had a scratch pad to jot things down. He testified that could fill a sheet of a legal pad each day with a name and number. Petitioner would open the log book, find the inmate's name and cell number and then go to the control panel and press the speaker button and call the inmate out of his cell. While in the control bubble petitioner was responsible for monitoring the four wings of the cell house. To do this petitioner would need to stand and move around the control bubble and access the two control panels. In the control bubble petitioner did not use any keys. His duties were limited to writing, pressing

the buttons on the control panel touch screen, answering calls, and walking around the control bubble to monitor the four wings.

With respect to the frequency of the activities petitioner performed in the control bubble, petitioner testified that he would receive at least 50 radio calls each day, and each call lasted between one and two minutes. Petitioner would record his radio calls on scratch paper and each entry would take him about a minute. Other logs that petitioner handled in the control room included a bed book that tracked the relocation of an inmate. He could track the movement of up to 10 inmates a day, and each log took about a minute. He testified that he opened and closed a lot of cell doors each day by pressing the touch screen button, and it took him approximately 1 to 2 seconds to touch the button. Petitioner could not provide the actual number, or estimate of the number of times he actually pressed the control panel touch screen button to open or close the cells on a daily or hourly basis.

When working as a core officer petitioner would be required to count and view the inmates, perform random pat downs of 60-70 inmates a day, and ensure all inmates are signed in and out of the housing unit. Petitioner testified that he would log the arrival and departure times of at least a couple hundred inmates in the log each day. Each log would take him between 5 and 10 seconds. If petitioner was performing a pat down of an inmate, he would run his hands along the inmate's body from his head to his feet, and each pat down would take about two minutes. In order to count and view the inmates in their cells petitioner would enter the cell through the wing door. If he could not see the inmates in the cell he would have to open the cell with a key. Petitioner would remove the key from his belt, place it in the cell door and turn it while he used his other hand to pull the cell door open. On average, petitioner would need to open about 20 cell doors a day in order to view the inmates. This process took approximately 2 minutes for each cell.

Another job petitioner could perform was that of a wing officer. The wing officer is in control of 102 cells. The wing officer's job is to ensure that the inmates are not doing anything wrong. Petitioner's duties in this position would include random shakedowns. A random shakedown is where the officers go into an inmate's cell and look through all their belongings in the cell and pat down the inmate. Random shakedowns are performed by two officers. One of the officers will open the cell by using his key, and both officers will go through the inmate's belongings. The officers will go through every piece of the cell including pulling the mattress and looking through all the inmates personal things. These things include unscrewing caps on various items of personal hygiene and food, inspecting the bed frame, looking under the shelves, checking the inmates clothing, and anything else that may be in the cell. A wing officer uses

his hands and wrists to perform these tasks. On average, a shakedown can take about 20 minutes, but could last as long as an hour if there are problems. The officer will also pat down the inmate. On average, 4 pat downs are performed a day.

As a wing officer petitioner would also do some paperwork. He would perform a wing tour 16 times a day and sign the log book indicating the time he was there. The log book is on a TV stand in a room were petitioner would use his key to enter the room. Wing officers are also required to pull on cell doors just to ensure that they are properly locked. If a cell door did not open from the control panel the officer would have to open the cell door by hand. This occurred rarely, no more than ten times a day.

Petitioner could also be assigned the job of the tower officer. As a tower officer petitioner would climb stairs and grab the hand rail on his way up to the tower. Petitioner would go up and down the tower stairs four times a day and each trip took less than 5 minutes each. Once in the tower petitioner would unload/reload two weapons and take visual count of the ammunition in the weapons. Petitioner would use both hands, wrists and arms to perform this task. This task would take him less than five minutes. In the tower petitioner would receive and make less than 10 radio calls per day, with each call lasting less than two minutes.

The last job petitioner testified that he may perform is that of a segregation officer. In the segregation area inmates are in double cells. With the exception of yard and shower the inmates never leave their cells. If an inmate was going to the yard or to the shower the petitioner would open the chuck hole of the cell with a Folger Adams key and handcuff the inmate through the chuck hole. Once the inmate was handcuffed the officer would open the door and shackle the inmate before taking them to the yard or the shower. This would take no more than 30 seconds if the inmate was compliant. Petitioner would cuff and transfer up to 24 inmates twice a day when there were shower and yard privileges, which was 4 days a week. If it was a day where there was no shower or yard privileges the officer may only be required to cuff and escort three inmates. The segregation officer is also responsible for providing 58 meal food trays to inmates. The officer pushes a cart full of meals through the unit using his hands and elbows. The officer opens the chuck hole of the cell and pushes the food tray through before closing the chuck hole. The officer also retrieves the food tray through the chuck hole. This takes no more than 30 seconds for each activity.

Depending on which position petitioner is performing on any given day the items he works with may include keys, pens, doors, handcuffs, guns, touch screens, phones, and radios. However petitioner does not work with all items every day. Petitioner testified that he uses his hands and elbows a lot at work

and started noticing problems with them in August 2010. He testified that these problems included dexterity problems, dropping things, and feeling like his fingers were swollen. Petitioner could not recall specifically the amount of time he would spend performing each task on any given day. Petitioner did give history of working nine consecutive months as a segregation officer, and being assigned to a cell house for eight years, approximately 4-5 years ago. Other than this petitioner did not testify as to the percentage of time he worked in each position.

Petitioner offered into evidence a job description that he put together. He noted that he pushes/pulls eight doors a day to get inside the prison and 2 doors to get into the unit where he's working. If he is a control officer he also enters two more doors to get to the control bubble. In the control bubble petitioner controls the entire building from a control panel where he uses a touch screen button to unlock the entry doors and take the inmates cell doors off lock. The inmates can only get back into their cells if the control officer again touches the button on the touch screen or the wing officer uses his wing keys to open the cell. Petitioner noted that the control officer also takes most of the phone calls for the house and calls out some of the lines that exit the house. The officer calls out the lines by pushing a PA button and other buttons. That officer also writes information down throughout the day in log books.

In his job description the petitioner noted that the core officer signs out his first lines of the day, school, work, and call passes. Then he helps count by counting two wings where he has to use a push/pull door to get on and off each wing. After that he noted that the core officer goes back to signing out the lines after count checks, which means signing each time an inmate enters or leaves the house for a call pass, work, or school detail. He noted that the core officer also counts the mass movement of lines that go out of the house to the yard, gym, and chow, and does random inmate searches throughout the day.

In his job description petitioner noted that the wing officer counts three wings each so that each wing has two counters that work together to count each wing. Additional doors get pushed and pulled increasing his pull/push door count by two. He noted that the wing officer also helps out the core and control officers throughout the day by relieving them for breaks. He noted that the wing officers also have to do half hour wing checks which means going down their wings at least 16 times and signing a logbook on the upper deck that has a locked door with a turn knob on it. Petitioner also noted that the wing officer also shakes down a percentage of the inmate lines that come and go from the house to the yard, gym, chow, school, work, and call passes. An example he gave was that if a chow line had around 300 inmates he would shake down one out of every ten, or 30 inmates.

In his job description the petitioner estimated that the total number of doors he pushes and pulls on a given day is around 80, not including the inmate cell doors. He noted that there are total of 120 inmates in each wing. He noted that an inmate can ask a wing officer to be let into their cells and that requires the use of a key and pull to open the door. He could not estimate the number of cell doors that a wing officer has to open during the day stating it depends upon the number of inmates that are out or want out after the doors are placed on lock. He noted that this changes all the time. Lastly he stated that at the end of the day the officer goes through all of the doors in reverse order to make sure that they are locked. Petitioner noted that he has worked as a correctional officer for 21 years and that the job can change daily.

Petitioner's attorney had petitioner complete a repetitive trauma/job description. Petitioner stated that for the last five years he had worked mostly wings, relief and academics. He identified the tools that he used as keys, ink pens, doors, handcuffs, occasional guns, touch screens, phones and radios.

Greg Gossett, Acting Assistant Warden of Operations, was called as a witness on behalf of Respondent. Gossett started working as a corrections officer in 1983, moved up the ranks, and has been in his current position since 2011. Gossett was at Illinois River Correctional facility from 1989-2001, and then returned about 2 weeks prior to trial. Gossett testified that the job duties have only changed a little over the years he was gone from Illinois River. He testified that he performed all the duties of a correctional officer in all positions. Gossett testified that the 6-7 doors to get into the facility and roll call do not open with keys, and are not heavy.

Gossett testified that the work activities of a correctional officer at Illinois River require the officer to use hands and elbows daily. He estimated that an officer may use his hands 4-5 hours a day. He testified that an officer's hands are used to open doors, chuck holes, do searches, perform pat downs of inmates and cells, opening tubes and jars, and a lot of writing depending on assignment. Gossett testified that the officers use their hands to operate keys, the Folger Adams key in segregation, handcuffs, radio on the belt, keys on the belt, and the touch screen in control bubble. He further testified that the officers lay elbows on the surface when operating the control panel. Gossett stated that when in the tower the officers load and unload guns using their hands, wrists and elbows. When operating as a control, core and wing officer, Gossett stated that the officers use their hands and elbows during the day. When in the segregation unit he was of the opinion that the officers use their hands and elbows less than 1 ½ hours a day, and spend the majority of the time walking the gallery. If however it is a shower and yard day, the officer may use his hand up to 3 hours a day. Gossett testified that when officers are in the tower unit they may use their hands and elbows 2 hours a day, and 3-4 hours a day or less when in the wing unit.

Petitioner has a 1700 hp Yamaha motorcycle that he bought in 2007. Petitioner has been riding motorcycles for a long time. He testified that a couple of times per summer he would ride it to work. The drive to work is 15 minutes. Petitioner also played as a pitcher on a softball team once a week in a summer park league. He testified that he never pitched more than 4 innings. He also testified that he hunts with a bow and gun, but not since 2000.

On 9/28/10 petitioner presented to Dr. Ben Phillips with a chief complaint of bilateral hand pain and numbness for months now, gradually getting worse to where he was waking up every night having to shake his hands out. He reported that his symptoms were affecting his work. He noted that he was losing his grip strength and had been dropping things. Following an examination Dr. Phillips diagnoses were bilateral hand pain and numbness, probable compressive neuropathies with carpal tunnel syndrome and possibly cubital tunnel syndrome. Dr. Phillips had a strong suspicion that petitioner had carpal tunnel syndrome and may have cubital tunnel syndrome. He referred petitioner to Dr. Troung. Petitioner was released to full duty work.

On 10/18/10 petitioner underwent an EMG/NCV. The impression was severe right carpal tunnel syndrome, moderately severe left carpal tunnel syndrome, and bilateral ulnar cubital syndrome.

On 11/2/10 petitioner followed up with Dr. Phillips. His physical examination was unchanged. After reviewing the results of the EMG/NCV Dr. Phillips diagnoses were bilateral carpal tunnel syndrome, right worse than left, and bilateral cubital tunnel syndrome. Dr. Philips recommended a right carpal tunnel release and ulnar nerve transposition. He indicated that when the right hand/arm was healed he would perform surgery on the left.

On 11/19/10 petitioner presented to Dr. Jeffrey Garst. Petitioner reported progressively worsening right hand numbness, tingling, and pain for approximately one year. He reported that all five fingers are numb, and he wakes up at night with symptoms and has to shake his hands to partially alleviate them. Following an examination and review of the EMG/NCV testing Dr. Garst's diagnosis was right carpal tunnel syndrome and cubital tunnel syndrome. His recommendation was a right open carpal tunnel release and right on her nerve transposition.

On 11/ 24/10 petitioner underwent a right carpal tunnel release and right subcutaneous anterior ulnar nerve transposition. This procedure was performed by Dr. Garst. Petitioner's postoperative diagnoses were right carpal tunnel syndrome and right cubital tunnel syndrome. Petitioner followed up postoperatively with Dr. Garst.

On 12/14/10 petitioner returned to Dr. Garst. He reported that he had been experiencing numbness and tingling in his entire left hand and it was aggravated by activities, and was causing him to awaken at night. He also complained of pain in the medial aspect of his left elbow. Following an examination Dr. Garst's diagnosis was left carpal tunnel syndrome and cubital tunnel syndrome. He recommended a left open carpal tunnel release and ulnar nerve transposition.

On 12/23/10 petitioner underwent a left carpal tunnel release and left subcutaneous anterior ulnar nerve transposition performed by Dr. Garst. Petitioner's postoperative diagnoses were left carpal tunnel syndrome and left cubital tunnel syndrome. Petitioner followed up postoperatively with Dr. Garst.

On 1/4/11 petitioner followed up with Dr. Garst. An examination revealed a weak grip on the left side. Dr. Garst removed all the stitches and instructed petitioner to work on range of motion and strengthening of the left hand and forearm. He referred him for therapy at Graham Hospital. On 1/17/11 petitioner demonstrated full range of motion of the right elbow, wrist, and fingers. His scar site was still very sensitive on the right side. With respect to his left side, petitioner's range of motion was about 25-130 degrees of flexion, and he had 60° of supination and pronation. He also still had a very weak grip and stiffness at the left wrist and fingers. Dr. Garst was of the opinion that petitioner needed more therapy. On 2/8/11 petitioner returned to Dr. Garst complaining of a lot of problems with regards to the left ulnar nerve transposition. He testified that it had actually gotten worse over the last two weeks. Dr. Garst examined petitioner but did not think there was any infection or disruption of the surgery. He instructed petitioner to continue therapy for the left arm. On 3/8/11 Dr. Garst recommended a repeat EMG/NCV due to the fact that petitioner was still having a lot of symptoms with the left elbow.

On 4/4/11 petitioner returned to Dr. Garst with ongoing complaints of left elbow pain and ring and little finger numbness. He noted that he was doing well with respect to his right carpal tunnel release and ulnar transposition. He also testified that his left carpal tunnel was much better. Dr. Garst was of the opinion that the repeat EMG/NCV showed moderate residual of the current neuropathy of the ulnar nerve at the elbow more pronounced than it was in October 2010. His diagnosis was continued cubital tunnel syndrome after previous ulnar nerve transposition on the left. Dr. Garst recommended a redo of the left ulnar nerve transposition.

On 5/4/11 petitioner underwent a redo left ulnar nerve transposition. This procedure was performed by Dr. Garst. His postoperative diagnosis was left cubital tunnel syndrome. Petitioner followed up postoperatively with Dr. Garst.

On 6/7/11 petitioner returned to Dr. Garst and reported that he was still having trouble. He stated that he was not having too much pain, but gets puffiness around the elbow, and at night gets paresthesias in the whole hand. Dr. Garst continued petitioner in physical therapy to work on further range of motion and strengthening of the left elbow. Dr. Garst released petitioner back to work as of 6/19/11.

Petitioner last followed up with Dr. Garst on 7/19/11. On examination he still had some stiffness of the left elbow, and a little bit of paresthesias in the forearm and ulnar nerve distribution. His left hand was much improved. Dr. Garst was of the opinion that petitioner had a good result after the second surgery, and he would simply leave petitioner alone at this point. Petitioner stated that he was happy with the results even though he still had some residual troubles with the left elbow. Petitioner stated that he was back working his regular duty job. Dr. Garst released him from his care.

On 4/4/12 petitioner underwent a section 12 examination performed by Dr. James Williams at the request of the respondent. Petitioner reported that he is right hand dominant, has worked for respondent for 21 years, and has been at the Illinois River Correctional Center since 1992. Petitioner provided a description of his symptoms.

With regards to his job petitioner testified that he works from 6:45 AM to 3 PM, with a 30 minute lunch. He stated that his duties vary daily. He stated that he supervises inmates. He stated that the control officer runs the control panel, and a core officer stands at the core and signs inmates out and opens and closes doors with keys and hands. He noted that although there are no Folger Adams keys in regular population, there are some in segregation. Petitioner stated that there are two wing officers per house on the day shift. He noted that there is no cuffing of inmates unless they go to segregation. Petitioner stated that there is a computerized control panel, but the officers have to open and close the doors themselves with small keys. He testified that there are 112 inmates in a wing and 56 cells per wing.

Petitioner gave a past medical history that was significant for hypertension, asthma, and sleep apnea. He denied any history of diabetes or thyroid dysfunction. Dr. Williams reviewed petitioner's Form 45, the Supervisor's Report of Injury or Illness, Employee's Notice of Injury or Illness, and Records of Dr. Garst. Dr. Williams also performed a physical examination. Dr. Williams' impression was that petitioner had successfully had both a right carpal and right cubital tunnel release, as well as a left carpal tunnel release. He further noted that petitioner still exhibited problems with the left cubital tunnel for which he underwent a second surgery on 5/4/11, with a failure to resolve his symptoms. Dr. Williams opined that he did not believe the petitioner's diagnoses or problems were related to his work duties of turning keys or of opening or closing cell doors. Dr. Williams also noted that nowhere in Dr. Garst's

report does he indicate that these injuries are related to work. Dr. Williams noted that petitioner had a history of hypertension, as well as increased body mass index, and rode both motorcycles and hunted with a bow and gun most of his life. Dr. Williams was of the opinion that petitioner had reached maximum medical improvement with regards to his work related injury, and that the problems petitioner still had on the left side were probably permanent, but not related to work.

On 10/18/12 the evidence deposition of Dr. James Williams was taken on behalf of the respondent. Dr. Williams testified that he had the opportunity to tour the facility where petitioner works. He stated that he visited all the different cell houses and a guard post tower. Dr. Williams also used the large Folger Adams keys in segregation and the smaller keys in other parts of the facility. He also opened and closed chuckholes and saw property boxes. Dr. Williams opined that having had the opportunity to perform some of the same activities of the petitioner, especially as it relates to opening and closing doors, opening and closing chuckholes and using keys, that the petitioner's job activities were not a contributing factor in the development of petitioner's carpal and cubital tunnel.

Dr. Williams opined that petitioner has other risk factors that may cause or contribute to carpal tunnel syndrome and cubital tunnel syndrome that include a history of hypertension, hobbies that include hunting with a bow and a gun, riding motorcycles, increased body mass index of 33.2, and chewing tobacco. Dr. Williams was of the opinion that it has been shown that carpal tunnel syndrome could be caused by the vibration from a motorcycle and guns. Dr. Williams opined that petitioner's job did not contribute to, aggravate, or accelerate petitioner's carpal tunnel syndrome or cubital tunnel syndrome.

On cross examination Dr. Williams testified that he did not observe petitioner performing his work related duties. He further testified that he used the Folger Adams key and smaller keys to open locks and believed he was familiar with the amount of force needed to perform these activities. Dr. Williams agreed that in the world of possibilities that petitioner's carpal tunnel and cubital tunnel may be related to his work activities. However Dr. Williams did not feel that it was possible based on what he had performed. Dr. Williams testified that he did not know how many times petitioner performed any of his work activities on any given day, but agreed that he would use his hands and elbows to perform some of them.

On redirect examination Dr. Williams was of the opinion that most etiology with respect to carpal tunnel is idiopathic. He was further of the opinion that there are other medical problems that cause carpal tunnel such as hypertension, diabetes, thyroid dysfunction, and inflammatory type arthritis. He was further of the opinion that tobacco use in general, and hobbies that involve hunting and motorcycle riding,

are activities that can at least aggravate or cause carpal tunnel syndrome. Dr. Williams opined that in the prison there were a lot of automated doors. Dr. Williams was of the opinion that the activity of opening a door where you extend your arm, bend it, put it back, and extend it would not cause cubital tunnel syndrome. Dr. Williams was further of the opinion that if someone is performing activities at work and performing the same activities outside of work it would be difficult for a doctor to opine that the activities during work were the ones that caused the problem, but could say that they both contributed to it.

Dr. Williams testified that that it is possible that petitioner's work activities could have contributed to petitioner's condition of ill-being as it related to his carpal tunnel syndrome and cubital tunnel syndrome. He further indicated that petitioner's placement of his elbows on the counter while working the control panels, could have contributed to his cubital tunnel syndrome. Nonetheless, Dr. Williams did opine that he did not believe petitioner's work activities caused or aggravated his carpal tunnel or cubital tunnel syndrome.

The evidence deposition of Dr. Garst was taken on behalf of petitioner on 12/5/12. Respondent's attorney failed to appear or cancel after being given timely notice of the deposition. Petitioner conducted the deposition without respondent's attorney. Respondent subpoenaed Dr. Garst to appear at trial. Dr. Garst appeared at trial and respondent's attorney questioned him.

Dr. Garst testified that he was familiar with petitioner's work activities for the state of Illinois to the extent that he knew petitioner worked as a jail guard at the Department of Corrections. He stated that he had been shown, prior to his deposition, some things relating to petitioner's jobs, and a description that petitioner had typewritten himself. Dr. Garst opined that there is a casual connection between petitioner's conditions of ill being that he treated him for, and petitioner's work activities. Dr. Garst opined that the surgeries he performed on petitioner were reasonable and necessary, and related to his work as a correctional officer for the Illinois River Correctional Center.

Dr. Garst reviewed a copy of petitioner's description of his job duties. Dr. Garst opined that assuming that petitioner's list of activities was true his opinion would be that there is a causal connection between petitioner's bilateral carpal tunnel and petitioner's work activities as he described them (in PX4). Dr. Garst further opined that there is a causal connection between petitioner's cubital tunnel and petitioner's work activities as he described them. Dr. Garst also looked at the repetitive trauma/job description petitioner completed and opined that the tools petitioner identified that he uses, and the activities he claimed he performed, could contribute to the conditions of ill being that he treated.

Dr. Garst also reviewed a job duty statement from the State Retirement Systems. However, there was no job title identified on the job duty statement. The name of the agency was hand written and identified as the Department of Corrections IRCC. On this job duty statement the frequency of lifting 1 to 10 pounds, climbing stairs, reaching above shoulder level, use of hands for gross manipulation (grasping, twisting, handling), and use of hands for fine manipulation (typing, good finger dexterity) were all listed as 0 to 2 hours a day. Based on the amount of time identified with respect to manipulation and gripping Dr. Garst was of the opinion that these work activities could have contributed to petitioner's carpal tunnel and cubital tunnel conditions.

Dr. Garst opined that if petitioner had treated in the past for hypertension, but it had been controlled; that petitioner had a body mass index of 33.2; that petitioner hunted once a year and may have used a bow or gun once or twice a year; that petitioner chewed tobacco; and rode a motorcycle in the summer, that would not change his opinion on causation.

At trial respondent questioned Dr. Garst. Dr. Garst testified that specific job duties the petitioner performed that could cause carpal and cubital tunnel included opening doors, using keys, and shakedown of inmates. Dr. Garst testified that he had never been inside the prison where petitioner worked. He based his opinion on petitioner's history that he turned keys all day and opened doors. Dr. Garst believed that this type of activity was repetitive. He indicated that his causal connection opinions are based strongly on the history his patients provide him. He testified that he gives the petitioner the benefit of the doubt and went by what the petitioner told him his work duties were when formulating his opinions.

Dr. Garst testified that most of the time the cause of carpal tunnel and cubital tunnel is idiopathic. He indicated that some of the medical causes of carpal and cubital tunnel are diabetes, hypothyroidism, inflammatory arthritis, fluid retention from renal disease, and other medical conditions. He did not agree that obesity is a cause of carpal tunnel and cubital tunnel. He did not see smoking as a cause either. Dr. Garst indicated that he had no history that petitioner had thyroid problems, inflammatory arthritis, hypertension, or diabetes. He was of the opinion that if petitioner did have thyroid problems that would raise a red flag, but would not change his opinion as to causal connection. Dr. Garst opined that if someone performed a repetitive job most of the day for many years that he would find it causally related. Dr. Garst also opined that if hands and wrists are in a flexed position on a repetitive basis and a person is turning keys eight hours a day that could contribute to carpal tunnel syndrome and cubital tunnel syndrome. He further opined that pushing on a screen to open doors on a regular basis with flexed wrists can also contribute to carpal tunnel syndrome.

Respondent offered into evidence the records from Great Plains Orthopedics for the period prior to 8/17/10. On 12/5/08 petitioner presented to Graham Medical Group. Petitioner's current medications included levothyroxine 25 mcg once a day. On 7/8/09 petitioner returned to Graham Medical Group. Petitioner's current medications included levothyroxine 50 mcg once a day. On 10/8/09 petitioner identified a past medical history that included hypothyroidism. His current medication list included 50 mcg of levothyroxine. On 11/24/10 Dr. Garst indicated on petitioner's pre-surgical testing form that petitioner had hypertension, high cholesterol, and tobacco abuse.

Petitioner testified that his hands today are not the same as they were. He testified that since the surgery his grip is not as strong as it was before the surgery. With respect to his right hand specifically, petitioner testified that he has difficulty with dexterity and it gets colder faster. Petitioner testified that his elbows tingle quite a bit.

C. DID AN ACCIDENT OCCUR THAT AROSE OUT OF AND IN THE COURSE OF PETITIONER'S EMPLOYMENT BY RESPONDENT?

Petitioner alleges he sustained accidental injuries to his bilateral hands and elbows due to repetitive work activities that arose out of and in the course of his employment by respondent and manifested itself on 8/17/10.

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

Since petitioner is claiming an injury to his bilateral hands and elbows 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.

The petitioner has selected a manifestation date of 8/17/10. It is unclear what occurred on this date to support a finding that this was the date on which both the fact of the injury and the causal relationship of the injury to the petitioner's employment would have become plainly apparent to a reasonable person. When the petitioner first present to Dr. Phillips on 9/28/10 for treatment he gave a history of bilateral hand pain and numbness for months, with gradual worsening to the point where he was waking up every night having to shake his hands out. The arbitrator finds 8/17/10 was not the date the petitioner first sought medical attention for the condition; not the date the petitioner was first informed by a physician that the condition was work related; not the date the petitioner was first unable to work as a result of the condition; not the date when the symptoms became more acute at work; and not the date that the petitioner first noticed the symptoms of the condition. The arbitrator finds no evidence to support a finding that 8/17/10 was the date on which both the fact of the alleged injury and the causal relationship of the injury to the petitioner's employment would have become plainly apparent to a reasonable person.

Next, the petitioner must prove by a preponderance of the credible evidence that his work involves constant or repetitive activity that gradually causes deterioration of or injury to a body part. Petitioner spent a significant amount of time at trial describing the various duties of the control officer, core officer, wing officer, segregation officer and tower officer. However, petitioner himself testified his duties varied daily. He testified that his duties could include pressing a touch screen button on a control screen while resting his elbows on a hard surface, making entries in log books, pushing and pulling doors, opening and closing cell doors with a key, shaking down inmate cells and patting down inmates, and unloading and reloading guns. The arbitrator notes that this a summary of the task petitioner performs in all these positions.

Although petitioner testified to performing varying tasks while working in different areas of the facility over the past 21 years, the arbitrator finds it significant that when the petitioner completed a "repetitive/job description" for his attorney he specifically stated that for the last five years he had worked mostly as a wing officer, as well as relief and academics officer. In his job description the petitioner

indentified that he relieved core and control officers when they were on break. However, the petitioner presented no evidence that identified the specific jobs he performed when working relief and academics based on the times he relieved those officers, or the amount of time he spent performing these duties.

Given that petitioner himself documented that he had been working mostly as a wing officer for the past five years, and his symptoms did not present until several months prior to his visit to Dr. Phillips on 9/28/10, the arbitrator is going to focus mainly on the duties of a wing officer. As a wing officer petitioner's duties include random shakedowns of cells. This job is performed by two officers and can take anywhere from 20 minutes to an hour. The wing officer goes through every piece of the cell using their hands, wrists and arms. On average only 4 pat downs are performed a day. As a wing officer petitioner would also be required to perform a wing tour 16 times a day. This would require petitioner to open a room where the log book was with a key and door knob 16 times a day. He would also have to make a short entry in the log book each time. In addition to the 4 shakedowns a day petitioner is required to perform random pat downs of inmates that come and go from the house to the yard, gym, chow, school, work and call passes. Petitioner testified that he would pat down approximately 1 out of every 10 inmates with his hands. Petitioner uses his hands and wrists to pat down the inmates and each pat down may take 1-2 minutes. Lastly, petitioner testified that as a wing officer he is required to pull on cell doors to ensure they are properly locked. On occasion, and no more than ten times a day, the petitioner may have to open a cell door manually with a key, if the cell door did not open from the control panel.

Petitioner testified that he could not estimate the actual amount of time he spent each day using his hands, wrists and elbows as a wing officer. However, Gossett estimated that it could be less than 3-4 hours. As a wing officer the petitioner duties did not include resting his elbows on a hard surface while pressing buttons on the control panel touch screen. Additionally, in this position petitioner did not load and unload guns, or press any buttons on a control panel touch screen. Petitioner also did not spend a lot of time on the radio or making a lot of entries in the log book to monitor inmate movement. Petitioner also was not required to use the Folger Adams key as a wing officer. He also did not need to cuff shackle inmates to transfer them to and from the yard or shower, and did not need to open and close all the chuckholes to place and retrieve meals. Although petitioner may have performed these duties in his "relief" position, how often he performed relief activities is unknown. Additionally, the arbitrator had no information regarding the duties associated with "academics".

In addition to his work as a wing officer petitioner would still be required to go through 8 push/pull doors to enter and exit the facility. Petitioner may also have to enter and exit an additional 6 doors to get the housing assignment.

In reviewing the credible medical records the arbitrator finds both Dr. Garst and Dr. Williams based their opinions on a belief that petitioner performed all the duties of a control officer, core officer, wing officer, tower officer and segregation officer. However, based on petitioner's own description of his job duties, his primary assignment for the past 5 years was as a wing officer, with some time in relief and academics, with the actual time spent on these duties unknown.

Dr. Garst opined that his causal connection opinions were based on petitioner's description of his duties as identified in PX4. However, other than those as wing officer, it is unknown the actual time petitioner spent on the other assignments when he was performing relief. As such, the arbitrator finds Dr. Garst did not have a detailed and accurate understanding of the petitioner's work activities on which to base his causal connection opinion.

In the alternative, Dr. Garst did not base his opinions solely on the petitioner's description of his job duties. However, since petitioner's assignment over the last five years was primarily as a wing officer and in relief and academics, petitioner's work in the other assignments would not be repetitive on a daily basis. The arbitrator finds that Dr. Williams also did not have a detailed and accurate understanding of the petitioner's work activities on which to base his causal connection opinion.

Having had an opportunity to review petitioner's prior medical records, it appears that despite petitioner's claim that he did not have a thyroid problem it is documented that petitioner was taking 25 mcg of levothyroxine as early as 12/5/08, and 50 mcg of levothyroxine as recently as 7/8/09. There is nothing in the records that show that petitioner's prescription of levothyroxine was discontinued by any healthcare provider. However, what is known is that petitioner stopped taking this medication at some point. Additionally, as recently as 11/24/10 Dr. Garst noted a medical history that included hypertension, high cholesterol and tobacco abuse. Petitioner also has a BMI of 33.2. Both Dr. Garst and Dr. Williams opined that some or all of these medical conditions could contribute to carpal tunnel and cubital tunnel.

Based on the above, as well as the credible evidence, the arbitrator finds the petitioner has failed to prove that he sustained an accidental injury due to repetitive work activities that arose out of and in the course of his employment by respondent on 8/17/10. The arbitrator finds there is nothing that occurred on 8/17/10 to support a finding that this was the date on which both the fact of the injury and the causal

relationship of the injury to the petitioner's employment would have become plainly apparent to a reasonable person. The arbitrator further finds that although petitioner testified to a lot of job duties that he could possibly perform, he was not very clear as to those he actually performed in the years leading up to the onset of his symptomatology. Additionally, petitioner did not address at trial his own claim to his attorney that in the 5 years prior to his injury date his primary assignment was that of a wing office, and relief and academics. Additionally, petitioner did not present any evidence on how often he performed the "relief and academics" assignments and what job duties he performed when relieving these positions. The arbitrator also bases this opinion on the fact that petitioner himself testified that his duties varied every day.

F. IS PETITIONER'S CURRENT CONDITION OF ILL-BEING 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?
K. WHAT TEMPORARY BENEFITS ARE IN DISPUTE?
L. WHAT IS THE NATURE AND EXTENT OF THE INJURY?

Having found the petitioner had failed to prove by a preponderance of the credible evidence that the petitioner has sustained an accidental injury due to repetitive work activities that arose out of and in the course of his employment by respondent on 8/17/10 the arbitrator finds these remaining issues moot.

14IWCC0774

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

Brenton Franklin,

Petitioner,

vs. NO: 09 WC 31325

Anderson Ford Mercury Inc.,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of accident, 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 September 6, 2013, is hereby affirmed and adopted.

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

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

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $100. The party commencing the 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 14 2014
o8/27/14
RWW/rm
046

Ruth W. White

Charles J. DeVriendt

Daniel R. Donohoo

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

FRANKLIN, BRENTON
Employee/Petitioner

Case# **09WC031325**

14IWCC0774

ANDERSON FORD MERCURY INC
Employer/Respondent

On 9/6/2013, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.05% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

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

0238 WOLF & WOLFE LTD
WILLIAM JENSEN
25 E WASHINGTON ST SUITE 700
CHICAGO, IL 60602

14IWCC0774

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

Brenton Franklin,
Employee/Petitioner

v.

Anderson Ford Mercury, Inc.,
Employer/Respondent

Case # **09** WC **031325**

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 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. [x] Is Petitioner's current condition of ill-being causally related to the injury?
G. [ ] What were Petitioner's earnings?
H. [ ] What was Petitioner's age at the time of the accident?
I. [ ] What was Petitioner's marital status at the time of the accident?
J. [x] Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. [x] What temporary benefits are in dispute?
   [ ] TPD [ ] Maintenance [x] TTD
L. [x] What is the nature and extent of the injury?
M. [ ] Should penalties or fees be imposed upon Respondent?
N. [x] Is Respondent due any credit?
O. [ ] Other _____

FINDINGS

On **April 6, 2009**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**$2540.85**; the average weekly wage was $**$358.05**.

On the date of accident, Petitioner was **24** 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 $**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 he injured his right shoulder in the April 6, 2009 accident or that his current condition of ill-being in his right shoulder is causally connected to that accident.

Petitioner further failed to prove he sustained any permanent partial disability to his left shoulder as a result of the April 6, 2009 accident.

Respondent shall pay reasonable and necessary medical services, pursuant to the medical fee schedule for medical bills incurred on April 7, 2009 from Prairie Emergency Group, Ltd. ($255.00); Dr. John Warner Hospital ($418.65); and Clinical Radiologists ($56.50).

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

STATEMENT OF INTEREST RATE If the Commission reviews this award, interest at the rate set forth on the *Notice of Decision of Arbitrator* shall accrue from the date listed below to the day before the 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 3, 2013
Date

SEP 6 - 2013

At the time of arbitration, the disputed issues were causal connection, medical expenses, temporary total disability, credit, and nature and extent. Witnesses testifying at the hearing included Petitioner, Davina Franklin, and Carol Franklin.

The Arbitrator finds:

Petitioner testified he was employed by Respondent as a Detailer. On April 6, 2009 he and three co-workers were carrying a 500 pound car differential from the first to the second floor of Respondent's facility. Two men were on one end of the differential and two men were on the other end. Petitioner and a co-worker were at the bottom end of the differential as they carried it up the stairs. Petitioner advised his Supervisor of the accident and then went home.

Petitioner returned to work the following day (April 7, 2009) but was in pain, so Respondent sent him to Dr. John Warner Hospital. According to the Hospital's general information sheet, Petitioner's diagnosis was "Left Shoulder Work Injury." (PX 10) Petitioner was initially seen by the triage nurse where he gave a history of lifting a 300 to 400 pound differential. (RX #1, Dep. EX #3; PX 10). According to the note, Petitioner advised the nurse that the differential had landed on his left shoulder. Id. The Triage Nurse's note references a left shoulder injury in multiple places. (PX 10) Petitioner was subsequently seen by Dr. David Smith. Dr. Smith noted Petitioner's description of the accident – "A portion of the differential fell onto the top of his left shoulder and then rested there as he carried the differential up the steps." (PX 10) Dr. Smith examined Petitioner's left shoulder and ordered x-rays. Id. His examination documented limited range of motion of Petitioner's left arm. Id. X-rays were performed on Petitioner's left shoulder and showed no evidence of a fracture. Id. Dr. Smith diagnosed Petitioner with a left shoulder contusion, prescribed a sling for Petitioner's left arm, and ordered him to follow up with his family physician. Id.

On April 8, 2009, Petitioner was seen by Dr. Juliana Kaminski at Sugar Creek Medical Associates. (RX #1, Dep. EX #4, P. 8) Petitioner gave a history to Dr. Kaminski of carrying a differential that weighed 300 to 500 pounds with two other persons when it dropped onto his left shoulder causing immediate pain and his toe being stubbed and a numbness feeling. Id. (See also PX #1, Dep. Ex. 3) Dr. Kaminski diagnosed Petitioner with shoulder pain[1], asked to review the x-ray and emergency room notes from the day before, prescribed Aleve, and ordered Petitioner to return to work on Monday. Id. Petitioner was taken off work April 7 – 9, 2009. (PX #10)

Petitioner testified that on May 27, 2009 he completed an "Injured Worker Questionnaire." Petitioner gave a history of a differential falling on his shoulder (Petitioner did not indicate which one) and noted he had suffered a "strained shoulder and pinched nerve." (RX #2) The Questionnaire also included a question "Have you recovered"; Petitioner responded "Yes." Id.

Petitioner signed his Application for Adjustment of Claim alleging injuries to his "right shoulder, arm, and other parts of his body" on July 6, 2009. (AX 2)

[1] Which shoulder was not identified.

On October 26, 2009, Petitioner was seen by Dr. Lawrence Li. (RX #2, Dep. EX #5, P. 32) At his visit with Dr. Li on October 26, 2009, Petitioner complained of bilateral shoulder pain. Id. He gave a history of an accident where the differential he was carrying fell onto his left shoulder and he injured his right shoulder when he went to catch the differential. Id. Petitioner, who is right hand dominant, complained that his right shoulder was more painful than his left shoulder. Petitioner reported that he experienced pain with above the chest level reaching and lifting, repetitive use of his shoulder, and overhead activities. He denied using any nonsteroidal anti-inflammatory medications for the previous month. On physical examination both shoulders had positive Neer's tests and Hawkins' tests, tenderness to palpation at the greater tuberosity, and restricted ranges of motion. Suspecting bilateral tears, Dr. Li ordered MRIs for both of Petitioner's shoulders. Id. The MRI of the left shoulder was essentially negative showing evidence of low grade tendinopathy and peritendinitis. Id. at 40. The MRI of the right shoulder showed evidence of an inferior labral tear with a paralabral cyst. Id. at 39. Upon review, Dr. Li recommended surgery to Petitioner's right shoulder, noting the right shoulder tear was definitely related to his work injury. (Id. at 31-32; PX 11) He further believed the left shoulder pain would resolve with time. (PX 8)

A November 2, 2009 "shoulder history" form indicates Petitioner had a right shoulder injury in April of 2009 when a rear differential fell and landed on his left shoulder, jerking the right arm downward. (PX 7)

On January 26, 2010, Dr. Li performed a right shoulder arthroscopy and debridement of a superior labrum anterior posterior tear. Id. at 46. (See also PX 8) Following surgery, Petitioner testified he underwent physical therapy and sought follow up treatment with Dr. Li. (PX 9, 10)

As of April 6, 2010 Petitioner was reporting difficulty with sleeping and removal of his shirt. Overhead reaching was also still difficult. (PX 9)An April 13, 2010 physical therapy evaluation noted mild limitation with reaching and lifting and mild limitation when dressing. Petitioner's right shoulder range of motion was 158 degrees of flexion and 165 degrees of abduction. (PX 10)

On May 14, 2010, Petitioner was still experiencing occasional shoulder pain but it was noted he was able to throw a football and was discharged by Dr. Li on June 29, 2010. (RX 2, p. 31)

Dr. Li also testified on behalf of Petitioner. Dr. Li testified he first saw Petitioner on October 26, 2009 with complaints of bilateral shoulder pain. (PX #1, P. 8) Petitioner gave a history of the accident indicating he was assisting somebody else carrying a rear differential when one end of the differential dropped and hit his left shoulder and he caught it with his right arm. Id. Dr. Li examined both shoulders and recommended MRIs for each. Id. at 10-11. Dr. Li testified that range of motion for Petitioner's left shoulder was pretty close to normal. (PX #1, p. 10) The MRI of Petitioner's right shoulder showed evidence of a labral tear and paralabral cyst. Id. at 12. Dr. Li characterized the MRI of the left shoulder as "essentially negative." Id. at 13. Dr. Li recommended surgery to Petitioner's right shoulder. Id. at 14. Surgery was performed on January 26, 2010. Id. at 15. Petitioner sought follow up treatment with Dr. Li and was last saw him on June 29, 2010. Id. at 17. Dr. Li testified that Petitioner was unable to work from October 26, 2009 to May 14, 2010. Id. at 15 and 17. Throughout the time Dr. Li treated Petitioner after his surgery, Petitioner never mentioned any left shoulder complaints. (PX 11)

Dr. Li testified that Petitioner's right shoulder condition was consistent with the mechanism of injury described to him by Petitioner. Id. Immediately before Dr. Li's testimony was given, he was provided copies of the emergency room records from Dr. John Warner Hospital and Dr. Kaminski. Id. at 19-20. He testified the additional records did not change his opinion regarding causal connection concluding that Petitioner's left shoulder pain would have been more dominant than the pain to his right shoulder

at that time. Id. at 19 -20. On cross-examination, Dr. Li acknowledged that the records from Dr. John Warner dated April 7, 2009 and Dr. Kaminski's from April 8, 2009 made no mention of right shoulder pain. Id. at 28-29. Dr. Li further testified that the left shoulder pain would have been more dominant than the right shoulder pain and Petitioner would have experienced right shoulder pain when he used his right arm in a manner that stretched the ligaments. Id. at 29-30.

Dr. Neault testified at the request of Respondent. Dr. Neault reviewed records from Dr. John Warner Hospital, Sugar Creek Medical Associates (Dr. Kaminski), Orthopedic Sports and Medicine Center (Dr. Li), and MRI films. (RX #1, P. 6-7 and 9) Dr. Neault opined that Petitioner's April 6, 2009 accident resulted in a contusion to Petitioner's left shoulder. Id. at 20. With respect to his right shoulder, he opined that the condition of Petitioner's right shoulder and the treatment provided was not causally related to the accident because there were no complaints of right shoulder pain contemporaneous with the incident and the first record of right shoulder pain was six months after the purported accident. Id. at 20-21. On cross-examination, Dr. Neault was asked whether the differential falling on his left arm caused or aggravated his left shoulder tendinitis. Id. at 28. In response, Dr. Neault testified that the differential falling directly on Petitioner's shoulder would not "cause an injury, whether a labrum tear, rotator cuff tear, tenderness, anything. It would just cause a bruise to the shoulder." Id. at 29.

Petitioner testified that he had been working for Respondent approximately 2-3 months on the day of his accident. April 6, 2009 was also Petitioner's grandmother's birthday. Prior to April 6, 2009, Petitioner's right shoulder was in "great condition." Petitioner denied any problems performing his job and had never undergone surgery, an MRI, or seen a physician for his right shoulder. Petitioner testified that when the accident occurred the differential fell on his shoulder and his arm went numb. According to Petitioner, his right shoulder hurt immediately and "a lot" while his left shoulder hurt a little. He finished his shift but noticed he had trouble while working at shoulder height on a Ford Focus. Petitioner testified his supervisor told him to put ice on it.

Petitioner further testified that when he went to the hospital the next day, medical personnel examined both of his shoulders. Petitioner testified that he had a chance to look at the records from the hospital and noted very little reference to his right shoulder. His only explanation for that was that the hospital, located in Clinton, Illinois, was "backwoods." On cross-examination Petitioner testified that any reference in the John Warner Hospital records regarding the left shoulder should really be his right shoulder. Petitioner further testified that he was given ice for both shoulders but only the left shoulder was x-rayed.

Petitioner also testified that Dr. Kaminski examined both of his shoulders. On cross-examination he also agreed that her records should state "right shoulder" as opposed to "left shoulder."

According to Petitioner, he suffered from pain and physical restrictions/limitations between April 8, 2009 and October 26, 2009. He had trouble washing his hair, brushing his teeth, and was unable to put a t-shirt on by himself. Petitioner was examined by Dr. Li on October 26, 2009, and he ordered an MRI and ultimately performed right shoulder surgery on January 26, 2010, followed by physical therapy. Dr. Li released Petitioner on May 14, 2010. Petitioner testified he did not work between October 26, 2009 and May 14, 2010. Petitioner testified he continues to notice restricted range of motion, discomfort and pain in his right shoulder.

On cross-examination Petitioner acknowledged RX 2 bears his signature and reflects his handwriting.

Petitioner's mother, Davina Franklin, testified on behalf of Petitioner. Ms. Franklin works for an insurance company. Ms. Franklin recalled that April 6, 2009 was her mother's birthday. According to Ms.

Franklin, Petitioner was living with her on the date of his accident. She saw him that day and he was in a lot of pain and had difficulty raising his arm. She further testified that Petitioner's left arm was okay but he was experiencing pain between his shoulder blades. It was "excrutiatingly painful" for Petitioner to make a fist. She also described her son as having a high pain tolerance.

According to Ms. Franklin, Respondent sent her son to the emergency room the next day. She testified she saw him that day and he had a sling on and was in lots of pain. She testified she observed Petitioner following the April 6, 2009 accident and noted Petitioner had difficulty lifting a gallon of milk with his right arm or raising his right arm above his head. She further testified that between the accident of April 6, 2010 and Petitioner's first visit with Dr. Li on October 26, 2009 she observed Petitioner exhibiting continuous pain with his right arm. Petitioner had difficulty taking care of himself, including brushing his teeth, fastening clothes, and putting on shoes. Petitioner could not shave his face with a razor or lift his arm. When his right arm was in a sling, he needed assistance.

Ms. Franklin also testified that she was able to add her son to her health insurance in 2010 after the law changed to allow him to be included. Petitioner was then able to proceed with treatment as he had no insurance available before then.

Petitioner's grandmother, Carol Franklin, also testified on behalf of Petitioner. Petitioner's grandmother testified that Petitioner was living with her on the date of his accident. She recalled Petitioner calling from work on that date and indicating he needed to be picked up. Carol Franklin went and picked him up. Carol Franklin testified that she remembered redness in Petitioner's right shoulder. Carol Franklin observed her grandson favoring his right arm at that time. As the day progressed, he appeared to be in pain and she gave him extra strength Tylenol.

Petitioner's grandmother also testified to picking Petitioner up from the John Warner Hospital the following day. He had paperwork that needed to be provided to Respondent. When she went to pick him up at John Warner Hospital, she observed him wearing a sling for his left arm and she asked him why he was wearing the sling on his left arm and further commented that he should switch it to his right arm. Carol Franklin also testified that she went to Petitioner's appointment with Dr. Kaminski on April 8, 2009 and was in the room when Petitioner was examined. She observed Petitioner having trouble lifting his arm. According to Carol Franklin, Petitioner never used his right arm between April of 2009 and October of 2009 when Petitioner went to Dr. Li.

The Arbitrator concludes:

1. Causal Connection.

Petitioner failed to prove that he injured his right shoulder in his accident of April 6, 2009 or that his current condition of ill-being in his right shoulder is causally related to that accident. Petitioner's testimony was not credible as it was not corroborated by the medical records.

The first indication of any bilateral shoulder problem is found in late October of 2009 when Petitioner presented to Jeff McGee, PA-C for Dr. Li. At that time Petitioner related that a differential had dropped and struck his left shoulder but that he caught it with the right arm. Due to the increased force upon the right arm Petitioner was then experiencing right shoulder pain. (PX 4) This was six months after the accident, several months after Petitioner had retained legal counsel, and sometime after he had been laid off from his job with Respondent. (PX 4)

The Arbitrator concludes that on April 6, 2009, Petitioner was carrying a differential that weighed 300 to 500 pounds with three other persons, and during the course of carrying the differential from the first to second floor of respondent's facility he suffered a contusion to his left shoulder when the differential fell onto his left shoulder. Petitioner did not injure his right shoulder in that accident. In reaching this conclusion, the Arbitrator relies upon the medical records from Dr. John Warner Hospital and Sugar Creek Medical Associates (Dr. Kaminski).

The Arbitrator further concludes that Petitioner failed to establish that the condition of his right shoulder and the medical treatment to remedy his right shoulder condition was causally related to his April 6, 2009 accident. In reaching this conclusion, the Arbitrator relies upon the medical records from Dr. John Warner Hospital, Sugar Creek Medical Associates (Dr. Kaminski), and Dr. Lawrence Li, and the Injured Worker Questionnaire Petitioner completed on May 27, 2009. Medical records are more reliable than later testimony because there is a presumption that a person will not falsify statements regarding his medical condition and the cause of the condition to physicians from whom he expects and hopes to receive medical aid over later inconsistent histories. *Shell Oil Company v. Commission*, 2 Ill.2d 590, 602; 119 N.E.2d 224, 231 (1954); *Linville, v. Ikon Office Solutions*; 13 IWCC 391 (2013).

Petitioner testified while carrying the differential he lost his grip on the differential and it landed on his right shoulder. The medical records of his treating physicians contradict his testimony. Petitioner was seen by the triage nurse at Dr. John Warner Hospital and reported suffering an injury to his left shoulder when a differential landed on it. RX#1, Dep. Ex. #3. After seeing the triage nurse, Petitioner was seen by Dr. David Smith where he gave the same history. Id. X-rays were performed on his left shoulder after which time Dr. Smith diagnosed Petitioner with a left shoulder contusion and ordered him to follow up with his family physician. Id. There is no indication in the records from Dr. John Warner Hospital that Petitioner voiced complaints of right shoulder pain. While Petitioner claims the references to his "left shoulder" should be the "right shoulder" neither the triage nurse or Dr. Smith were deposed regarding the matter. Furthermore, even if that were true, it would not explain why Petitioner only underwent a left shoulder x-ray.

On April 8, 2009, Petitioner was seen by Dr. Kaminski at Sugar Creek Medical Associates. He gave a history to Dr. Kaminski of a 300-500 pound piece of equipment falling on his left shoulder. RX #1, Dep. Ex. #4, P. 8. Dr. Kaminski diagnosed Petitioner with shoulder pain and asked for copies of the emergency room records and X-rays. Id. There is no indication in Dr. Kaminski's records supporting Petitioner's claim that he voiced complaints of right shoulder pain nor was the doctor deposed for clarification.

On May 27, 2009, Petitioner completed an "Injured Worker Questionnaire". He reported on the Questionnaire that he had suffered a "strained shoulder & pinched nerve." RX #2. Petitioner also noted on the Questionnaire that he had returned to work on April 13, 2009 at Dr. Kaminski's request. Id. Lastly, the Questionnaire included a question asking Petitioner whether he had recovered; Petitioner responded "Yes." Id. This Questionnaire carries great weight. Petitioner himself completed it. While he didn't indicate which shoulder he injured, he refers to the "shoulder," not "shoulders." Furthermore, he claimed no ongoing difficulties.

The Arbitrator finds that Petitioner's statements made to the triage nurse and Dr. Smith at Dr. John Warner and Dr. Kaminski are more credible than Petitioner's testimony or the testimony of Davina and Carol Franklin, his mother and grandmother. The statements Petitioner made regarding the mechanism of injury (the differential fell directly onto his left shoulder) and the body part injured (left shoulder) were the same with each of the three providers. Moreover, in none of the records from Dr. John

Warner Hospital or Dr. Kaminski is there any evidence Petitioner complained of right shoulder pain. The Arbitrator also notes that Davina Franklin's testimony is inconsistent with Petitioner's responses contained in the May 27, 2009 Questionnaire. Petitioner's mother testified that she observed Petitioner from April 8, 2009 to October 26, 2009 in pain with limited use of his right arm; however, Petitioner indicated in the May 27, 2009 Questionnaire that his condition had resolved. Furthrmore, both Carol and Davina Franklin testified that Petitioner was unable to use his right arm during the time preceding his first appointment with Dr. Li. This is not credible in light of the fact Petitioner was continuing to work for Respondent until he was laid off and there was no evidence presented that Petitioner's lay-off was in any way connected to his work accident.

Additionally, the Arbitrator notes Petitioner's testimony regarding the mechanism of injury was contradicted by the history he gave to Dr. Li at his October 26, 2009 visit. Petitioner testified the differential fell on his right shoulder; in contrast, Dr. Li's records note that Petitioner gave a history of the differential falling on his left shoulder; however, he injured his right shoulder catching it. PX #1, Dep. Ex. 5, P. 32. The Arbitrator does not find Dr. Li's opinions on causal connection credible. His opinion regarding causation was based on a purported mechanism of injury that is not supported by Petitioner's testimony. His understanding of the accident was that the differential fell onto Petitioner's left shoulder and he injured his right arm catching the differential. However, Petitioner testified that the differential fell directly onto his right arm.

Assuming, arguendo, that Petitioner had testified consistent with the history he provided Dr. Li on October 26, 2009, the Arbitrator would still not find Dr. Li's testimony credible because (a) the records from Dr. John Warner Hospital and Dr. Kaminski do not support an injury to Petitioner's right shoulder or complaints of right shoulder pain, and (b) the Questionnaire Petitioner completed on May 27, 2009 documents the injury to his shoulder had resolved. Lastly, albeit Petitioner's testimony that the differential fell on his right shoulder was first voiced on the day of trial, Dr. Neault's un-rebutted testimony is that a differential falling directly on top of Petitioner's shoulder would not cause a labrum tear, rotator cuff tear, or tenderness and would only cause a bruised shoulder. RX #1, P. 28-29.

2. Medical Expenses.

The Arbitrator awards Petitioner payment of the medical bills for treatment rendered to his left shoulder only. The following bills should be paid to Petitioner pursuant to the negotiated rate or the lesser of the amount owed under the Fee Schedule or the actual charge as provided in Section 8(a) and 8.2 of the Act:

Prairie Emergency Group, Ltd.	April 7, 2009	$ 255.00
Dr. John Warner Hospital	April 7, 2009	$ 418.65
Clinical Radiologists	April 7, 2009	$ 56.50

Based upon her causal connection determination the Arbitrator denies payment of any other claimed bills.

3. Temporary Total Disability.

Consistent with her decision on causal connection, the Arbitrator denies Petitioner's claim that he is entitled to temporary total disability benefits for the period from October 26, 2009 to May 14, 2010.

4. Nature and Extent of the Injury.

Petitioner suffered a contusion to his left shoulder which fully resolved by May 27, 2009. Petitioner did not testify to any ongoing problems with his left shoulder. Petitioner failed to prove any permanent partial disability with respect to his left shoulder.

5. Credits.

The Arbitrator concludes that Respondent is not due any credits.

****

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

Rosie Jackson,

Petitioner,

14IWCC0775

vs.

NO: 10 WC 44130

Solomon Colors Inc.,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of accident, 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 November 13, 2012, is hereby affirmed and adopted.

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

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

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

DATED: SEP 14 2014
o8/27/14
RWW/rm
046

Ruth W. White

Charles J. DeVriendt

Daniel R. Donohoo

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

14IWCC0775

JACKSON, ROSIE
Employee/Petitioner

Case# **10WC044130**

10WC032138

SOLOMON COLORS INC
Employer/Respondent

On 11/13/2012, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.15% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

1909 ACKERMAN, JAMES W
230 W CARPENTER
SPRINGFIELD, IL 62703

1433 McANANY VANCLEVE & PHILLIPS
LISA HENDERSON
515 OLIVE ST SUITE 1501
ST LOUIS, MO 63101

14IWCC0775

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

Rosie Jackson

v.

Solomon Colors, Inc.
Employer/Respondent

Case # **10 WC 44130** Employee/Petitioner
Consolidated cases: **10 WC 32138**

The only disputed issue is the nature and extent of the injury. An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Douglas McArthy**, Arbitrator of the Commission, in the city of **Urbana**, on **September 24, 2012**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

On the date of accident, **6/17/2008**, 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 not causally related to the accident.

In the year preceding the injury, Petitioner earned $**29,005.22**, and the average weekly wage was **$577.29**.

At the time of injury, Petitioner was **39** years of age, **married** with **4** dependent children.

Necessary medical services and temporary compensation benefits have not been provided by Respondent.

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

ORDER

The Petitioner has failed to show a causal connection between her accident and condition of ill being. The claim is denied.

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

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

D. Dylan McCarthy
Signature of Arbitrator

11/7/12
Date

Findings of Fact

The petitioner, Rosie Jackson worked for respondent nearly 11 years, from March of 1998 until 10/17/08. She would work eight plus hours a day, forty plus hours a week. From March of 1998 until 2006 her job entailed taking a scoop with her right hand, scooping powdered color into a bag. She would then weigh it on a scale, pinch the bag to seal with her left hand and then send it down the line. The bags weighed anywhere from one ounce to fifty pounds. She did this for 4 hours. She would also pack bags into a case with both hands, push them down, push a case through a taper, pick up a box and place the box on a pallet. The box weighed about fifty pounds. She did this for the other four hours of the day. From 2006 to 2008 she worked the bottling line. She would pick up twenty plastic bottles and place them on a turntable, push them to go down, then a machine filled them with liquid and she would pick up boxes to put on a pallet. The boxes weighed anywhere from ten to twenty pounds each. She would do this for four hours a day. She would also pick up full bottles and pack them into cases up to three hundred fifty cases in four hours. (Pet #20)

The petitioner testified that she began having pain and numbness in her hands, and stopped pinching the bags because of her symptoms. She had experienced similar symptoms and received extensive prior treatment, including multiple surgeries involving her thumbs, wrists and elbows, beginning around 2000. Her injuries were accepted as work related, and she received three settlements with the last coming in 2005. Her settlement contracts were not offered as evidence, and no claim for credit is being made by the respondent.

On June 17, 2008, the petitioner was assaulted sexually by a male co-worker. The evidence shows that he was trying to remove her clothes, and removed her shirt, touching her breasts. The accident was stipulated to by the parties. She testified that after the assault, her life changed. She was fearful of others at all times, did not leave the home often, and had auditory and visual hallucinations. On direct exam, she said she'd not had any psychological problems prior to the assault. On cross- exam, however, she admitted to being hospitalized many years ago after a suicide attempt, and suffering from ongoing depression, which she said was nearly in remission prior to her work assault. She also admitted on cross that she had been sexually assaulted by her stepfather, and worked as a prostitute, again many years prior to her accident.

With respect to her upper extremities, the petitioner first called Dr. Wottowa, one of the physicians who had treated her elbows previously, followed by a call to another former treating doctor, Dr. Greatting. Nerve conduction studies were then performed by Dr. Trudeau on Oct. 9, 2008, showing bilateral carpal tunnel syndrome, the right greater than the left, and mild ulnar neuropathy on the right. Her claim alleging an accident on that date is also stipulated to by the respondent .

Personally, the petitioner at the time of her accidents was a 39 year old with an eighth grade education, and no GED. She lives with her husband and takes care of six grandchildren. Before beginning with the respondent, she worked as a custodian in a hotel, cleaning rooms and the lobby. She also had some experience driving a fork lift. Following her accidents and treatment, which are discussed below, she was employed as a home care assistant for an elderly man, a job which she held for only three weeks.

Petitioner was seen by Dr. Bansal at the SIU Health Clinic on June 24, 2008 regarding depressive symptoms included insomnia, psychomotor retardation, fatigue, impaired concentration, and recurrent thoughts of or suicide. Psychosocial stress factors included a recent traumatic event of inappropriate touching on one of her bosses. It was noted that she had a personal history of depression. The doctors

impression included depression, major, recurrent, and he noted she was going to see a counselor that day for the depression. She was started on Paxil.

Later that day, she saw Brenda Flesch, a counselor and related that she had symptoms were being sexually harassed at work. She said that the assault brought back a lot of feelings related to sexual abuse she had sustained a relative earlier in her life. She was scheduled to see the counselor again on July 2, 2008 but notes indicated she failed to attend the appointment.

Her next treatment for depressive symptoms was on March 31, 2009 with Dr. Gleason again at S I U. She reported frequent crying spells, was sometimes forgetful, seemed to be disorganized, and had difficulty sleeping. She had lost her job he felt that might be raised related to her depression and or disorganization. She related a history of using cocaine in the distant past. Recently, she had used alcohol and some marijuana. She was somewhat concerned that she might go back to the drugs if she did not get some relief. Diagnosis was major depression, she was prescribed Cymbalta.

On May 22 2009 she saw Linda Snyder, a counselor at the same facility, on referral from Dr. Gleason. At that time she reported that she was seeing bugs on her arms and other areas. Ms. Snyder wanted her to see Dr. Gleason and perhaps be hospitalized , but the petitioner refused. Diagnosis was to rule out a brief psychotic disorder.

She was seen for a comprehensive assessment at Mental Health Centers of Central Illinois on July 8, 2009. She stated that she did not know what she needed help with. It was noted that she asked the staff to open the door and frequently wiped her arms and legs, stating that there were bugs. At one point, she started crying hysterically due to the bugs. She said that life was bothering her and that she heard things in your mind. She did not feel suicidal. She stated that her 24-year-old daughter took care of her. The staff felt she would benefit from case medical services, but she already shown poor compliance. Diagnosis was depressive disorder, recurrent, severe with psychotic features.

Dr. Gleason saw her on August 3, 2009, noting that both he and Ms. Snyder had tried to get her directly admitted to the hospital for psychiatric evaluation; however, she had declined to do so. Diagnosis was depression with psychotic features. He discussed an emergency room admission with evaluation by the site response team, but petitioner was opposed to that treatment. The doctor started her on Risperdal, and he referred her for psychological evaluation. On September 8, 2009, she reported improvement to Dr. Gleason. He increased her dosage, advised her to continue stretching exercises that have been recommended for her lower back pain.

She was seen by Dr. Bennett, a psychiatrist, at Mental Health Centers of Illinois on November 3, 2009. She reported that she had been hearing voices and seeing bugs for the past year. She felt very sad, and she reported taking medication for depression for a long time. She had one hospitalization related to psychiatric illness 20 years before when she had a suicidal ideation and had overdosed on iron pills. He said that her depression had been on and off since that time. She said that she had abused drugs in the past that had been clean for 12 years. She did not tell Dr. Bennett that she had been sexually assaulted at work. He did note that history in her chart. He diagnosed her as being schizophrenic; bipolar and suffering from Post Traumatic Stress Disorder.

She saw Ms. Snyder November 30, 2009 and said that the medication prescribed by Dr. Bennett had been helping, but the bugs had gotten bigger and the voices were angrier. She was encouraged to take her medications and keep her appointments with Dr. Bennett. She was not seen again for any psychological complaints until June 15, 2010 when she saw Dr. Gleason. She said that her counseling with the Mental Health Center had not worked out because her counselors constantly changed because

of frequent turnover. Her symptoms included fatigue forgetfulness and a decreased mood. The Dr. felt that she was better than she had been in August 2009, which had been a low point for her. He started her counseling with Ms. Snyder again, and prescribed Paxil.

She returned to the Mental Health Center on October 8, 2000, seeing counselor Jessica Loveless. She reported a history of mental illness which she was able to cope with for years. She says it was nearly in remission when she was attacked by at work by a man who tried to rape her. She was referred to another psychiatrist, Dr. Bland, and provided him a similar history. She also reported auditory, visual and tactile hallucinations. His diagnosis was to rule out posttraumatic stress disorder. She was seen on a fairly regular basis through 2011 reporting many of the same symptoms and continuing with the same diagnosis from Dr. Bland. He noted on October 25, 2011 that the petitioner was not attending her prescribed therapy. She did relate her problems to her assault at work and he diagnosed posttraumatic stress disorder. Dr. Bland saw her on June 21, 2012. She reported that she had not been doing therapy, was at home taking care of her grandchildren and was experiencing some nightmares, which sounded like possibly being related to her "trauma". She was last seen August 16, 2012. Her symptoms had improved. Dr. Bland diagnosed posttraumatic stress disorder, schizoaffective disorder, depressed type by history. He recommended she increase Prazosin, and continue on Celexa and Haldol. He recommended further treatment and noted a desire to continue to explore the inconsistencies between her presentation and verbalizations.

Dr. Bennett testified by way of deposition. He said that he ultimately diagnosed the petitioner with a schizoaffective disorder but added that he did not believe that it was causally related to the petitioner's sexual assault. (P X 12 at 25) He also diagnosed posttraumatic stress disorder which he said was consistent with a traumatic event in the past. While he said that the trauma could have been a sexual molestation, Dr. Bennett was not sure of what type of molestation or with whom. He admitted that he did not know that the petitioner had been sexually assaulted by her stepfather in the past. When informed, he said there posttraumatic stress disorder could be related to that event.(P X 12 at 14, 40, 41, 45)

Petitioner went to Dr. Trudeau on the date of the accident. He diagnosed bilateral median neuropathies at the wrists, mild to moderately severe on the right side and mild and neuropractic on the left side. She also had ulnar neuropathy at the right elbow, mild. He noted that she is a packer at Solomon Colors and has worked there for eleven years, packing materials that are manufactured for coloring brinks. He said that the patient is very specific that her work activities both bring on and aggravate her symptoms. He said "this should be considered work related." (Petitioner's exhibit #2)

On October 24 2008 Dr. Greatting took her off work with no repetitive activities and no lifting over 5 pounds pending her surgery.

Dr. Greatting said on 11/16/08 that she has been diagnosed with recurrent right cubital tunnel syndrome, right wrist de Quervain's tenosynovitis and recurrent bilateral carpal tunnel syndrome. He said "it is my opinion that her work activities have caused or contributed to her developing these conditions. " (Pet #3)

On January 23, 2009 Dr Greatting performed a neurolysis and revision, transposition for the right ulnar nerve, released her DeQuervain syndrome and re-released the right carpal tunnel. He found scar tissue overlying the nerve in the carpal tunnel. He released the scar tissue. (Pet #3)

On April 7, 2009, Dr. Greatting performed a release of the left carpal tunnel. He found that the nerve was encased in scar tissue. (Pet #3)

Petitioner went to Danielle Edens for a functional capacity evaluation on June 30, 2009. Ms Elders wrote that the worker "participated fully in the testing." She provided acceptable effort. She recommended 25# occasional, 22.5# frequently, and 11.25 constant. She said petitioner should engage in no more than occasional reaching, gripping, find motor activities and no more than frequent lifting and carrying. (Pet #3)

Dr. Greatting wrote, on July 9, 2009, that petitioner has carpal and cubital tunnel, as well as De Quervain tenosynovitis. He said she has been unable to return to her previous work activities. He reviewed the FCE and concluded that "I do not think she could return to her previous type of employment. I think this is going to be difficult for her to obtain any type of employment which will require her to use her upper extremities, particularly her right upper extremity, for any type of frequent lifting, gripping, pushing, pulling or carrying activities; and for any type of fine motor activities, particularly with the right. She is considering applying for long term disability, and I think this is mostly likely necessary and reasonable." (Pet #3)

Dr. Trudeau saw her again on 9/14/09. He noted that she "is unable to do repetitive motion type of activities without running into difficulties." (Petitioner's #2)

Petitioner saw Dr. Pruitt for an independent medical evaluation on May 3, 2010. He did not dispute that her arm and hand conditions were related to her work activities at Solomon Colors. He felt she should not undergo any more surgery because it would likely cause further scarring. He did think one more EMG/NCV study would be appropriate to "be certain there is nothing else to do." He felt she could not return to her old line of work. He thought she might be able to do something sedentary, maybe answering phones. He agreed with Dr. Greatting's restrictions. He felt vocational retraining might be helpful. (Pet #17)

Petitioner requested vocational rehabilitation from the respondent. (Pet. #18). There is no evidence that the respondent was able to place petitioner, or that it even tried to help place her.

On February 11, 2010 Dr Greatting gave her permanent restrictions not lifting more than 2 pounds regularly and 5-10 pounds occasionally with her right arm and that would require her to do no writing or keyboarding more than 15 minutes per hour with her right arm (Pet #3)

He saw her again on June 17, 2010, noting that her ulnar nerve symptoms and electrical studies had gotten worse. He said that she was limited to sedentary type work, and suggested that she have no additional surgery. (PX 3)

On September 14, 2010 Dr. Greatting tightened her restrictions even further. He said she should not lift over 1 pound. She should not push or pull over 1 pound with the right. These restrictions are permanent. He noted the petitioner's complaints of constant burning pain in the right arm, and diagnosed chronic right cubital tunnel and recurrent right carpal tunnel syndrome. (Pet #3)

Her next treatment came over one year later, on November 1, 2011. She saw Dr. Greatting, with complaints of a decreased grip in the right hand. He recommended a new electrical study, and continued his diagnosis of chronic right carpal and cubital tunnel. (PX 3)

On or around December 19, 2011 Dr. Trudeau saw her for her ulnar neuropathy. He diagnosed ulnar neuropathy at the elbow with acute features as well as chronic ones. He also found median neuropathy at the right wrist, which was new since the previous study of 5/17/10. He wrote that "These difficulties are related to her work injury with Solomon Colors." (Pet. #2)

Dr. Greatting saw the petitioner again on Jan. 4, 2012. He noted the electrical studies, and diagnosed a recurrent carpal tunnel syndrome. He provided conservative care, including a splint and injection, but said that if they did not provide relief, surgery would be indicated. He reiterated that he did not recommend any further surgery in the right elbow. (PX 3)

Conservative care did not provide relief and on Mar. 13, 2012 Dr. Greatting performed another right carpal tunnel release. In surgery he noted the median nerve was entrapped in adhesions and scar tissue. He saw the petitioner for follow up visits on Mar. 28 and again on June 7, 2012, noting significant improvement in the petitioner's first three fingers, but some ongoing symptoms in her fourth and fifth fingers. He told the petitioner to use her hand as tolerated and to come back as needed. There is no indication that he lifted or changed her restrictions from June 2010, which he had characterized as permanent. (PX 3)

The respondent sent petitioner for an independent medical exam with Dr. David Brown on April 17, 2012. He did not dispute that her injuries were related. He did think that the most recent surgery was unrelated to her work for the respondent because she developed carpal tunnel when she had not worked for some time. He also opined that he would not have performed her most recent, or any other, surgeries on the petitioner because of her past history of surgery followed by a reoccurrence of symptoms. (PX 20)

Petitioner's restrictions on this case, not to mention the assault case, are very restrictive. Dr. Greatting imposed restrictions of not lift over 1 pound. She should not push or pull over 1 pound with the right. These restrictions are permanent. She is not to work repetitively. He thought that permanent disability was a reasonable option. Dr. Pruitt agreed that Dr. Greatting's restrictions were reasonable. (PX 17) No doctor felt she could work at a more strenuous level than sedentary.

Petitioner is unable to care for herself. Her children and husband help to take care of her. (Tr. 27-8) Petitioner has a lot of pain in her hands all the time. The pain will not go away. She has trouble lifting bottles of milk. Her elbows hurt her from her biceps down to her hands. (Tr. 31-32) Nothing makes it better. When she uses her hands and arms it makes it worse. The left has the same inability to grip and feel things, but does not hurt as much. Petitioner's right hand will lock up so that she has to pry it open, especially when she drives. She has difficulty combing her hair now. Her daughter has to help her with more complicated hair styles. Since being discharged by the respondent on Oct. 31, 2008, the petitioner has not performed much work outside the home. She tried to work as a personal assistant to an elderly man with disability, but testified that she was unable to continue the job due to fear of being alone with him. She testified that she looked for other work, but was nonspecific and did not show any consistent job search.

Frank Trares, a vocational expert hired by the petitioner for an evaluation which took place in Oct. 2010, testified at arbitration. His testimony was the only vocational evidence offered into evidence; though the respondent had sent the petitioner for a vocational assessment in Feb. 2012 with James England, Jr. His report was not offered into evidence by the respondent, and the respondent objected to the petitioner's offer of his report.

Mr. Trares met with the petitioner, discussed her case, reviewed the restrictions from Dr. Greatting, and reviewed the report of the expert that the respondent had hired. He was familiar with the other expert, James England, having worked with him previously. He felt the respondent's expert was correct when he said that he would not be able to find a job for petitioner with a stable market. He testified to three factors which he said prevented the petitioner from obtaining any gainful

employment. He noted her lack of education, her ongoing psychological issues, and the restrictions placed on the petitioner by Dr. Greatting, which he characterized as very restrictive. He did not consider the FCE results done over a year before Dr. Greatting prescribed his restrictions, stating that he customarily relied upon the doctors opinions in making his vocational assessment.

Respondent has paid TTD through the trial date.

Conclusions of Law

The petitioner has failed to show a causal relationship between her assault at work in June 17, 2008 in her current conditions of ill being. For that reason, the claim is denied.

The evidence shows that the petitioner had a long history of depression related to many factors including prior sexual assaults. Dr. Bennett in his testimony diagnosed to conditions. The first, a schizoaffective disorder, could not be causally related to the assault. His second diagnosis, post traumatic stress disorder, also could not be related to her assault of June 17, 2008. It is clear from Dr. Bennett's testimony that he did not have sufficient information to provide opinions on causal connection.

The petitioner's testimony and reported symptoms contained many inconsistencies. In addition, she had a number of stressors in her life which just as easily could have produced either condition.

For the above reasons this claim is denied.

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

Melvin, Christopher,

Petitioner,

14IWCC0776

vs.

NO: 11 WC 43941

Illinois Department of Transportation,

Respondent.

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed October 17, 2013, is hereby affirmed and adopted.

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

14IWCC0776

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 14 2014
o8/27/14
RWW/rm
046

Ruth W. White

Charles J. DeVriendt

Daniel R. Donohoo

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

MELVIN, CHRISTOPHER
Employee/Petitioner

Case# **11WC043941**

14IWCC0776

ILLINOIS DEPT OF TRANSPORTATION
Employer/Respondent

On 10/17/2013, 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 0.15% 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:

0190 LAW OFFICES OF PETER F FERRACUTI P
THOMAS M STROW
110 E MAIN ST
OTTAWA, IL 61350

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

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

OCT 17 2013

KIMBERLY B. JANAS Secretary
Illinois Workers' Compensation Commission

14IWCC0776

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

Christoper Melvin
Employee/Petitioner

v.

Illinois Department of Corrections
Employer/Respondent

Case # 11 WC 43941

Consolidated cases: N/A

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

On September 1, 2010, Petitioner ***did*** sustain an accident that arose out of and in the course of employment.

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

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

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

Respondent is entitled to a credit of $11,453.99 under Section 8(j) of the Act.

ORDER

Respondent shall pay Petitioner temporary total disability benefits of $959.73/week for 2 6/7 weeks, commencing 3/5/2012 through 3/16/2012 and 7/10/2012 through 7/17/2012, as provided in Section 8(b) of the Act.

Respondent shall pay reasonable and necessary medical services of $66,386.79, as provided in Sections 8(a) and 8.2 of the Act. Respondent shall be given a credit of $11,453.99 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 the remaining $600.00 in unpaid medical bills and reimburse Petitioner for $75.00 paid in out-of-pocket expenses.

Respondent shall pay Petitioner permanent partial disability benefits of $669.64/week for 137.40 weeks, because the injuries sustained caused the 15% loss of the right arm, 15% loss of the left arm, 15% loss of the right hand and 15% loss of the left hand, as provided in Section 8(e) of the Act.

Penalties and fees are denied.

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

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

S J Mathis

Signature of Arbitrator

10-11-13

Date

OCT 17 2013

Christopher Melvin v. Illinois Department of Corrections, 11 WC 43941
Petitioner's Proposed Decision
Date of Hearing: August 13, 2013

I. STATEMENT OF FACTS

Petitioner Christopher Melvin testified that he has been working for the Illinois prison system for over twenty years. He testified that he is currently employed by Dixon Correctional Center and, immediately prior to that, was employed by Pontiac Correctional Center. At all times relevant and material the present claim, Petitioner was an employee at Pontiac.

Petitioner prepared a synopsis of his job duties performed over the years. (PX8). He testified that this information is an accurate representation of what he did in his previous positions including at Pontiac Correctional Center. In addition, Petitioner has testified that PX7 contains an accurate description of his Central Management Services job descriptions. Petitioner testified that he marked this document to represent which of these descriptions pertained to past positions and which pertained to additional supplemental positions he had at the time of the alleged onset of symptoms. (PX7).

Petitioner further testified that his job duties at Pontiac Correctional Center increased in July 2010 as the prison faced multiple retirements. Petitioner filled three vacant positions at this time and was therefore performing the work of four facility positions: Public Service Administrator – Administrative Assistant 3, Public Service Administrator – Business Administrator, Executive Secretary 3, and Administrative Assistant 2. (PX8 at 2).

In taking on these additional positions, several of Petitioner's new job duties required the increased repetitive use of his hands and wrists. For instance, Petitioner was responsible for conducting daily, weekly, and monthly Warden's Office reports that included various offender, employee, and external data ranging from fiscal to operational information. (PX8 at 2). He also served as the point of contact on behalf of the Warden to outside agencies and public entities in dealing with contract monitoring, labor relations, budgetary issues, offender issues, staffing issues, and any other related issues. Petitioner would then provide daily, weekly, and monthly written or typed reports based on these ongoing contacts. (PX8 at 2).

Petitioner was also responsible for creating and sending daily email reports regarding any number of issues related to the Warden's Office ranging from policy issues to confidentiality issues. (PX8 at 2). Petitioner would also write or type out all labor relations documentation including 1st, 2nd, 3rd, and 4th level grievance resolutions. He would then file or distribute this documentation, prepare the reports, email the reports, and submit them for the monthly reports. (PX8 at 2).

In addition, Petitioner would write, type, and file various employee-related documents including annual employee evaluations, benefit time off, jury duty services, personnel documentation, and other similar information. (PX8 at 2). Petitioner also possessed and exercised signature authority for the Warden and was responsible for signing inmate disciplinary

tickets, gate passes, purchase requests, travel documentation, mail office issues, Governor's Office issues, and suggested responses. (PX8 at 2).

Petitioner also performed research both online and over the various network programs regarding offender, employee, and visitor issues. (PX8 at 2). Additionally, in the absence of an executive assistant, Petitioner performed special projects on behalf of the executive level staff including district reports and emails for the Deputy Director. (PX8 at 2). Furthermore, Petitioner conducted and documented weekly tours of the stores within the business office and facility, prepared and wrote the reports of such in the log book, and emailed the results or findings to the Warden. (PX8 at 2).

In addition to all of the duties listed above, Petitioner acted on behalf of the warden as executive clerical staff due to a vacancy in that position for the previous five years. These duties included preparing, writing, typing, and disbursing various policies, memorandums, bulletins, emails, and similar documents. (PX8 at 2), From this information, it is clear that beginning in July 2010 a great deal of the Petitioner's work revolved around writing and typing various documents and emails.

Petitioner reported that he typically sat at an L-shaped desk made of plywood. (PX9). His chair had wheels and an arm rest, and it was capable of being raised or lowered. (PX9). He used a flat-panel monitor that sat on the left side of the desk. (PX9). He used a keyboard with no pad and a mouse with no pad as well. (PX9). Petitioner rested his wrists and forearms on the plywood desk while doing his keyboarding. (PX9). Sometimes he also used a workstation that consisted of a straight, non-L-shaped desk made of pressboard. (PX9). Again, there was no keyboard pad, no mouse pad, and no pull out tray for the keyboard. (PX9).

Petitioner testified that he first complained of pain in his hands and wrists bilaterally in September 2010. On November 4, 2011, Petitioner filled out a personnel form for his employer titled "Workers' Compensation Employee's Notice of Injury" that described injuries to the left and right wrists, forearms, and elbows. (PX6). On this form, Petitioner noted that the injury occurred at the Pontiac Correctional Center–Warden's Assistant Office and was a result of "transcribing, typing, [and] writing labor documents." (PX6).

Petitioner first sought treatment on October 28, 2011 with Dr. David K. Deets at Katherine Shaw Bethea Hospital. At this visit, Petitioner complained that his hands were starting to tingle and feel numb to a point where he could not grip anything. (PX2 at 10). At this time, his grip was so poor that he had been frequently dropping things such as glass and dishes. (PX2 at 14). Dr. Deets' assessment of Petitioner at this time was that he had symptoms of bilateral carpal and cubital tunnel syndrome. (PX2 at 14).

Dr. Deets then referred Petitioner to Dr. Sulaiman Mohammad, whom Petitioner saw on November 22, 2011 at Katherine Shaw Bethea Hospital. Dr. Mohammad performed an EMG nerve conduction velocity study that showed bilateral carpal tunnel syndrome, right worse than the left side, and suggestive of but not diagnostic of mild ulnar nerve neuropathy most likely due to compression across the elbow. (PX2 at 18). No evidence of cervical radiculopathy was seen. (PX2 at 18).

Petitioner followed up with Dr. Deets on December 2, 2011. Dr. Deets noted the previously stated findings of Dr. Mohammad. Dr. Deets also notes that the cock-up splints Petitioner had been wearing had not provided much relief of either numbness or pain, and Petitioner had increasingly been dropping things due to suffering from poor grip strength. (PX2 at 7). At this visit, Petitioner had his grip strength tested by an Occupational Therapist. It was determined that Petitioner had a 65 pound grip strength in his right hand and a 50 pound grip strength in his left hand. Dr. Deets suggested that these readings should be at 110 pounds for a man of Petitioner's build and age. (PX2 at 7).

Petitioner next saw Dr. Tyler Gunderson on February 3, 2012 at Katherine Shaw Bethea Hospital. At this meeting, Dr. Gunderson confirmed that there is evidence Petitioner suffered from bilateral carpal tunnel syndrome and bilateral cubital tunnel syndrome, and Dr. Gunderson's plan was to proceed with surgical decompression due to the apparent failures of conservative treatments up to that point. (PX3 at 25).

On March 5, 2012, Dr. Gunderson performed the right carpal tunnel release and right cubital tunnel release on Petitioner. At the follow-up visit, Petitioner reported some pain, but was doing well overall. (PX3 at 14). On July 10, 2012, Dr. Gunderson performed the left carpal tunnel release and left cubital tunnel release on Petitioner. At the follow-up visit, Petitioner showed minimal signs of swelling and tenderness, and he again appeared to be doing well overall. (PX3 at 8).

In his November 19, 2012 deposition, Dr. Gunderson testified that he understood Petitioner's increased job duties in July 2010 consisted of spending most of his day at the computer typing reports and inputting data. (PX4 at 13). In Dr. Gunderson's opinion, sitting at a computer typing and inputting in the manner described by Petitioner would certainly be an aggravating factor for both carpal tunnel and cubital tunnel. (PX4 at 14). He added, taking into account Petitioner's increased workload and his experiencing symptoms more prominently shortly after this time, that a sufficient temporal relationship existed to conclude these symptoms were "more likely than not" aggravated by Petitioner's work duties. (PX4 at 14-15). Dr. Gunderson testified that the surgeries performed were necessary due to the symptoms that he believes were aggravated by his work activities. (PX4 at 21).

Dr. Gunderson also testified that Petitioner did not have any specific predisposing factors for carpal tunnel or cubital tunnel such as diabetes or obesity. (PX4 at 27). He does not believe Petitioner is obese despite having a body mass index of 36, stating that he does not consider body mass index to be a reliable measure. (PX4 at 27-28).

Petitioner was evaluated for an Independent Medical Evaluation by Dr. James Williams on March 20, 2013. Petitioner's counsel, not Respondent's, offered the report for evidence at trial. Dr. Williams indicated that he reviewed and was familiar with Petitioner's medical history relating to the carpal tunnel and cubital tunnel up to that date. (PX9). In addition, Dr. Williams indicated that he reviewed and was familiar with Petitioner's job description and work duties up to that point, including the duties Petitioner performed at Pontiac Correctional Center as of July 2010. (PX9). Dr. Williams has previously toured Pontiac Correctional Center on December 9,

2011. (PX9). Dr. Williams also had Petitioner draw a picture of Petitioner's workstation. Dr. Williams recounted in his report a detailed overview of everything he reviewed for his evaluation of Petitioner.

Upon physical examination, Dr. Williams noted that Petitioner overall appeared to be well-healed from the previous surgeries. (PX9). Petitioner was not showing any symptoms and had good strength. (PX9). Dr. Williams could not find any evidence of impairment and felt that Petitioner had done well after treatment. (PX9). In the opinion of Dr. Williams, Petitioner had reached maximum medical improvement at this time. (PX9).

Upon review of all the evidence presented, Dr. Williams determined that Petitioner had suffered from bilateral carpal tunnel syndrome as well as bilateral cubital tunnel syndrome. (PX9). Dr. Williams felt that Petitioner's work duties could:

> "at least have been an aggravating and/or contributing factor to his problems based upon the multiple different activities that he performed and based upon the fact that it sounds like his work in many different non-ergonomic type positions where he has rested his wrists and forearms on the [table] which could be aggravating of carpal and/or cubital tunnel syndrome." (PX9).

In other words, Dr. Williams believes that the nature of Petitioner's work duties – especially those duties starting in July 2010 – could have aggravated Petitioner's bilateral conditions that developed in September 2010. Dr. Williams does note that other risk factors were present in the Petitioner such as hypothyroidism, hypertension, and an increased body mass index. (PX9). However, he emphasizes the fact that petitioner had to constantly rest his wrists and forearms in several non-ergonomic positions throughout his work day could be an aggravating or contributing factor to both bilateral carpal tunnel syndrome and bilateral cubital tunnel syndrome. (PX9).

Petitioner testified he felt the surgeries were a success. Petitioner testified that following his procedures, he currently experiences some residual symptoms of pain and soreness, but for the most part the strength has returned to his hands.

Respondent offered no exhibits or witness testimony at trial to rebut any of Petitioner's evidence.

II. CONCLUSIONS OF LAW

In support of the Arbitrator's Decision as to C. WHETHER AN ACCIDENT OCCURRED THAT AROSE OUT OF AND IN THE COURE OF PETITIONER'S EMPLOYMENT, the Arbitrator finds the following:

The Arbitrator finds that Petitioner sustained accidental injuries that arose out of and in the course of employment.

Petitioner provided detailed documentation of his job duties dating back to September 1993. These documents were marked as Petitioner's Exhibit Numbers 7 and 8. In these documents, Petitioner notes that he began working for Pontiac Correctional Center beginning in November 1996 as a correctional officer. (PX8 at 1). Subsequently, Petitioner held several different positions at this facility over the years, and in July 2010 he began the task of performing four positions at once. (PX8 at 2).

Petitioner noted that these four positions required a great deal of writing and typing. Petitioner acted in many ways as a liaison between the Warden's Office and any employees, representatives of offenders, outside agencies, or public entities. (PX8 at 2). As a result, Petitioner was responsible for preparing various documents and reports on a daily, weekly, and monthly basis regarding a litany of issues related to contract monitoring, labor relations, budgetary concerns, offenders, staffing, personnel, confidentiality, and the everyday operations of the Warden's Office. (PX8 at 2). Furthermore, Petitioner used the office's network programs as well as the internet to conduct research related to these issues. (PX8 at 2). Additionally, Petitioner noted that he possessed and exercised signature authority for the warden and was responsible for signing inmate disciplinary tickets, gate passes, purchase requests, travel documentation, mail office issues, Governor's Office issues, and suggested responses. (PX8 at 2). Petitioner noted that he would either email or write out reports related to just about all of his listed duties as a way to keep the warden and other employees up to date on the various happenings in the office. (PX8 at 2).

As a direct result of these increased duties in July 2010, Petitioner suddenly found himself spending the bulk of his work days performing tasks on the computer. Petitioner noted that he sits at an L-shaped plywood table with no padding on the keyboard or mouse. (PX9 at 1). While typing, Petitioner rests his forearms and wrists on the table. (PX9 at 2). Petitioner also uses another workstation consisting of a table made of pressboard. (PX9 at 2). This station also lacks padding on the keyboard or mouse. (PX9 at 2). As a result, Petitioner's workstations during this time period were not ideal from an ergonomic perspective.

Petitioner testified that shortly after he took on these added duties in July 2010, he began to experience pain in his elbows and hands bilaterally. Petitioner testified that he submitted an official complaint with regard to these injuries in September 2010.

The Arbitrator finds that September 1, 2010 is an appropriate accident date for Petitioner's repetitive trauma accident as this was when Petitioner provided notice of injury to the Illinois Department of Central Management Services. (PX6).

Further, Dr. Williams wrote in his report that the ergonomics of Petitioner's workstation could have at least been an aggravating factor. (PX9).

Based upon the greater weight of the evidence, the Arbitrator finds that Petitioner suffered a repetitive trauma accident affecting both upper extremities arising out of his employment with Respondent that culminated and manifested itself on September 1, 2010.

In support of the Arbitrator's Decision as to F. WHETHER PETITIONER'S CURRENT CONDITION OF ILL-BEING IS CAUSALLY RELATED TO THE INJURY, the Arbitrator finds the following:

The Arbitrator finds that Petitioner's current condition of ill-being is causally related to the Petitioner's work accident.

Dr. Tyler Gunderson, treating orthopedic surgeon, testified that Petitioner's condition of ill-being was likely aggravated by his job duties. Dr. Gunderson understood that Petitioner's job involved a lot of transcription, typing, and writing work. (PX4 at 8). Dr. Gunderson testified that Petitioner complained of numbness in his hands upon the increase of activity at work. (PX4 at 9). Based upon his physical examination and review of the EMG, Dr. Gunderson diagnosed Petitioner with bilateral carpal tunnel and bilateral cubital tunnel syndrome. (PX4 at 10).

Dr. Gunderson testified that based on what he understood about Petitioner's job, he believes that sitting at the computer inputting would certainly be an aggravating factor for both carpal tunnel and cubital tunnel. (PX4 at 14). Dr. Gunderson also testified that he believes a relevant relationship existed between Petitioner's increase in job duties in July 2010 and his increase in symptoms culminating in September 2010. (PX4 at 14). Dr. Gunderson testified that a temporal relationship exists between this increased workload and the increased symptoms. (PX4 at 14). Dr. Gunderson testified that this is due to Petitioner's nerves being either directly compressed or compressed due to positional pressure changes at the wrist – each a direct result of sitting at his desk inputting all day. (PX4 at 15).

Respondent's IME, Dr. Williams, similarly reported that Petitioner's symptoms could have a causal relationship to his job duties. Dr. Williams reported that he understood Petitioner's job duties at Pontiac Correctional Center during the time Petitioner was experiencing increased symptoms. (PX9). Dr. Williams also reported that he understood how Petitioner's workstation was set up at the time Petitioner was experiencing increased symptoms. (PX9). Dr. Williams also reported that he understood Petitioner's full medical history including his history of complaints up to the time of the IME. (PX9).

Dr. Williams reported that he believed Petitioner had right and left carpal tunnel syndrome as well as right and left elbow cubital tunnel syndrome. (PX9). Dr. Williams does not believe that Petitioner's previous cervical issues could have contributed to these conditions due to the EMG not showing any signs of cervical radiculopathy. (PX9). However, Dr. Williams did report that he felt Petitioner's work duties could have been an aggravating and/or contributing factor to Petitioner's bilateral carpal tunnel and bilateral cubital tunnel conditions. (PX9). Dr. Williams based this assessment on Petitioner's multiple different work activities performed in many non-ergonomic type positions. (PX9). Dr. Williams reported that resting wrists and forearms on a desk in the manner described by Petitioner could be aggravating of both carpal tunnel syndrome and cubital tunnel syndrome. (PX9).

The Arbitrator finds the opinions of both Dr. Gunderson and Dr. Williams to be credible. The Arbitrator notes that this is a case where both Petitioner's treating physician and Respondent's examiner both suggest a possible causal relationship. Respondent has offered no

negative medical opinion, or any exhibits or opinions at all for that matter, to dispute either doctor's opinions.

Based upon the greater weight of the evidence, the credible testimony of Petitioner as to his symptoms, the medical opinions of Dr. Gunderson and Dr. Williams - Respondent's own IME - and the totality of the evidence, the Arbitrator finds that Petitioner's current condition is causally related to his repetitive trauma work accident of September 1, 2010. The Arbitrator finds that Petitioner provided sufficient evidence that, at the very least, his work activities over time contributed and aggravated his condition, causing him to become symptomatic in both of his upper extremities, leading to surgery.

In support of the Arbitrator's Decision as to J. 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 Mr. Melvin's medical care. (PX1). The Arbitrator finds that Petitioner shall be entitled to total medical expenses of $66,368.79. Respondent shall be given a credit of $11,453.99 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 the remaining $600.00 in unpaid medical bills and reimburse Petitioner for $75.00 paid in out-of-pocket expenses.

In support of the Arbitrator's Decision as to K. WHETHER PETITIONER IS ENTITLED TO TEMPORARY TOTAL DISABILITY BENEFITS. the Arbitrator finds the following:

Based upon the Arbitrator's findings of accident and causal connection and the testimony of Petitioner and Dr. Gunderson, Respondent shall pay Petitioner temporary total disability benefits of $959.73/week for 2 6/7 weeks, for the periods commencing 3/5/2012 through 3/16/2012 and 7/10/2012 through 7/17/2012, as provided in Section 8(b) of the Act.

In support of the Arbitrator's Decision as to L. THE NATURE AND EXTENT OF THE INJURY. the Arbitrator finds the following:

Petitioner testified that following his procedures, he currently experiences some residual symptoms of pain and soreness, but for the most part the strength has returned to his hands.

In support of the Arbitrator's Decision as to M. PENALTIES AND FEES. the Arbitrator finds the following:

The Arbitrator finds pursuant to Hale v. State of Illinois/Menard Correctional Center, 13 I.W.C.C. 0201, the Petitioner is not entitled to an assessment of penalties and fees. In Hale, the Petitioner's treating physician supported the petitioner, and the respondent's IME found that the work activities "could be" an aggravating factor. The same could be said of the current case, in which Dr. Gunderson was supportive and Dr. Williams indicated the symptoms "could be"

related to Petitioner's clerical work. It was still incumbent upon Petitioner to prove those work activities at the time of trial. The Commission still held because this duty of proof existed, penalties and fees were not appropriate.

Based upon the Commission's findings in Hale, the Arbitrator does not award penalties and fees in the present case.

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

Douglas Clark,

Petitioner,

14IWCC0777

vs.

NO: 11 WC 35583

Vermilion County Public Defenders Office,

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed December 16, 2013, is hereby affirmed and adopted.

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

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

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

DATED: SEP 14 2014
o8/27/14
RWW/rm
046

Ruth W. White

Charles J. DeVriendt

Daniel R. Donohoo

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

CLARK, DOUGLAS
Employee/Petitioner

Case# **11WC035583**

14IWCC0777

VERMILION COUNTY PUBLIC DEFENDER'S OFFICE
Employer/Respondent

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:

0465 SCHEELE CORNELIUS & HARRISON
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7223 S ROUTE 83 PMB 228
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0522 THOMAS MAMER & HAUGHEY LLP
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CHAMPAIGN, IL 61820

14IWCC0777

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)

DOUGLAS CLARK
Employee/Petitioner

v.

VERMILION COUNTY PUBLIC DEFENDER'S OFFICE
Employer/Respondent

Case # 11 WC 35583

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Brandon J. Zanotti,** Arbitrator of the Commission, in the city of **Urbana**, on **October 21, 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 **October 22, 2010**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$46,800.00**; the average weekly wage was **$900.00**.

On the date of accident, Petitioner was **50** years of age, ***single*** with **0** dependent children.

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

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

ORDER

Because the Arbitrator has found that Petitioner failed in his burden of proving that an accident occurred which arose out of and in the course of his employment, and further failed in his burden of proving that he gave adequate or proper notice of any work related injury within the time periods set forth in the Act, all claims for benefits are hereby denied.

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

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

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

Signature of Arbitrator

12/10/2013
Date

ICArbDec19(b)

DEC 16 2013

14IWCC0777

STATE OF ILLINOIS)
)SS
COUNTY OF CHAMPAIGN)

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

DOUGLAS CLARK
Employee/Petitioner

v. Case # 11 WC 35583

VERMILION COUNTY PUBLIC DEFENDER'S OFFICE
Employer/Respondent

MEMORANDUM OF DECISION OF ARBITRATOR

FINDINGS OF FACT

Petitioner, Douglas Clark, claims bilateral carpal tunnel syndrome (CTS) resulting from his regular duties as an Assistant Public Defender in the office of Respondent, the Vermilion County Public Defender's Office. Petitioner testified that his duties mainly consisted of going to court on behalf of Respondent, and that is where he spent his most of his working day. He testified to assembling files beginning at some point during his employment, and performing what he viewed as increased data processing responsibilities following implementation of a new software program entitled Legal Edge, which Petitioner testified occurred sometime in September 2010. Petitioner testified that he told his direct supervisor, Jacqueline Lacy, on October 18, 2010, that he was having pain in his hands and that his left thumb had swollen to double its size. Petitioner claimed the thumb was still twice normal size at trial, but did not display it to the Arbitrator. Petitioner's last day of work with Respondent was October 22, 2010. Petitioner had been seen on only one occasion for medical care at a free clinic, Aunt Martha's Health Center, on July 25, 2011 (Petitioner's Exhibit (PX) 2), nine months after his last day of employment with Respondent, which is also claimed as the accident date. The note from that visit indicates that Petitioner was complaining of chronic hand pain. Under "chief complaint," the note indicates, "carpal tunnel both hands." (PX 2).

Ms. Lacy, the Vermilion County Public Defender, testified at trial. Ms. Lacy testified that she was never advised by Petitioner of any physical problems during his employment, and specifically denied that he had spoken to her on October 18, 2010, or displayed any deformed or disfigured member. Ms. Lacy testified that she took over the Vermilion County Public Defender's Office in July 2010, and set about making changes in the office to make it more efficient. One of these changes was to adopt a legal scheduling software program called Legal Edge, which was put into use on or around October 11, 2010. Respondent's Exhibit 1 is the licensing agreement for the software dated October 11, 2010, eight days before Petitioner's last day at work.

Ms. Lacy testified that Petitioner was suspended from work on October 19, 2010, pending an investigation into alleged misbehavior. Her subsequent investigation revealed that Petitioner had screamed at the victim of a crime while on the telephone in the Vermilion County State's Attorney's Office, and otherwise abused employees in that office verbally. Petitioner was advised of a subsequent meeting to discuss the results of the investigation, and when he did not appear for the meeting, his employment was considered voluntarily terminated effective October

22, 2010. Ms. Lacy's testimony is supported by Respondent's Exhibit 2, a letter to Petitioner dated October 25, 2010, advising of the voluntary termination.

Ms. Lacy confirmed that Petitioner's primary duty was to appear in court. She testified that due to his assignment to traffic and misdemeanor cases, he would appear at a daily court docket beginning at 8:30 a.m., which could last two to three hours. There was then another daily docket beginning at 1:00 p.m. of similar duration. Ms. Lacy testified that prior to the use of the Legal Edge software beginning October 11, 2010, the attorneys had no word processing or data entry duties. Respondent's office included two secretaries who assisted the attorneys. These secretaries would perform all data processing, assemble the physical files and deliver them to the attorneys, as well as prepare most, if not all, of the pleadings. Ms. Lacy testified that Legal Edge was a "point and click" type of software, which involved clicking boxes on a form as opposed to word processing or data entry. The software had been designed specifically for a public defender's office, and so contained information relevant to that practice, specifically as to dispositions and other standard entries. Ms. Lacy confirmed that Legal Edge was a scheduling and docket control tool.

Ms. Lacy also testified that Respondent's Exhibit 3 is an example of the accident reporting forms used by Respondent when any employee reports an injury at work. Ms. Lacy stated that this procedure was not followed in the present case because there was no report. She testified that if such a report had been made by any employee, including Petitioner, these forms would have been completed and an investigation would have been performed by the Human Resources Department.

Tracy Warbritton also testified at trial. Ms. Warbritton was a secretary with Respondent. She worked for Respondent for a total of 35 years before retiring. Ms. Warbritton affirmed that she assisted Petitioner in his daily practice, including typing motions, performing any data entry required, and physically preparing the files and delivering them to Petitioner. Ms. Warbritton confirmed that there was minimal data processing and computer work in general involving the cases. She testified that even after the implementation of the Legal Edge software, she still performed most of Petitioner's typing and data entry tasks.

Petitioner was evaluated at his attorney's request by Dr. Jeffrey Coe on September 19, 2012. According to the doctor's report, Petitioner reported that changes were made in Respondent's office in "approximately 2010," whereby the clerical duties of the attorneys in that office changed. He reported to Dr. Coe that prior to these changes, secretaries and clerical aides were available to perform routine clerical work, including data entry and filing. Petitioner reported that after the office changes, he would enter data on more than 50 files per day and perform paper filing duties. Dr. Coe performed an examination, and noted tenderness over both thumbs, positive bilateral Phalen signs bilaterally, and negative Tinel signs bilaterally. Dr. Coe opined that Petitioner suffered repetitive strain injuries to both hands, and that said injuries were a factor in causing the development of clinical symptoms consistent with bilateral CTS. Dr. Coe also opined that there was a causal relationship between Petitioner's bilateral hand overuse injuries while working with Respondent, and his current state of impairment. Dr. Coe recommended additional treatment. (PX 1).

Petitioner testified that between leaving employment with Respondent and having his one and only office visit at Aunt Martha's Health Center, he was employed by a janitorial service performing janitorial duties.

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 has failed to prove that his job with Respondent involved any repetitive usage of his hands and wrists. Petitioner did not quantify any part of a typical work day as involving data entry or word processing. It is apparent from his testimony, as well as that of Ms. Lacy and Ms. Warbritton, that Petitioner's primary task was attending court. Petitioner testified that there was increased word processing with the advent of the Legal Edge software; however, as testified to by Ms. Lacy and as supported by Respondent's Exhibit 1, that software was put into place eight days prior to Petitioner's suspension from work on October 19, 2010. The Arbitrator finds that that is simply too short a period of time to have caused or aggravated his problems, and notes Ms. Warbritton's credible testimony that even after the new software was implemented, she continued to perform most of Petitioner's data entry and word processing, as well as physically preparing the files for his use.

The Arbitrator finds significant the lack of medical care until nine months after the alleged date of accident, a period during which Petitioner was employed as a janitor, work which is typically much more hand intensive than being an attorney.

Petitioner was seen for an independent medical examination at his attorney's suggestion by Dr. Coe on September 19, 2012, a period of nearly two years after the last day Petitioner worked for Respondent. The Arbitrator notes that in the very first paragraph, Dr. Coe claims to have had "reviewed a number of [Petitioner's] medical records including reports of his treating physicians." Based on the evidence at trial, only one page of records actually exists, and that is an office note and not a "report." The Arbitrator questions the reliability of Dr. Coe's assessment based on his notion that he reviewed "a number" of Petitioner's medical records from his "treating physicians," as there is only one office note at issue.

Further, the Arbitrator scrutinizes the reliability and persuasiveness of Dr. Coe's report, as the history provided to him is questionable at best. Dr. Coe's report indicates that at some approximate time in 2010, Petitioner's duties changed to the point where he was performing clerical duties, including performing data entry on more than 50 files per day. The weight of the evidence shows that Petitioner's duties changed in early October 2010, just days before his termination. However, these "changes" in his duties were not significant, as the software used did not require extended periods of typing or data entry. Further, the credible testimony of Ms. Warbritton establishes that even after the duty changes in October 2010, she was still performing most of Petitioner's typing and data entry duties. For the foregoing reasons, the Arbitrator finds that Dr. Coe's opinion on causal connection is not reliable.

The Arbitrator finds the testimony of Ms. Lacy and Ms. Warbritton credible. Both testified in an open and forthcoming manner, and endeavored to be giving the full truth during both direct and cross-examination.

All benefits are therefore denied based upon a failure by Petitioner to prove that an accident occurred which arose out of and in the course of his employment by Respondent. The issue of causal connection is rendered moot.

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

The Arbitrator finds that Petitioner failed to prove that he gave notice to Respondent of a physical condition arising out of work within 45 days of the date claimed. Petitioner's testimony was that he displayed his left hand to Ms. Lacy on October 18, 2010, to show her that his left thumb was twice the normal size, and that he also complained to her of pain in his hands. Ms. Lacy testified that said event never occurred. The weight of the evidence supports Ms. Lacy's testimony. As previously noted, the Arbitrator found Ms. Lacy to be a credible witness at trial.

First, there has never been any evidence that Petitioner's thumb was twice its normal size, including during his one visit to a treating doctor and the examination by his own independent medical examiner. Secondly,

Respondent's Exhibit 3 is an exemplar of the accident reporting forms used by Respondent when any employee reports an injury at work. Ms. Lacy testified that this procedure was not followed in the instant cause because there was no report of any injury. She testified that if such a report had been made by any employee, including Petitioner, these forms would have been filled out and an investigation performed by the Human Resources Department. Again, that was not done because there was no report.

It is clear from Ms. Lacy's credible testimony that Petitioner's separation from his employment was confrontational. Petitioner had numerous opportunities to report an incident or injury during his employment up to and including the final meeting with Ms. Lacy and a representative of the Human Resource Department, and failed to do so. The evidence of lack of notice is supported by the lack of medical care for a nine month period, indicating that no such incident or injury took place.

Based on the foregoing, the Arbitrator finds that Petitioner has failed to provide notice of an injury or incident within 45 days of the claimed date of accident.

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

The Arbitrator denies all claims for prospective medical care based upon the failure to prove accident and notice, as discussed *supra*.

STATE OF ILLINOIS)
) SS.
COUNTY OF CLINTON)

☐ 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

Ronald Riley,
Petitioner,

vs. NO: 05 WC 47623

Mid-States Express,
Respondent.

14IWCC0778

DECISION AND OPINION ON REVIEW UNDER SECTION 8(a)

This cause comes before the Commission on Petitioner's Petition under Section 8(a) of the Act. Petitioner also seeks penalties and fees under Sections 19(k), 19(l) and 16. A Settlement Contract Lump Sum Petition and Order was approved by Arbitrator Granada on March 11, 2013, leaving medical benefits under Section 8(a) open. A hearing on the Petitioner's Petition under Section 8(a) was held before Commissioner Donohoo in Mt. Vernon, IL on November 14, 2013. Both parties were represented by counsel.

The Commission, after having reviewed the entire record, hereby denies Petitioner's Section 8(a) Petition and finds that Petitioner failed to prove that his current condition of ill-being is causally related to the work accident of August 8, 2005. 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 August 8, 2005 injury. The Commission also declines to award penalties and fees under Sections 19(k), 19(l) and 16.

Prior to approval of the settlement contract in March, 2013, a Section 19(b) hearing was held before Arbitrator Teague on November 8, 2006, with a decision issued on December 21, 2006. The decision was not appealed and became final. The decision stated Petitioner was employed by Respondent as an outboard supervisor and sustained a work related injury on August 8, 2005. As a driver was leaving the terminal, Petitioner ran after the truck and his heels slipped on an angle iron causing him to fall head first off the loading dock. He sustained multiple injuries, including injury to his knees, left shoulder, elbows and low back.

The March 11, 2013 Settlement Contract terms state that the parties were entering into a compromised settlement of a disputed claim after an accident on August 8, 2005 with injury to Petitioner's bilateral knees, neck, back, left wrist and elbow after a slip and fall off a loading dock. The terms stated:

> "This is a compromised settlement of a disputed claim... The parties agree that all of Petitioners medical rights remain open under Section 8(a) of the IL Workers' Compensation Act. Respondent also maintains its rights to dispute future medical in accordance with Section 8(a). Respondent will pay medical bills related to Petitioner's

14IWCC0778

bilateral knees with dates of service through 10/30/2012, the date of Dr. Lehman's most recent IME report, even though such treatment is disputed based on Dr. Lehman's opinions...The medical evidence indicates Petitioner may need future medical treatment and this has been addressed by the parties by agreeing that Petitioner's medical rights under Section 8(a) remain open for life. Therefore, Medicare's interest have been considered and addressed. Notwithstanding, Respondent disputes that Petitioner's need for future medical treatment is causally related to the underlying incident that occurred on August 8, 2005 and maintains its right to dispute any request for future medical treatment under 8(a)."

At the review hearing on November 14, 2013, Petitioner testified that since the settlement contract was approved, he has had problems with his left knee. Petitioner testified he was doing very well but about six months after he underwent a total left knee replacement on December 13, 2011, Petitioner was getting out of a chair when he felt his knee pop. He testified that he did not slip or fall getting out of the chair but instead was pushing himself out of the chair, and the left knee made a popping sound; he fell back into the chair.

Petitioner testified that since the incident getting out of the chair, he has experienced swelling of the left knee with use, and his knee will lock when rising from a seated position. Medical records submitted at the Section 8(a) hearing show Petitioner presented to Dr. Bonutti on July 23, 2013 with complaints of left knee pain. The history contained in that record states that Petitioner was getting up from a chair in June or July of 2012 when he felt a loud pop in his knee that knocked him back into the chair. Petitioner returned on November 5, 2013 and again stated that he continued to have left knee pain. The history contained in the November 5, 2013 note states that Petitioner did well with regard to his left knee for six months [post surgery] and then torqued his leg. Since that point, Petitioner has had sharp burning pain in his left knee which pops when going from flexion to extension. The history notes Petitioner stated that he had absolutely no symptoms and his knee was great for six months before it started locking. The November 5, 2013 note also suggested that Petitioner had evidence of symptom magnification at that visit. Dr. Bonutti reported that Petitioner has always had some degree of symptoms that exceed his objective pathology. The doctor further noted that in the past, Petitioner had been aggressive and abusive toward his staff. This was discussed with the Petitioner, after which he left the office without making any decisions regarding treatment and was observed by the doctor carrying his cane. The November 5, 2013 note stated that Petitioner was to contact the office if he wanted a second opinion or if he wished to discuss arthroscopic evaluation of the patellofemoral joint.

Petitioner argued that Respondent is relying upon the October 30, 2012 report of Dr. Lehman in denying treatment for the left knee. Dr. Lehman's October 30, 2012 Section 12 Report is attached to the March 2013 settlement contract. In it, Dr. Lehman opined there was no acute pathology as it relates to the left knee and the treatment Petitioner had to date resolved the issues related to the work injury. Dr. Lehman opined that Petitioner had multiple surgeries, his prognosis was poor and his symptoms seemed to be in gross excess of objective findings. Dr. Lehman opined that the surgeries Petitioner had undergone had addressed the work related pathology and any further treatment to the knees would be related to long term preexisting degenerative arthritis. Petitioner argued that to rely on Dr. Lehman's opinion without a recent exam is unreasonable and therefore, Petitioner also seeks penalties under Sections 19 and 16 of the Act.

Respondent argued that Petitioner is not automatically entitled to any kind of future medical treatment just because medical rights were left open in settlement. The Petitioner bears the burden of proof by a preponderance of the evidence that he is entitled to an award of medical care under Section 8(a). Respondent argues that Petitioner has not met that burden with the medical records in evidence.

14IWCC0778

Respondent notes that Dr. Bonutti, Petitioner's treating doctor, stated in his November 5, 2013 office note that Petitioner had been doing very well for six months and then torqued his left leg and developed sharp burning pain in his knee. Dr. Bonutti also noted that his patient had evidence of symptom magnification, and he found no significant objective pathology in the left knee. Dr. Bonutti made no comment and rendered no opinion regarding causation. Respondent argues that Petitioner's symptoms in the left knee resolved after surgery, and then he developed new symptoms after a new injury when he arose from a chair.

The Commission finds that Petitioner has not met his burden of proof that the current condition of his left knee is casually related to the work accident of August 8, 2005. Petitioner testified that his left knee was in good condition and he was doing very well until approximately June 2012 when he felt his left knee pop when getting out of a chair. Petitioner further testified that since the incident getting out of the chair, he has experienced swelling of the left knee with use and his knee will lock when rising from a seated position. Petitioner does not identify or provide in evidence any medical records or opinions that support his position that his current left knee complaints are causally related to the August 8, 2005 accident.

For the foregoing reasons, the Commission finds Petitioner's left knee condition is not causally connected to his August 8, 2005 work injury. The Commission further finds that the Petitioner has not met his burden of proof that the treatment requested under Section 8(a) is reasonably required to cure or relieve him from the effects of the work injury. Petitioner's Petition for benefits under Section 8(a) is hereby denied. Petitioner's request for penalties and fees is also denied.

IT IS THEREFORE ORDERED BY THE COMMISSION that Petitioner's Petition under Section 8(a) is hereby denied. Petitioner's request for penalties and fees is also 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.

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: SEP 11 2014

Daniel R. Donohoo

Charles J. DeVriendt

Ruth W. White

o-7/22/14
drd/adc
68

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

James L. Gray,

Petitioner,

vs.

Costco Wholesale,

Respondent,

14IWCC0779

NO: 09WC 23259

DECISION AND OPINION ON REVIEW

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

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

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $14,500.00. 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.

14IWCC0779

DATED:
o090814
MJB/bm
052

SEP 1 2 2014

Michael J. Brennan

Kevin W. Lamborn

Thomas J. Tyrrell

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

GRAY, JAMES L
Employee/Petitioner

Case# 09WC023259

14IWCC0779

COSTCO WHOLESALE
Employer/Respondent

On 10/31/2013, 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:

0575 SACKS GUBBINS & RAGAS
MATTHEW T GUBBINS
ONE DEARBORN SQ SUITE 300
KANKAKEE, IL 60901

0210 GANAN & SHAPIRO PC
AMY L TURNBAUGH
210 W ILLINOIS ST
CHICAGO, IL 60654

STATE OF ILLINOIS)
)SS.
COUNTY OF WILL)

14IWCC0779

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

James L. Gray
Employee/Petitioner

v.

Costco Wholesale
Employer/Respondent

Case # 09 WC 23259

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 **Ottawa, Illinois** on **7/24/13**. 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. [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 _____

14IWCC0779

FINDINGS

On 12/18/2008, 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 $21,784.88; the average weekly wage was $418.94.

On the date of accident, Petitioner was 43 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 $8,657.99 for TTD, $0 for TPD, $0 for maintenance, and $0 for other benefits, for a total credit of $8,657.99.

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 $299.67/week for 23 weeks, commencing 12/23/08 through 6/1/09, as provided in Section 8(b) of the Act.

Respondent shall pay Petitioner the temporary total disability benefits that have accrued from 12/18/08 through 7/24/13, and shall pay the remainder of the award, if any, in weekly payments.

Respondent shall pay Petitioner permanent partial disability benefits of $299.67/week for 25 weeks, because the injuries sustained caused the 5% loss of the person as a whole, as provided in Section 8(d)2 of the Act.

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

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

Signature of Arbitrator

10/29/13
Date

OCT 31 2013

FINDING OF FACTS:

James Gray (hereinafter "Petitioner") testified that he was employed by Costco Wholesale Corporation (hereinafter "Respondent") since 2004. His job was that of a forklift driver. On the date of accident of December 18, 2008, Petitioner was working as a forklift driver with a regular shift of 7:00 a.m. to 2:30 p.m. He indicated that it was his job to move and/or load pallets of produce and food items. Petitioner stated that he was feeling fine that morning. Petitioner provided that on December 18, 2008, he was driving into and out of a semi truck, loading produce. He indicated the forklift drove over a board that had snapped under the right tire which jerked the forklift to the left, resulting in twisting his back. He indicated the forklift tipped approximately twenty to twenty five degrees and then fell back to the right and at that time he then felt a twinge in his back.

Petitioner testified that one hour later his back tightened on the lower left side. He then reported to his supervisor and an accident report was completed. He was taken to Morris Hospital where he was seen at the occupational clinic for initial evaluation. X-rays taken at that time were negative. Petitioner was placed on light duty and referred back to the orthopedic surgeon who performed a recent surgery, Dr. Harvey. (Px 1) Petitioner testified that this was the physician who treated him originally and performed a surgery on his back.

Petitioner testified that he had a prior back condition and prior back surgery. That surgery consisted of a lumbar laminectomy and discectomy at L5-S1 on August 13, 2008. (Px 10) Petitioner provided that he had returned to work in mid to late October 2008 prior to this incident occurring.

Petitioner saw Dr. Harvey on December 23, 2008 with complaints of low back pain that radiated to the back of his left leg. Petitioner also complained of pain to his scrotum. Dr. Harvey felt Petitioner had recurrence of sciatic pain. Because of Petitioner's bladder complaint, the doctor recommended a MRI and kept Petitioner off work. (Px 2)

On January 13, 2009, Dr. Harvey noted the lumbar MRI taken on December 18, 2008 showed no evidence of recurrent or residual disc. There was enhancing soft tissue within the operative bed of the left discectomy. Dr. Harvey noted that although there was no evidence of recurrent disk, there was some epidural scarring. As such, Petitioner was referred to a Dr. Santiago-Palma. (Px 2, 8)

Petitioner presented to Dr. Santiago-Palma on January 16, 2009. The doctor obtained a history, reviewed the recent MRI and performed an examination. Dr. Santiago-Palma assessed left sciatica and status post lumbar discectomy. The doctor noted the MRI of the lumbar spine revealed enhancing soft tissue related to the prior discectomy on the left at L5-S1. Dr. Santiago-Palma recommended a left L5 and S1 transforaminal epidural steroid injection. This was carried out on February 10, 2009. Dr. Santiago-Palma also performed an epidural lysis of adhesions on March 31, 2009. (Px 3,4,5)

On April 16, 2009, Dr. Santiago-Palma noted Petitioner only received temporary relief of his symptoms from the injections. He continued to complain of pain in his low back shooting down his left leg. At that time a discussion was held regarding the possibility of a spinal cord stimulator. (Px 3)

At the request of Respondent, pursuant to Section 12, Petitioner was evaluated by Dr. Komanduri on June 1, 2009. A review of Dr. Komanduri's report indicates that at the time of the initial evaluation on June 1, 2009,

Dr. Komanduri was provided multiple records for his review, including the accident report, a written job analysis from Respondent, x-rays from as far back as 1997, the operative report from Dr. Harvey from August 13, 2008, medical records from Dr. Santiago-Palma and prior medical records from at least 2006 going forward. Dr. Komanduri commented and described a long history of complaints of left sided back pain as far back as April of 2003. He noted the non work related injuries Petitioner sustained with respect to his back as far back as October 29, 2007 where he fell off a foundation at his home. He confirmed Petitioner had been disabled from work from October 29, 2007 to April of 2008 and then again had complaints of low back pain after lifting a heavy object while digging at home in June of 2008. This precipitated the surgery occurring with Dr. Harvey in August 2008 in the form of L5-S1 laminectomy and discectomy. (Rx 1)

Dr. Komanduri performed an examination indicating Petitioner was able to heel and toe walk. He could forward flex to seventy degrees and extend to twenty degrees. Nerve root tension signs were negative. Reflexes were equal and symmetric and Petitioner had no motor or sensory deficits. In regard to the opinions rendered, Dr. Komanduri indicated that Petitioner had a very minor issue at work when he drove over a small piece of wood. Dr. Komanduri's opinion was that Petitioner had long standing degenerative disc disease in his back as well as degenerative stenosis. Dr. Komanduri opined that the forklift injury was not causally related to Petitioner's long standing, ongoing back pain. Dr. Komanduri felt Petitioner had a persistent disc bulge at L5-S1 with additional extensive degenerative disc disease on multiple levels. He also indicated Petitioner may have segmental instability. (Rx 1)

Dr. Komanduri opined that Petitioner may or may not be candidate for a spinal cord stimulator. However, he felt this was irrelevant and any ongoing need for and/or recommendation for the same was not causally related to any alleged work injury Petitioner may have sustained. Specifically Dr. Komanduri opined that there was no medical evidence that any actual injury was sustained on December 18, 2008, requiring treatment for Petitioner. He also opined that Petitioner's described mechanism of alleged injury is not consistent with Petitioner's current problems. Dr. Komanduri opined Petitioner has segmental instability with degenerative disc disease and a recurrent disc bulge/herniation at L5-S1. He opined that the amount of trauma involved in driving over a small piece of wood was not consistent with the causation of the various conditions which are chronic and long standing in nature. (Rx 1)

Ultimately, Petitioner chose to undergo surgery for the spinal cord stimulator and the initial/temporary stimulator was placed on November 4, 2009. The permanent stimulator was then placed on December 1, 2009. (Px 3, 6, 7)

On December 21, 2009, Petitioner reported excellent relief of his symptoms. He rated his pain level at 0/10 in intensity. Petitioner was released to return to work in a full duty capacity as a forklift driver for Respondent. Dr. Santiago-Palma assessment at that time was left sciatica; failed back surgery syndrome; and status post lumbar discectomy. (Px 3)

Petitioner testified that he continued to perform his full duty work until the Spring of 2010 when he chose to terminate his employment with Respondent. Petitioner provided that his choice to quit was not pain related.

Dr. Komanduri examined Petitioner a second time on September 28, 2011. At the time of the second evaluation on September 28, Dr. Komanduri reviewed his previous IME, a video job analysis regarding the forklift/ power equipment operator at the warehouse, medical records from Boston Scientific regarding the spinal cord stimulator and updated medical records that he did not have access to previously. He again performed a physical examination indicating that Petitioner could forward flex to forty eight degrees and extend to fifteen degrees with pain. He was able to walk without any obvious limits. There was no antalgic gait. He complained

of increased pain on a straight leg raise with dorsiflexion and plantar flexion of his feet. Dr. Komanduri indicated some of the responses were inconsistent and non-anatomic. Specifically, Petitioner during the evaluation noted there was pain on pelvic rotation which would not have affected his lumbar spine. Dr. Komanduri could not localize or reproduce anterior thigh pain except with activity. He indicated that straight leg raise was positive at about thirty degrees per Petitioner but seated straight leg raise was not positive until beyond sixty degrees. Petitioner advised Dr. Komanduri that he believed the spinal cord stimulator was not working (The Arbitrator notes that Petitioner testified at trial that the spinal cord stimulator was working and he used it consistently). Dr. Komanduri reiterated his opinion that the need for the spinal cord stimulator was not causally related to Petitioner's work injury. (Rx 2)

Petitioner testified that his current complaints consist of good days and bad days. He stated that he has increased pain when doing yard work with additional activity. He continues with the spinal cord stimulator and actively uses the same. He takes over the counter Ibuprofen for medication and otherwise does not seek additional treatment and has not sought treatment since returning to work full duty.

With respect to (F), whether the Petitioner's current condition of it being is causally related to the injury, the Arbitrator finds the following:

The Arbitrator, after reviewing the entire record and the opinions of the treating physician and Respondent's Section 12 examiner, finds that while Petitioner may have sustained a work related injury on December 18, 2008, his current low back condition of ill-being and the need for the spinal cord stimulator are not causally related to the work accident sustained. The Arbitrator relies on the report and opinions of Dr. Komanduri in support of this finding. Specifically, Dr. Komanduri had the benefit of Petitioner's entire, complete medical record dating back to 2003 which documented significant ongoing low back complaints on the left side, which are the exact complaints Petitioner complained of at the time of the alleged incident on December 18, 2008.

The Arbitrator also notes the lumbar MRI taken on December 18, 2008 showed no evidence of recurrent or residual disc. There was enhancing soft tissue within the operative bed of the left discectomy. Dr. Santiago-Palma felt the MRI findings revealed enhancing soft tissue related to the prior discectomy on the left at L5-S1.

Based upon Dr. Komanduri's opinions, Petitioner reached maximum medical improvement as of June 1, 2009, and was capable of returning to work in a full duty capacity. The Arbitrator finds Petitioner is not entitled to benefits after June 1, 2009, relying on Dr. Komanduri's Section 12 report.

With respect to (J), whether the medical services provided to Petitioner were reasonable and necessary and whether Respondent paid all appropriate charges, the Arbitrator finds the following:

Respondent is only liable for charges for treatment up through the date of the Section 12 examination of June 1, 2009. Of note, the Arbitrator acknowledges that the only outstanding medical bill is the Illinois Health Care and Family Services medical itemization for charges from October 2, 2009 through December 3, 2009. As the Arbitrator finds that these are not causally related to the work injury, Respondent is not liable for the same.

With respect to (K), what temporary benefits are in dispute, the Arbitrator finds the following:

The Arbitrator notes Respondent paid Petitioner lost time benefits during the initial period of lost time. Specifically, while Petitioner appeared in occupational health on December 19, 2008, the Arbitrator notes that Petitioner did not receive an off work statement until his visit to Dr. Harvey on December 23, 2008. As such,

Petitioner is entitled to lost time benefits from December 23, 2008 through June 1, 2009, the date of Respondent's Section 12 examination. Respondent shall have credit for all benefits paid.

With respect to (L), the nature and extend of the injury, the Arbitrator finds the following:

Based on all of the above, the Arbitrator finds that Petitioner sustain minor trauma as result of the December 18, 2008 forklift incident. As such, the Arbitrator finds that Petitioner is entitled to 5% loss of the person 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

Cezar H. Lopez,

Petitioner,

vs.

Delta Air Lines,

Respondent,

14IWCC0780

NO: 12WC 43969

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed April 15, 2013, is hereby affirmed and adopted.

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

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

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $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:
o090914 SEP 1 2 2014
MJB/bm
052

Michael J. Brennan

Kevin W. Lamborn

Thomas J. Tyrrell

14IWCC0780

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

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

Cezar Lopez,

Petitioner,

v. Case No. 12 WC 43969

Delta Air Lines,

Respondent.

Petitioner's Application, filed pro se on December 21, 2012, alleges multiple work accidents, with the first such accident allegedly taking place on January 14, 1999. On April 9, 2013, Respondent filed a motion to dismiss, arguing that the claim(s) were time-barred, that it did not receive statutory notice of several of the alleged accidents and that one of the accidents alleged by Petitioner was the subject of a prior claim, numbered 06 WC 15239, which was ultimately settled. Respondent submitted the affidavit of Susan Alford, an ESIS claims specialist, in support of its motion.

At my April 2013 status call, Respondent's motion received a hearing date of today, April 25, 2013. Respondent's counsel, Justin Kanter, appeared before me today. Petitioner did not appear. Respondent's counsel represented that Petitioner attended my April 2013 status call and was aware of both the motion to dismiss and today's hearing date. I asked Respondent's counsel to come back later in the morning so as to allow Petitioner some additional time to appear. Respondent's counsel returned later, as directed. Petitioner still had not appeared at that time. Nor did Petitioner appear at any later point today.

Based on the foregoing, I order that this case is dismissed for want of prosecution. The dismissal is based solely on Petitioner's failure to appear at a scheduled hearing date. It is not based on the substantive issues raised in the motion to dismiss. Respondent is free to raise those issues in the future in the event of reinstatement.

Molly C Mason

Arbitrator Molly C. Mason

4/25/13

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

Guadalupe Barraza,
Petitioner,
vs.

NO: 08WC 39027

Millard Group,
Respondent,

14IWCC0781

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed May 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 $48,200.00. 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: SEP 12 2014
o091014
CJD/jrc
049

Charles J. DeVriendt

Daniel R. Donohoo

Ruth W. White

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

BARRAZA, GUADALUPE
Employee/Petitioner

Case# **08WC039027**

MILLARD GROUP
Employer/Respondent

14IWCC0781

On 5/20/2013, 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 0.08% 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:

0147 CULLEN HASKINS NICHOLSON ET AL
JOSE RIVERA
10 S LASALLE ST SUITE 1250
CHICAGO, IL 60603

0766 HENNESSY & ROACH PC
ERIN FIORE
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

14IWCC0781

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Guadalupe Barraza
Employee/Petitioner

Case # **08WC039027**

v.

Consolidated cases: **N/A**

Millard Group
Employer/Respondent

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Molly C. Mason**, Arbitrator of the Commission, in the city of **Chicago**, on **April 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 _____

14IWCC0781

FINDINGS

On 08/05/2008, 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 lumbar spine condition of ill-being *is* causally related to the accident.

In the year preceding the injury, Petitioner earned $16,620.76; the average weekly wage was $319.63.

On the date of accident, Petitioner was 47 years of age, *single* with 1 dependent child.

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

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

Respondent shall be given a credit of $3,409.44 for TTD in accordance with the parties' stipulation. Arb Exh 1.

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

ORDER

Respondent shall pay Petitioner temporary total disability benefits at the rate of $268.67/week from August 6, 2008 through March 5, 2009, a period of 30 2/7 weeks, as provided in Section 8(b) of the Act, with Respondent receiving credit for the $3,409.44 in benefits it paid prior to arbitration, pursuant to the parties' stipulation. Arb Exh 1.

See pages 11 and 12 of the attached conclusions of law for the Arbitrator's award of medical and prescription expenses.

Respondent shall pay Petitioner permanent partial disability benefits of $268.67/week for 50 weeks, because the injuries sustained resulted in permanency equivalent to 10% loss of the person as a whole, as provided in Section 8(d)2 of the Act.

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

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

Molly C Mason
Signature of Arbitrator

5/18/13
Date

ICArbDec p. 2

MAY 20 2013

Guadalupe Barraza v. Millard Group
08 WC 39027

14IWCC0781

Arbitrator's Findings of Fact

Petitioner testified through a Spanish-speaking interpreter.

The parties agree Petitioner was injured while working for Respondent on August 5, 2008. Arb Exh 1. Petitioner testified her housekeeping job for Respondent involved cleaning various rooms, appliances and mirrors. On August 5, 2008, she fell backward while descending a ladder after cleaning a tall mirror in a bathroom. After she fell, she noticed her mouth was bleeding. The fall also affected her back. A co-worker offered to call an ambulance but she declined. She rested for an hour and then went home.

Later the same day, Petitioner saw Mark Gerber, M.D. at the Fullerton Drake Medical Center. Dr. Gerber's brief note of that date reflects that Petitioner "was doing well until 8/5/08 when, while working as a housekeeper, she climbed a ladder to clean some mirrors and fell." Dr. Gerber noted complaints of severe pain in the thoracic spine, lumbar spine, left forearm and elbow. No examination findings are noted. Dr. Gerber prescribed MRI scans of the thoracic spine, lumbar spine and left elbow. He also prescribed physical therapy three times a week. He administered therapy consisting of "EMS hot packs and range of motion exercises." PX 1, p. 17. He indicated he planned to send Petitioner to Dr. Kiang in the near future. He took Petitioner off work. PX 1, p. 13.

In a lengthier note dated August 6, 2008, Dr. Gerber recorded a somewhat different history, indicating that Petitioner "was doing fine until approximately 3 weeks ago when, while working, she fell off a ladder, striking her left side and back upon impact." He noted no prior history of injuries to the back, left side, left elbow or left forearm. He listed various examination findings, noting no abnormalities. There is no indication he examined Petitioner's spine or left arm. PX 1, p. 14.

On August 6, 2008, Petitioner underwent the recommended MRI scans. The thoracic spine MRI was unremarkable. PX 1, p. 51. The lumbar spine MRI demonstrated a 2-3 mm posterior subligamentous disc bulge/protrusion indenting the thecal sac, without significant stenosis or narrowing, at both L1-L2 and L4-L5. PX 1, p. 50. The radiologist, Dr. Kuritza, noted no fractures or significant subluxations. The left elbow MRI demonstrated "some mild soft tissue swelling in the area of clinical symptomatology, probably post-traumatic soft tissue bruising." PX 1, p. 55. Petitioner also underwent X-rays of the chest, left elbow, left forearm and left ribs. None of these X-rays demonstrated any acute abnormalities. PX 1, pp. 52-54, 56.

Petitioner continued seeing Dr. Gerber at very regular intervals thereafter, with the doctor continuing to keep Petitioner off work. The doctor's notes are brief and duplicative.

At Respondent's request, Petitioner saw Dr. Carl Graf for a Section 12 examination on August 22, 2008. Dr. Graf is associated with the Illinois Spine Institute. In his report of August 22, 2008, Dr. Graf indicated he interviewed Petitioner "with our Spanish translator in the office."

Dr. Graf's report reflects that, on August 5, 2008, Petitioner was getting back on a ladder after stepping onto a sink to clean a mirror when she slipped and fell backward 4 to 5 feet, landing on her back and left arm. Dr. Graf noted complaints relative to the back and left elbow. He indicated Petitioner described her left elbow pain as resolved and rated her mid to low back at 9/10. He also indicated that Petitioner reported deriving little benefit from the chiropractic manipulations she had undergone during the preceding three weeks. He noted that Petitioner denied any past or current medical problems. Petitioner's current medications included Alprazolam, Celebrex and Hydrocodone.

On examination, Dr. Graf described Petitioner's gait as normal. He indicated that Petitioner had no difficulty with toe or heel walking. He deferred a cervical spine examination "secondary to no complaints." He noted a full and painless range of left elbow motion. On spinal examination, he noted no spasm and "mild, diffuse pain to palpation throughout the lower thoracic and lumbar spines." He described sitting and supine straight leg raising as negative bilaterally.

Dr. Graf indicated he reviewed only one treatment note, i.e., Dr. Gerber's initial note of August 5, 2008. He also reviewed the three MRI reports and reports concerning the left rib and left forearm X-rays. He further reviewed a film of the August 6, 2008 lumbar spine MRI. He described this film as a "poor quality, open sided MRI film without STIR image sequences." He interpreted this film as showing an "anterosuperior endplate fracture of L2 with increased bone marrow edema on the T2 saggital images." He noted that the radiologist who interpreted this MRI did not comment on this fracture in his report.

Dr. Graf opined that Petitioner "should be treated as [having] an L2 superior endplate fracture." He did not recommend bracing. He recommended standing X-rays "now and at periodic intervals to ensure there is no collapse." He indicated it "may be advisable to have [Petitioner] return for additional STIR image sequences to confirm the presence of a fracture, though open-sided MRI scans oftentimes miss bone marrow edema due to poor image quality." He indicated that "one may consider ordering a high field 1.5 or 3.0 Tesla MRI scan, including STIR image sequencing, to best confirm this finding."

Dr. Graf found Petitioner capable of resuming light duty with no lifting over 5 pounds and no bending, twisting, pushing or pulling. He indicated that Petitioner would likely require two months of light duty "with subsequent physical therapy" to return her to a normal work level. He anticipated that the fracture would heal on its own, with no need for surgery. He recommended that Petitioner be treated by an orthopedic spinal surgeon "as injuries such as this are not typically treated by either chiropractors or pain management specialists."

Dr. Graf indicated that he advised Petitioner of his finding of an L2 fracture. He also indicated he "advised [Petitioner] not to undergo any further chiropractic manipulations as this may further exacerbate any fracture." He further stated that he "spoke with Ms. Langoria-Leal concerning [his] findings to convey this to her so the appropriate measure can be taken." [Dr. Graf directed his report to Ms. Langoria-Leal, a nurse case manager affiliated with Triune Health Group.]

Dr. Graf noted he did not receive any of the bills relating to the X-rays, MRI scans or manipulation. He found no justification for an MRI for left elbow pain without any conservative measures. He recommended that "payment for such be reviewed." RX 1.

There is no evidence indicating Petitioner ever underwent the high field Tesla MRI that Dr. Graf recommended. It does appear that Petitioner eventually underwent standing X-rays, which confirmed the suspected L2 fracture, but not until March 5, 2009, about seven months after Dr. Graf's examination. See Dr. Sclamberg's note of March 5, 2009, PX 2, p. 13, and further discussion below.

On August 28, 2008, Petitioner saw Richard Kiang, M.D. The doctor's two-page report of that date reflects that he is board certified in pain management and physical medicine and rehabilitation. PX 1, p. 46. The report reflects that Petitioner was "doing well until August 5, 2008" when she climbed a ladder in order to clean a mirror and fell off. The doctor indicated that Petitioner "estimates she fell 3-4 feet, striking her back, left arm and head." He noted complaints relative to the low back, bilateral thighs, neck and left arm. He indicated Petitioner rated her low back pain at 9/10.

On examination, Dr. Kiang noted 4+/5 motor power in the right L4 myotome and right L4 paresthesias at 30 degrees of positive straight leg raising, with "positive Kernig, bowstring and nuchal flexion signs."

Dr. Kiang reviewed the MRI results. He described Petitioner as having an "abnormal history, abnormal physical exam and abnormal MRI scan." He recommended, and performed, a bilateral lower extremity EMG/NCV. He found the EMG/NCV results to be "consistent with a moderate acute right L4 radiculopathy. He found peripheral polyneuropathy and tarsal tunnel syndrome to be "much less likely" diagnoses. He viewed the radiculopathy as "likely due to" the disc bulge/protrusion at L4-L5. He recommended that Petitioner continue therapy as well as "a series of three interventions," namely caudal epidurals and a right L4 selective nerve root injection. PX 1, pp. 45-49.

On September 4, 2008, Petitioner filed an Application for Adjustment of Claim alleging a back injury of August 5, 2008. Arb Exh 2.

On September 5, 2008, Dr. Gerber noted that he had administered therapy on twelve occasions to date and that Petitioner's range of motion was "slowly increasing." He also noted the EMG and MRI results. PX 1, p. 17.

Dr. Gerber continued administering therapy (i.e., hot packs and range of motion exercises) to Petitioner at very regular intervals thereafter. On multiple dates through May 30, 2009, he issued the following statement, with no accompanying examination findings:

> "Mrs. Guadalupe Barraza remains under my care for her work-related injury to low back and mid back. Patient is disabled and unable to work and will remain so until [date]. "

At Dr. Gerber's referral, Petitioner saw Dr. Sclamberg, an orthopedic surgeon, on October 30, 2008. The doctor's history reflects that Petitioner "fell from the top of a counter where she was cleaning and landed on her back, hitting the countertop." The doctor noted that Petitioner denied having back pain prior to this accident.

On examination, Dr. Sclamberg noted mild, midline lumbar tenderness, no thoracic tenderness, a diminished lumbar range of motion, a full thoracic range of motion, negative straight leg raising and no tension signs. He also noted that Petitioner was able to walk on her heels and toes. He obtained lumbar spine X-rays and interpreted them as showing "mild lumbar spondylosis." He interpreted the lumbar spine MRI as showing 2-3 mm protrusions at the L1-L2 and L4-L5 levels. He reviewed the EMG.

Dr. Sclamberg diagnosed "low back pain after injury at work with EMG evidence of L4 radiculopathy." He opined that Petitioner "would benefit from injections" but noted that Petitioner declined to undergo same. He took Petitioner off work, recommended continued therapy and anti-inflammatories and instructed Petitioner to return in six weeks. PX 2, pp. 8-9, 19.

On December 16, 2008, Petitioner underwent a triple phase bone scan, a conventional lumbar spine CT scan and a 3-dimensional lumbar spine CT scan at Dr. Gerber's recommendation. The bone scan results were unremarkable. PX 1, p. 57. The lumbar spine CT scan demonstrated a 3-4 mm posterior disc protrusion/herniation indenting the thecal sac, with no significant stenosis or neuroforaminal narrowing, at L4-L5 and L5-S1. Dr. Kuritza, the same radiologist who interpreted the MRI, described the appearance of the remaining lumbar discs as unremarkable. He again noted no fractures or significant subluxations. PX 1, p. 59.

Petitioner returned to Dr. Sclamberg on December 19, 2008 and reported having recently undergone a bone scan per Dr. Gerber. Dr. Sclamberg noted that the bone scan had "not been read yet." Petitioner again complained of back pain. On re-examination, Dr. Sclamberg noted a restricted range of motion and mild paraspinal spasm and tenderness. He again diagnosed "low back pain after injury with EMG evidence of L4 radiculopathy." He asked Petitioner to provide him with the bone scan results. He recommended continued therapy and instructed Petitioner to stay off work and return to him in eight weeks. PX 2, pp. 10, 20.

At Respondent's request, Petitioner saw Dr. Lami for a Section 12 examination on February 6, 2009. Dr. Lami, like Dr. Graf, is associated with the Illinois Spine Institute.

In his report, Dr. Lami indicated that his female medical assistant and Petitioner's husband were present throughout his examination.

Dr. Lami noted that Petitioner was cleaning a mirror on August 5, 2008 when she slipped and fell backward, injuring her back and left elbow. He noted that the left elbow problem had resolved. He noted that Petitioner complained of pain "involving the thoracic and lumbar spines and bilateral scapulae and bilateral biceps." He also noted that Petitioner rated her pain level at 8/10. Petitioner denied any prior spinal problems. She informed Dr. Lami she had undergone a bone scan per Dr. Gerber but was not aware of the results. She indicated she had been undergoing therapy since August.

Dr. Lami noted no abnormalities on examination of Petitioner's cervical spine, shoulders, elbows, upper extremities, lumbar spine, hips and lower extremities.

Dr. Lami indicated he reviewed Dr. Graf's examination report as well as treatment notes authored by Drs. Gerber and Sclamberg, X-ray reports concerning the left elbow and left ribs and reports concerning the thoracic and lumbar spine MRIs.

Dr. Lami indicated he did not have access to the MRI film or the bone scan. He made no mention of the CT scan. He noted there was "contradictory information between the radiology report, which specifically says no fracture, and Dr. Graf's report, which suggests an L2 endplate fracture." He indicated he would be happy to review the radiographic studies and "make further comments." He went on to say that "even if [Petitioner] sustained an endplate fracture of L2 in August, this fracture should have healed within two to three months. [Petitioner] is currently over five months post this injury and should return to her previous job."

Dr. Lami described Petitioner's thoracic and lumbar pain as "subjective," unsupported by objective findings and "not amenable to injections." He found Petitioner to be at maximum medical improvement, noting: "she has already undergone physical therapy which was appropriate." He found Petitioner capable of full duty. RX 2.

Petitioner returned to Dr. Sclamberg on March 5, 2009. Dr. Sclamberg noted that Petitioner "brought her independent medical evaluation" to him on this date. He also noted that the independent medical examiner felt Petitioner "maybe had an L2 superior endplate compression fracture." On examination, he noted a diminished range of motion, mild mid-line tenderness, no tension signs and negative straight leg raising bilaterally.

Dr. Sclamberg obtained new lumbar spine X-rays. He noted that these X-rays "demonstrate evidence of L2 compression fracture superior endplate which appears stable." He started Petitioner on Mobic, Ranitidine and Tramadol. He recommended continued therapy three times weekly for six weeks. He continued to keep Petitioner off work. PX 2, pp. 2, 21-23.

Petitioner returned to Dr. Sclamberg on April 16, 2009 and indicated she was continuing to undergo therapy with Dr. Gerber. She complained of low back pain with mild radiation into the right buttock. On examination, Dr. Sclamberg noted diminished forward flexion, mild mid-line tenderness, no increased pain with hyperextension, 5/5 lower extremity strength and no tension signs. He diagnosed an "L2 endplate fracture with lumbar spondylosis and pain." He renewed Petitioner's medications and prescribed additional therapy. He instructed Petitioner to stay off work and return to him in four weeks, noting: "if she is not significantly improved at that time, I will obtain a functional capacity evaluation." PX 2, pp. 14, 25-26.

On May 15, 2009, Petitioner returned to Dr. Sclamberg and noted she was continuing to attend therapy twice weekly. She again complained of some mild mid-line pain. Dr. Sclamberg noted no tension signs on re-examination. He ordered a functional capacity evaluation along with "medication and therapy per Dr. Gerber." He continued to keep Petitioner off work. PX 2, pp. 15, 27-28.

On May 18, 2009, Dr. Gerber prescribed a functional capacity evaluation. PX 3, p. 28. Petitioner underwent this evaluation at La Familia Rehab on May 22, 2009. Dr. David Magnan, a chiropractor, performed this evaluation. On examination, Dr. Magnan noted strength deficits in the lumbar spine, palpatory tenderness in the lumbar region and moderate to severe lumbar range of motion restrictions. He described Petitioner's gait as antalgic. He indicated that Petitioner's housekeeping job "requires performance at the medium physical demand level." He found Petitioner to be functioning at a sedentary to light physical demand level, meaning that she could lift/carry 15 pounds occasionally and 8 pounds frequently. PX 3, p. 40.

Dr. Magnan described Petitioner's prognosis as poor. He recommended she continue with treatment. PX 3, p. 30.

On June 10, 2009, Dr. Gerber issued a one-paragraph report indicating that Petitioner "has reached maximum medical benefit from therapy." He also indicated that "an FCE done at La Familia recently concluded that she will have difficulty returning to her pre-injury work abilities." He referred Petitioner to La Familia for work hardening and instructed Petitioner to remain off work. PX 1, p. 42.

Petitioner began a course of work hardening at La Familia Accident Injury & Rehab on June 15, 2009. The work hardening notes authored by Dr. Magnan reflect that, during the first week, Petitioner attended work hardening from June 15 through June 18, 2009 and was absent on June 19, 2009. During the second week, Petitioner attended work hardening from June 24 through June 26, 2009 and was absent on June 29 and June 30, 2009. PX 3, p. 17.

Petitioner returned to Dr. Sclamberg on June 19, 2009. The doctor reviewed the functional capacity evaluation. He did not find Petitioner to be at maximum medical improvement. He recommended that Petitioner see a pain management specialist for a possible injection. PX 2, p. 32. He renewed the Mobic, Omeprazole and Tramadol. He also

prescribed a lumbar corset. PX 2, p. 30. He instructed Petitioner to stay off work, "pending pain evaluation," and return to him in four weeks. PX 2, pp. 16, 29.

On July 17, 2009, Dr. Gerber issued a one-paragraph report indicating that Petitioner "attempted a work hardening program" but was "unable to complete it due to persistent pain." Dr. Gerber indicated he gave Petitioner medication for pain and depression. He imposed a permanent 15-pound lifting restriction and discharged Petitioner from treatment. PX 1, p. 43.

Petitioner returned to Dr. Sclamberg on August 7, 2009 and again complained of back pain. Petitioner indicated she had not seen a pain specialist. On examination, Dr. Sclamberg again noted a diminished range of motion. He noted that Dr. Gerber had released Petitioner with a 15-pound lifting restriction. He again prescribed a lumbar corset. PX 2, p. 33. He released Petitioner to sedentary duty "per her functional capacity evaluation" and instructed her to return to him on an as-needed basis. PX 2, p. 17.

Dr. Gerber issued the following note on July 9, 2010:

> "Patient is seen monthly by me . . . for medical management regarding lumbar radiculopathy due to a work-related injury. As an additional consequence of this traumatic injury, she has developed high blood pressure which she has also been treated for with hypertension medication. Patient is also prescribed anti-inflammatory and analgesic medicine. Patient cannot tolerate NSAIDS due to stomach pain and GI distress. Spasm is noted throughout the injured region. Patient is prescribed Hydrocodone for pain, Meloxicam for inflammation reduction, Traumanil pain gel for pain relief, Carisoprodol for muscle spasm reduction and Omeprazole for protecting the stomach from GI distress."

PX 1, p. 44.

On October 2, 2012, Dr. Lami issued a supplemental report after reviewing the functional capacity evaluation and additional records from Drs. Gerber and Sclamberg. Dr. Lami again found Petitioner's diagnosis to be "subjective back pain." He reiterated that Petitioner was at maximum medical improvement and capable of full duty as of his examination. He addressed the additional treatment as follows:

> "It is my opinion that [Petitioner's] treatment in the records has been excessive. Dr. Gerber's notes are mostly a modality-based treatment and modalities which could have been achieved with a home exercise program.

I cannot support continuous medication use for [Petitioner]. In my opinion, she should have been done with the medication when I saw her on February 6, 2009. For occasional pain, she may take over-the-counter anti-inflammatories or Tylenol. However, the use of medications on a routine basis would be harmful to [Petitioner's] overall health."

RX 3.

Petitioner testified Dr. Gerber prescribed the following medications for her: 1) Enalparil, for hypertension; 2) Meloxicam, for "inflammation"; 3) Ranitidine, for "stomach protection"; 4) Tramadol, for pain; 5) Traumanilia, for pain; 6) Hydrocodone, for pain; 7) Omeprazole, to calm muscle pulling; 8) Carisoprodol, an anti-inflammatory; 9) Zolpidem, for pain-related sleep issues; and 10) Sertralin, for depression. Petitioner testified that, of the Tramadol and Traumanilia, one came in pill form while the other was a topical gel. Petitioner testified these medications helped with her pain. She no longer takes these medications. She takes over-the-counter medication "all the time."

Petitioner testified she has not worked since the accident because her pain does not allow her to work. She has been on Social Security disability for one year. She denied having any low back problems before the accident. She also denied any re-injuries after the accident. She tries to perform routine activities, such as washing dishes and sorting laundry, but has to stop after about five minutes due to pain. She feels burning in her entire back, her arms and her shoulders. She obtains help from her husband. She and her husband go to the grocery store together. She tries to lift groceries but is unable to do so, due to pain.

Under cross-examination, Petitioner recalled being examined by Dr. Graf in 2008. She did not recall seeing Dr. Lami. Nor did she recall receiving notice of a November 2012 examination by Dr. Lami. [Petitioner's counsel stipulated that Petitioner failed to attend Section 12 examinations with Dr. Lami in November and December of 2012.] Petitioner denied undergoing chiropractic care after the accident. She saw an orthopedic surgeon, not a chiropractor. She underwent physical therapy with Dr. Gerber. That therapy included manipulation of her neck and back. She is not sure whether Dr. Gerber is a chiropractor. She developed hypertension after the accident. She did not have this condition prior to the accident. She underwent a physical at the company clinic in 2008. She is not currently taking any prescription medication for her lower back.

No witnesses testified on behalf of Respondent.

In addition to the exhibits previously discussed, Petitioner offered into evidence records from the Injured Workers' Pharmacy, including several health insurance claim forms and prescriptions for Enalapril, Tramadol and Celebrex signed by Dr. Gerber. The Arbitrator notes

that most of these forms and prescriptions bear dates after July 9, 2010. The last note in evidence authored by Dr. Gerber is the July 9, 2010 note discussed above. PX 4.

Petitioner also offered into evidence outstanding bills from Prescription Partners, LLC totaling $41,570.68 for medication that Drs. Gerber and Sclamberg prescribed to Petitioner between March 5, 2009 and October 7, 2011. PX 5.

Over Respondent's relevancy objection, Petitioner also offered into evidence the Workers' Compensation Utilization Management Standards, Version 5.0. PX 6.

Respondent offered into evidence a lengthy retrospective utilization review report from Claims Eval dated December 26, 2012. The report is authored by Dr. Steven Blum. The last page of the report reflects that Dr. Blum has board certification in anesthesiology with sub-certification in pain medicine. Dr. Blum recommended non-certification of the following medications, prescribed between March 5, 2009 and August 25, 2011: Traumanil pain gel, Hydrocodone, Ranitidine, Meloxicam, Tramadol, Carisoprodol, Omeprazole, Zolpidem, Sertraline and Tranzgel. RX 4.

Respondent also offered into evidence a report sent by Triune Health Group to Dr. Gerber on January 31, 2013. This report, authored by Dr. Blum, relates to the same ten medications listed in the preceding paragraph. In the report, Dr. Blum recommended non-certification of the medications. RX 5.

Respondent also offered into evidence a print-out of temporary total disability and medical/prescription benefits it paid in this claim between September 17, 2008 and 2011. RX 6. The Arbitrator notes that some of the non-redacted payments listed on RX 6 were payments made to the Illinois Spine Institute, presumably in connection with the Section 12 examinations conducted in this case. Other non-redacted payments relate to travel expenses paid to Petitioner pursuant to Section 12.

Arbitrator's Conclusions of Law

Did Petitioner establish a causal connection between her undisputed work accident of August 5, 2008 and her current lumbar spine condition of ill-being?

The Arbitrator finds that Petitioner established causation as to her current lower back condition of ill-being. Specifically, the Arbitrator finds that Petitioner's undisputed work fall of August 5, 2008 resulted in an L2 superior endplate fracture and disc herniations at L4-L5 and L5-S1 (as confirmed by the 3-dimensional CT scan performed on December 16, 2008) and that Petitioner was continuing to experience symptoms secondary to those conditions as of the April 29, 2013 hearing. In so finding, the Arbitrator relies on the following: 1) Petitioner's credible denial of any pre-accident back problems; 2) Petitioner's credible testimony as to the mechanism of her accident, i.e., that she fell backward from a height, striking her lower back; 3) the opinions of Dr. Graf, Respondent's initial Section 12 examiner; 4) the 3-dimensional CT scan

performed on December 16, 2008; 5) the lumbar spine X-rays Dr. Sclamberg obtained on March 5, 2009; 6) Petitioner's credible testimony concerning her ongoing lower back complaints; and 7) the fact Petitioner never underwent the physical (as opposed to passive manipulative) therapy that Dr. Graf recommended in his report. The Arbitrator finds that Petitioner failed to establish causation as to the arm and shoulder problems she described at the hearing. The initial records do not reflect any complaints relative to either shoulder. While those records do reflect complaints relative to the left elbow, subsequent records reflect that Petitioner described the elbow problem as having resolved.

Is Petitioner entitled to temporary total disability benefits? Is Petitioner entitled to medical and prescription expenses?

At the hearing, Petitioner claimed temporary total disability benefits from August 6, 2008 (the day after the accident) through July 17, 2009 (the date on which Dr. Gerber imposed a permanent 15-pound lifting restriction), a period of 49 3/7 weeks. Respondent stipulated to temporary total disability from August 6, 2008 through October 22, 2008, presumably in reliance on the opinions Dr. Graf expressed in his report of August 22, 2008. The parties stipulated that Respondent paid $3,409.44 in temporary total disability benefits prior to the hearing. Arb Exh 1.

The Arbitrator has previously found that Petitioner's undisputed work accident resulted in an L2 superior endplate fracture and disc herniations at L4-L5 and L5-S1. When Respondent's first examiner, Dr. Graf, diagnosed the fracture on August 22, 2008, he took pains to relay his diagnosis and specific recommendations to Respondent's nurse case manager. Unfortunately for Petitioner, those recommendations were, for the most part, not followed. In the Arbitrator's view, Dr. Graf had a very reasonable basis for recommending additional radiographic studies to confirm the fracture. He also had a very reasonable basis for recommending that Petitioner discontinue the kind of manipulative therapy that Dr. Gerber was providing. He explained that such therapy could, in fact, cause the fracture-related symptoms to worsen. He indicated Petitioner required restrictions for two months, "with subsequent therapy [emphasis added]," in order to be able to resume full duty. He did not indicate exactly how much therapy would be required after the two months of restricted duty. There is no evidence suggesting that Respondent's nurse case manager contacted Dr. Gerber after leaving Dr. Graf's office to make him aware of the doctor's diagnosis or recommendations. Dr. Gerber, who was apparently relying on the MRI and EMG results, continued to provide manipulative therapy. Dr. Gerber did confirm two disc herniations on December 16, 2008, via the 3-dimensional CT scan, but did not obtain new lumbar spine X-rays. It was not until after Petitioner underwent a second examination, by Dr. Lami, and presented Dr. Lami's report to Dr. Sclamberg, on March 5, 2009, that Dr. Sclamberg confirmed the presence, and stability, of the fracture via the X-rays Dr. Graf had recommended many months earlier. Dr. Sclamberg also prescribed "therapy" but Petitioner resumed seeing Dr. Gerber thereafter. Not only did Petitioner never have the chance to undergo the physical therapy Dr. Graf recommended – she also continued undergoing the kind of manipulative therapy he specifically recommended against.

In the Arbitrator's view, this case is an example of the kind of failed communication and missed opportunity that can lead to a poor outcome following a work injury.

The Arbitrator finds that Petitioner was temporarily totally disabled from August 6, 2008 through March 5, 2009, a period of 30 2/7 weeks, with Respondent receiving credit for the $3,409.44 in benefits it paid prior to arbitration pursuant to the parties' stipulation. Arb Exh 1. It was on March 5, 2009 that new X-rays confirmed the L2 superior endplate fracture and showed the fracture to be stable. It was also on March 5, 2009 that Dr. Sclamberg noted negative tension signs and negative straight leg raising bilaterally. PX 2, p. 13. The Arbitrator finds that Petitioner's causally related fracture and disc herniations stabilized as of March 5, 2009. Interstate Scaffolding, Inc. v. IWCC, 236 Ill.2d 132 (2010). Petitioner underwent additional manipulative therapy after March 5, 2009, per Drs. Sclamberg and Gerber, but the Arbitrator finds this therapy to have been unnecessary and, at least potentially, deleterious, based on the opinions voiced by Dr. Graf.

At the hearing, Petitioner sought an award of the following unpaid medical and prescription expenses:

Fullerton Drake Medical Center (Dr. Gerber) 8/5/08 – 5/15/09	$	28,280.00
Illinois Bone & Joint (Dr. Sclamberg) 10/30/08 – 8/7/09	$	2,146.00
La Familia Accident Injury & Rehab 5/22/09 – 6/18/09 FCE and work hardening	$	5,455.00
Injured Workers Pharmacy 7/3/09 – 12/2/11, medications	$	93.95
Prescription Partners 3/5/09 – 10/7/11, medications	$	41,570.68

Arb Exh 1. Following the hearing, the parties submitted a fee schedule analysis of the foregoing charges.

With respect to Fullerton Drake/Dr. Gerber, the Arbitrator awards Petitioner the $20,133.99 in expenses paid by Respondent, with Respondent receiving credit for same. These paid expenses are enumerated on the second page of Respondent's print-out, RX 6. A paid bill is presumed to be reasonable and necessary.

With respect to Illinois Bone & Joint, the Arbitrator awards Petitioner the fee schedule charges associated with the treatment rendered by Dr. Sclamberg through March 5, 2009. These charges total $1,138.57 per the submitted analysis. The Arbitrator fails to understand why Dr. Sclamberg would prescribe additional manipulative therapy on and after the confirmatory X-rays of March 5, 2009.

The Arbitrator also awards the fee schedule charges totaling $4,372.54 associated with the functional capacity evaluation and work hardening performed at La Familia in June of 2009.

With respect to the Prescription Partners medication expenses, the Arbitrator awards the expenses totaling $4,315.46 associated with the medication that Dr. Sclamberg prescribed on March 5, 2009 ($1,047.07), April 16, 2009 ($1,047.07), June 19, 2009 ($1,110.66) and August 7, 2009 ($1,110.66), with Respondent receiving credit for the $1,596.58 it paid to Prescription Partners. PX 5, pp. 7-8, 13, 16. RX 6, last page. [Contrary to Respondent's assertions, the health insurance claim forms in PX 5 do not relate solely to medication prescribed by Dr. Gerber.] The Arbitrator takes issue with Dr. Sclamberg's recommendation of additional manipulative therapy after March 5, 2009 but finds his prescription of Omeprazole, Meloxicam and Tramadol after that date to be reasonable. The Arbitrator declines to award any of the other claimed expenses associated with the medication Dr. Gerber prescribed between May 7, 2009 and August 25, 2011. PX 5. Dr. Gerber's treatment records, such as they are, end on July 17, 2009. PX 1. The records through July 17, 2009 convey remarkably little information. They set forth no examination findings or blood pressure readings. Petitioner submitted no treatment records from Dr. Gerber post-dating July 17, 2009 other than a one-paragraph report dated July 9, 2010. PX 1, p. 44. In the Arbitrator's view, the July 9, 2010 report is a wholly inadequate substitute for actual treatment records, especially when two years' worth of prescription expenses is at stake.

Is Petitioner entitled to permanent partial disability benefits?

The Arbitrator has previously found that Petitioner established causation as to an L2 superior endplate fracture and disc herniations at L4-L5 and L5-S1. The Arbitrator assigns no weight to Dr. Lami's opinion that Petitioner's back condition is purely subjective. That opinion is at odds with the opinions expressed by Dr. Graf, Dr. Lami's associate, and the follow-up radiographic studies. Dr. Graf diagnosed an objective injury, a fracture, but recommended additional lumbar spine X-rays and a Tesla MRI because the original lumbar spine MRI was of poor quality. The Tesla MRI was never performed but Petitioner did undergo a 3-dimensional lumbar spine CT scan on December 16, 2008, per Dr. Gerber, and additional lumbar spine X-rays on March 5, 2009, per Dr. Sclamberg. The CT scan confirmed two disc herniations and the additional X-rays confirmed the L2 superior endplate fracture. Respondent's second examiner, Dr. Lami, expressed awareness of the March 5, 2009 X-ray results in his supplemental report but there is no evidence indicating he ever reviewed the MRI or CT scan. His opinions are based on an incomplete review.

The Arbitrator awards permanency equivalent to 10% loss of use of the person as a whole under Section 8(d)2, or 50 weeks of benefits. The Arbitrator bases this award on Dr. Graf's opinions, the CT scan results of December 16, 2008, the lumbar spine X-ray results of March 5, 2009, the functional capacity evaluation, the fact Petitioner never underwent the therapy recommended by Dr. Graf and Petitioner's credible testimony concerning her ongoing lower back complaints.

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

Mary Martinez,
Petitioner,

vs.

NO: 11WC 13808
14IWCC0782

Richlee Vans, Inc.,
Respondent,

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner and Respondent herein and notice given to all parties, the Commission, after considering the issues of causal connection, 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 21, 2013, is hereby affirmed and adopted.

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

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

Bond for 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: SEP 12 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

MARTINEZ, MARY
Employee/Petitioner

Case# **11WC013808**

RICHLEE VANS INC
Employer/Respondent

14IWCC0782

On 5/21/2013, 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 0.08% 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:

0320 LANNON LANNON & BARR LTD
MICHAEL S ROLENC
180 N LASALLE ST SUITE 3050
CHICAGO, IL 60601

0208 GALLIANNI DOELL & COZZI LTD
ROBERT J COZZI
20 N CLARK ST SUITE 1800
CHICAGO, IL 60602

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

STATE OF ILLINOIS)
)
COUNTY OF COOK)

ILLINOIS WORKERS' COMPENSATION COMMISSION

ARBITRATION DECISION

MARY MARTINEZ
Employee/Petitioner

Case #11 WC 13808

v.

RICHLEE VANS, INC.,
Employer/Respondent

14IWCC0782

An *Application for Adjustment 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 April 29, 2012. 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 January 28, 2011, 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 $18,527.08; the average weekly wage was $356.29.
- At the time of injury, the petitioner was 62 years of age, *single* with no children under 18.
- The parties agreed that the respondent paid the appropriate amount for all the related, reasonable and necessary medical services provided to the petitioner.
- The parties agreed that the respondent paid $2,515.20 in temporary total disability benefits.
- The parties agreed that the petitioner is entitled to temporary total disability benefits of $220.00/week for 12-1/7 weeks, from May 14, 2011, through July 27, 2011.

ORDER:

- The respondent shall pay the petitioner the sum of $220.00/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 person as a whole.

- The respondent shall pay the petitioner compensation that has accrued from January 28, 2011, through April 29, 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.

Robert E. Williams

Robert Williams

5/21/13

Date

MAY 21 2013

FINDINGS OF FACTS:

On January 28, 2011, the petitioner, a school bus driver, fell down the stairs of her school bus and injured her low back. She received immediate care at the Palos Heights Medical Center for middle, low back pain with radiation down the right leg to her knee. X-rays of her lumbar spine revealed osteopenia and degenerative joint disease of L4-L5 and L5-S1 with joint space narrowing, endplate sclerosis and osteophytes. The diagnosis was a mild lumbrosacral strain. She reported continuing low back pain on January 30th, sore knees, and the ability and desire to work.

The petitioner sought medical care with Dr. Dalawari of Pain Internists on March 12, 2011. She complained of right-sided pain and low back pain radiating down her right leg. An MRI on March 23rd revealed spondylolysis, bilateral pars defect at L5 with slight spondylolisthesis of L5 on S1, minimal bulging at L2-L3, L3-L4 and L4-L5, a small right paracentral protrusion at L5-S1 and degenerative disc disease most pronounced at L4-L5. An MRI of her right hip on March 24th revealed mild to moderate osteoarthritis of her hip joint with possible aseptic necrosis of the femoral head.

Dr. Alexander Ghanayem saw the petitioner on May 4th for her right hip and low back. Dr. Ghanayem's assessment was a herniated disc at L5-S1 and some stenosis at L3-L4, L4-5, and L5-S1. The petitioner started physical therapy at ATI on May 10th and followed up through June 30th. Pursuant to a referral for a lumbar epidural steroid injection, Dr. Raghavendra saw the petitioner on June 27th and noted avascular necrosis and vascular claudication with blockages in his right leg and the possibility that the vascular disease was the source of her right leg pain. He opined that an epidural steroid injection could worsen avascular necrosis and that it would be prudent to wait for a

lumbar epidural steroid injection until after her vascular procedure. On July 27th, the petitioner had a lumbar interlaminar epidural steroid injection. The same day, she reported feeling better to Dr. Ghanayem and that she felt she could return to bus driving. She was released to full-duty work.

The petitioner sought medical care for general health problems with Dr. Ronald Sam of Donte Medical on August 16, 2011. She established a primary care relationship with Dr. Otto Lee on December 12, 2011, and reported back pain during a review of her systems. Dr Lee noted, along with her other health issues, a little back pain during coughing fits on December 22nd and a history of chronic back pain on March 29, 2012, and her report of no further need of treatment or medication. On April 30th, she reported to Dr. Lee right sciatic pain, pain and weakness in right side for a year with increased pain starting the day prior. She was evaluated and approved for physical therapy 2x/week for four weeks at Athletex on May 9th. She was evaluated for therapy for her low back at Palos Community Hospital on May 15th and attended three sessions through June 15th. The petitioner reported back pain when she saw Dr. Lee for general medical care on June 26th. She reported back pain with radiation down her right leg among other problems to Dr. Lee on June 29th.

The petitioner saw Dr. Kornblatt on September 24, 2012, at the request of the respondent. His examination revealed tenderness in her low back, restricted motion, a positive straight leg raise on the right and normal strength, reflexes and sensation in her legs. He opined that the petitioner had lumbar spinal stenosis and degenerative right hip disease.

The petitioner had prior injuries to her lower back on February 10, 2010, July 17, 2010, May 6, 2002, and October 28, 2003, and worker's compensation claims. The petitioner received prior medical care for low back pain with radiation down her right leg from Dr. Dalawari on February 15, 2010, April 9, 2010, and December 30, 2010. She had an MRI of the lumbar spine on April 5, 2010.

FINDING REGARDING WHETHER THE PETITIONER'S PRESENT CONDITION OF ILL-BEING IS CAUSALLY RELATED TO THE INJURY:

Based upon the testimony and the evidence submitted, the petitioner proved that her current condition of ill-being with her low back is partially causally related to the work injury. The petitioner's pre-existing condition with her low back and right leg was aggravated by her work injury on January 28, 2011.

FINDING REGARDING THE NATURE AND EXTENT OF INJURY:

The petitioner returned to her regular job duties in July 2011 and is currently performing her regular job duties. She has occasional flare-ups of back pain with right leg radiculopathy. She currently complains that her back pain is severe and prevents her from socializing and doing chores. Her right buttocks and leg pain is aggravated with walking. The respondent shall pay the petitioner the sum of $220.00/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 person as a whole.

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

14IWCC0783

Lanny Kruckeberg,
Petitioner,

vs.

NO: 10WC 14099
10WC 20322

Cassens Transport,
Respondent,

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of accident, causation, temporary total disability, medical, 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 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.

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $75,000.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: SEP 12 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

KRUCKEBERG, LANNY
Employee/Petitioner

Case# **10WC014099**

10WC020322

CASSEN TRANSPORT
Employer/Respondent

14IWCC0783

On 7/9/2013, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

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

2489 LAW OFFICE OF JIM BLACK
JASON ESMOND
308 W STATE ST SUITE 300
ROCKFORD, IL 61101

0445 RODDY LEAHY ET AL
SAM CERNIGLIA
303 W MADISON ST SUITE 1500
CHICAGO, IL 60606

14IWCC0783

STATE OF ILLINOIS)
)SS.
COUNTY OF Winnebago)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Lanny Kruckeberg
Employee/Petitioner

v.

Cassens Transport
Employer/Respondent

Case # **10** WC **14099**

Consolidated cases: **10 WC 20322**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Douglas J. Holland**, Arbitrator of the Commission, in the city of **Rockford, IL**, on **June 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. [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 the date of accidents, **November 16, 2009 and April 9, 2010**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the November 16, 2009 injury, Petitioner earned **$78,720.20**; the average weekly wage was **$1,513.85**.

In the year preceding the April 9, 2010 injury, Petitioner earned **$57,936.84**; the average weekly wage was **$1,114.17.**

On the date of the November 16, 2009 accident, Petitioner was **51** years of age, **single**, with **1** dependant child. On the date of the April 9, 2010 accident, Petitioner was **52** years of age, **single**, with **1** dependant child.

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

Respondent shall be given a credit of $4,765.21 for other benefits (Short Term Disaiblity) 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.

ORDER

- The respondent shall pay the petitioner temporary total disability benefits of $ **742.78** /week for **17 & 3/7** weeks, from **June 14, 2010** through **October 14, 2010**, as provided in Section 8(b) of the Act.
- The respondent shall pay the Petitioner the sum of **$ 664.72** / week for a further period of **98.5** weeks, as provided in Sections 8(d)2 and 8(e) of the Act, because the injuries sustained caused **40% loss of use of the Petitioner's right leg (86 weeks) and 2. 5% of a whole person (12.5 weeks).**
- The respondent shall pay $ **31,898.78** for necessary medical services, as provided in Section 8(a) of the Act and consistent with the medical fee schedule. Respondent is entitled to credit for any of the awarded medical expenses that it has previously paid.

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

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

Douglas J Holland
Signature of Arbitrator

7-5-13
Date

ICArbDec19(b)

JUL 9 - 2013

STATEMENT OF FACTS

At trial, the parties stipulated that the Petitioner was an employee of the Respondent on both November 16, 2009 and April 9, 2010. The parties stipulated that Petitioner sustained an accidental injury that arose out of and in the course of his employment on November 16, 2009. The parties stipulated that notice of each accident was provided within the time limits stated in the Act. The parties stipulated that Petitioner's earnings in the year preceding the November 16, 2009 accident was $78,720.20 with an average weekly wage of $1,513.85 and that his earnings in the year preceding the April 9, 2010 accident were $57,936.84 with an average weekly wage of $1,114.17. The parties stipulated that Petitioner was 51 years of age as of November 16, 2009 and 52 years of age as of April 9, 2010, single, and with one dependant child.

Petitioner worked for Respondent as a truck driver. His job was to load and unload cars from a semi and drive them to other locations. Petitioner performed the job for Respondent for approximately 20 years and remains in the position as of the time of hearing. Petitioner would drive his semi across the street and set it up to drive cars onto it. He would drive a car onto the semi's frame and tie them down. The cars were tied down with chains attached to the tires and ratcheted down. Petitioner testified that when ratcheting each tire to the semi, 30-40 pounds of pressure was required. Petitioner would climb onto and around the semi's frame which was approximately eight to nine feet high. Petitioner would load approximately 10 cars onto the truck in approximately 2 hours. Each car was raised after it was loaded onto the truck. Petitioner would generally drive to Canada after loading his truck. The drive took approximately seven hours. Once at his destination, Petitioner would unload the cars in approximately an hour and a half. Petitioner would pop the chains off the tires climb into the vehicles, and drive them off the truck. Petitioner noted that the vehicles were difficult to get into given the frame of the semi. Because the cars were stacked to maximize the number that would fit on the semi, none were loaded on flat, level ground. Petitioner would awkwardly attempt to get into the vehicles without damaging them on the frame of the semi. Petitioner testified that he would have to climb into the back doors and then climb over to the driver's seat to unload approximately three of ten vehicles. Other times, he could only open the driver's side door very narrowly and wedge his way into the vehicles.

On November 16, 2009, Petitioner felt a strain in his lower back when ratcheting down a vehicle onto his truck. He immediately informed his supervisor, Tim Stewart, of his injury. Petitioner's delivery was handled by someone else and he sought treatment at Physician's Immediate Care the next day (Px. 1). The records from Physician's Immediate Care noted Petitioner's complaint of back pain while tying down a car the prior day. An x-ray revealed mild osteophytic spurring at L3 and L4, moderate lateral ostephytic spurring at L5-S1 and moderate disc space narrowing at L5-S1 (Px. 1). Petitioner was provided work restrictions and was kept off work through December 11, 2009. He underwent physical therapy through Physician's Immediate Care which improved his pain (Px. 1). While off work, he received temporary total disability benefits.

On April 9, 2010, while in the process of unloading vehicles from his truck, Petitioner felt a strain in his right hip. He noted that he was attempting to get into the second vehicle at the time. Petitioner was squeezing through the door which was opened very narrowly, and climbing into the driver's seat when he felt the strain. Petitioner continued unloading the vehicles with increasing pain in his right hip. Petitioner reported his injury to his supervisor, Chuck Anderson, and filled out an accident report (Px. 8). The accident report noted that while unloading position #2, he felt a strain in the inside right leg hip area upon entering the unit (Px. 8).

Petitioner was seen by Dr. Shin Chen the next day, April 10, 2010 (Px. 2). The records note right hip pain along with bilateral knee pain. Dr. Chen noted that Petitioner was very tender at the right inguinal ligament and diagnosed a strain (Px. 2). Prior records from Dr. Chen failed to note any problems with Petitioner's hip (Px. 2). Petitioner was seen by Dr. Hangan on May 4, 2010 (Px. 3). At that time, he reported pain in his lower back for approximately 3 days, worse with walking, stairs, and bending. Dr. Hangan noted that he had underwent x-rays of his hips and was experiencing pain in his thighs (Px. 3). On examination, right hip pain was noted on palpation of the trochanteric bursa with pain on adduction and internal rotation. Limited range of motion of the hip was also noted (Px. 3). Petitioner was given medication at that time. On May 20, 2010, Petitioner was seen again by Dr. Hangan for his right hip pain (Px. 3). He noted the pain medication was not helpful and that he was having a hard time with the pain that started about 6 weeks ago. Dr. Hangan's records note that Petitioner reported his pain was due to his job and that his truck was bouncing around a lot. The record noted that Petitioner had been seen two weeks ago for back and hip pain. Pain was noted to be radiating in the groin and along his right leg. Petitioner was referred to an orthopedic surgeon after x-rays revealed mild to moderate degenerative arthritis of the hip (Px. 3).

Petitioner was then seen by Dr. Mark Carlson on June 14, 2010 (Px. 4). Dr. Carlson took a history from Petitioner that included right hip and lower back pain from an injury on the job on April 9. The record notes that Petitioner was unloading cars when he began experiencing hip pain (Px. 4). In response to questioning at hearing, Petitioner testified that he was not sure of the source of his hip and back pain initially. He believed his pain to be the result of both his years of hauling cars and his April 9, 2010 injury. Dr. Carlson ordered an MRI for Petitioner's back and kept Petitioner off work. The MRI performed on June 16, 2010, revealed bilateral foraminal stenosis at L1-2 and L2-3, along with a large lateral disc protrusion at L3-4 displacing the left L3 nerve root and an L4-5 disc protrusion. An MRI was requested for Petitioner's right hip also. That MRI was performed on June 22, 2010 and revealed a labral tear and arthrosis (Px. 4). Dr. Carlson diagnosed right hip internal derangement secondary to labral tear beginning at work with underlying arthritis. Surgery was prescribed. On June 30, 2010, Dr. Carlson diagnosed endstage arthrosis of the right hip aggravated by Petitioner's on the job injury and low back pain aggravated by the hip injury. A right total hip arthroplasty with metal-on-metal component was recommended and performed on July 20, 2010 (Px. 5). Following surgery, Petitioner underwent physical therapy until being released to return to work on October 14, 2010 (Px. 4). At that time, Petitioner returned to work. He was not paid temporary total disability benefits while off work.

Dr. Michael Stover examined Petitioner at Respondent's request on July 15, 2010. (Rx. 1). Dr. Stover noted that Petitioner gave a history of feeling a strain in his hip when getting in a car while unloading his truck. Dr. Stover offered the opinion that Petitioner's hip arthritis was a longstanding problem, though acknowledging that Petitioner did not experience any symptoms in his right hip prior to his April 9, 2010 injury. (Rx. 1). Dr. Stover opined that if it was accepted that Petitioner reported hip pain on April 9, 2010, he may have suffered an exacerbation of a pre-existing hip arthritis. He stated that if the condition did not get better over time, it could not necessarily be a temporary exacerbation. (Rx. 1). Dr. Stover agreed that the act of getting into a car could aggravate an arthritic hip, but he could not differentiate that activity from activities of daily living. Dr. Stover noted that a big point for him regarding his causation opinion, was a lack of groin pain reported in the records on April 9, 2010. (Rx. 1).

Dr. Mark Carlson offered a narrative report relative to the causal relationship between Petitioner's work for Respondent and his condition of ill-being on April 4, 2011. Dr. Carlson was subsequently deposed regarding his opinions on February 1, 2012 (Px. 6). Dr. Carlson noted Petitioner's description of his job activities, including unloading and tying down cars. Dr. Carlson noted that initially, he recommended lumbar and hip MRI studies to help differentiate between the back and hip symptoms Petitioner was presenting. Following the MRI's a hip arthroplasty was performed. Dr. Carlson offered the opinion that Petitioner's work activities of getting in and out of vehicles and the reaching up and bending down to perform the tie-downs would aggravate his hip. Dr. Carlson felt that Petitioner's hip condition was aggravating Petitioner's back due to altered weight-bearing due to the hip pain. Dr. Carlson noted that activities of forceful pushing and pulling, climbing ladders, and climbing in and out of vehicles could aggravate hip arthritis (Px. 6). He noted that such aggravations could cause an arthritic condition to become symptomatic and surgery would not be performed for an asymptomatic arthritic hip condition. Dr. Carlson offered the opinion that Petitioner's activities of climbing and jumping off the truck were a causative factor in his condition. He also opined that Petitioner's specific incident in getting into the car on April 9, 2010 was a causative factor in his condition (Px. 6). Dr. Carlson explained that the April 9, 2010 incident caused Petitioner's pain, but it was the repetitive aspects of doing the unloading that would have aggravated his underlying arthritic condition (Px. 6). He opined that the April 9, 2010 incident likely caused or aggravated the tearing of the labram, noting that to be a permanent injury (Px. 6).

At the time of trial, Petitioner testified that his hip and leg pain were significantly relieved with his surgical procedure. He continues to experience some back pain now and then that is aggravated by sitting for three to four hours. He experiences discomfort in his hip with changes in weather and he cannot full squat. Petitioner continues to walk with a slight limp. He also noted that he recently attempted to return to riding a motorcycle, but has pain in his hip with doing so.

FINDINGS OF FACT AND CONCLUSIONS OF LAW ON THE DISPUTED ISSUES

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

The Arbitrator adopts the statement of facts detailed above and finds that an accident occurred that arose out of and in the course of the Petitioner's employment by Respondent April 9, 2010, necessitating the need for Petitioner's surgery on July 20, 2010. It was undisputed that Petitioner suffered an injury to his lower back on November 16, 2009.

Regarding Petitioner's right hip, it is clear from the medical records that Petitioner's April 9, 2010 work accident caused him pain. Petitioner reported his injury to his supervisor, Chuck Anderson, and filled out an accident report (Px. 8). The accident report noted that while unloading position #2 on April 9, 2010, he felt a strain in the inside right leg hip area upon entering the unit (Px. 8). Petitioner testified to squeezing into the vehicle at an awkward position when he felt the strain. Petitioner continued to unload vehicles with increasing right hip pain. The Arbitrator notes that Petitioner's work required he climb in and out of vehicles at awkward angles at least 20 times per day. This constitutes an increased risk associated with his employment.

Petitioner's treatment record from Dr. Chen the day after his injury noted his right hip pain (Px. 2). Dr. Chen noted that Petitioner was very tender at the right inguinal ligament and diagnosed a strain (Px. 2). Petitioner's subsequent records note that his right hip symptoms developed as a result of his April 9, 2010 accident.

Dr. Carlson testified that Petitioner's work activities of getting in and out of vehicles and the reaching up and bending down to perform the tie-downs would aggravate his hip. He explained that the April 9, 2010 incident caused Petitioner's pain, but it was the repetitive aspects of doing the unloading that would have aggravated his underlying arthritic condition (Px. 6). Dr. Carlson opined that the April 9, 2010 incident likely caused or aggravated the tearing of the labram, which led to Petitioner's hip arthroplasty on July 20, 2010 (Px. 6). Dr. Stover opined that acts of daily living, such as getting into a car, or up from a chair, could aggravate an arthritic hip condition. He noted that if it was accepted that Petitioner reported hip pain on April 9, 2010, he may have suffered an exacerbation of a pre-existing hip arthritis. He stated that if the condition did not get better over time, it could not necessarily be a temporary exacerbation. (Rx. 1). The accident report and initial treatment records from Dr. Chen evidence symptomatic hip complaints immediately following the April 9, 2010 injury. Further, the Arbitrator finds Dr. Carlson's opinion more convincing. While Dr. Stover could not differentiate between activities of daily living and Petitioner's work activities, based on Petitioner's testimony and Dr. Carlson's opinions, the requirements of Petitioner in getting in and out of the vehicles while in the course of his employment were differentiated from activities of daily living. Petitioner did not merely get into cars as is done in his personal life. Petitioner had to climb, squeeze, and crawl into vehicles while in the course of his employment. It was this activity that resulted in a symptomatic hip condition on April 9, 2010. Petitioner also testified that he had no prior problems relative to his right hip. Doctors Stover and Carlson agreed that there was no evidence of any symptoms or treatment relative to Petitioner's right hip prior to April 9, 2010.

Therefore, the Arbitrator finds that Petitioner suffered an injury to his right hip that arose out of and in the course of his employment by Respondent on April 9, 2010.

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

The Arbitrator finds that Petitioner's current condition of ill-being is causally related to his work injuries of November 16, 2009 and April 9, 2010. The Arbitrator relies upon the records of the treating physicians, including the June 22, 2010 right hip MRI and Dr. Carlson's medical records, which evidence that Petitioner experienced significant hip pain following his April 9, 2010 injury which was not resolved until his July 20, 2010 arthroplasty. Additionally, the records evidence that Petitioner's lower back condition was aggravated by Petitioner's right hip injury and improved following the hip replacement.

The Arbitrator relies upon the well-established rules set forth by the Illinois Supreme Court that "the fact that an employee may have suffered from a preexisting condition will not preclude an award if the condition was aggravated or accelerated by the employment. The employee need not prove employment was the sole causative factor or even that it was the principal causative factor, but only that it was **a causative factor** in the resulting injury." Williams v. Industrial Com., 85 Ill. 2d 117, 122 (1981).

Thus, even if the claimant had a preexisting degenerative condition which made him more vulnerable to injury, recovery for an accidental injury will not be denied as long as he can show that his employment was also a causative factor. Sisbro, Inc. v. Industrial Comm'n, 207 Ill. 2d 193 (2003).

Petitioner testified at length that his work for Respondent required he climb in and out of cars at awkward positions throughout his day and that he engage in forceful pulling and ratcheting to secure the vehicles to the truck. Dr. Stover agreed that if Petitioner reported hip symptoms immediately following his injury, he may have suffered an exacerbation of his pre-existing arthritis. The accident report and treatment records, most notably Dr. Chen's records the day after the injury, establish hip symptoms immediately following the April 9, 2010 injury. Dr. Stover also opined that if the condition did not improve, the exacerbation couldn't necessarily be temporary. The treatment records clearly establish that Petitioner suffered immediate symptoms to his right hip that were not resolved until the July 20, 2010 hip arthroplasty. As such, it is clear that Petitioner suffered a permanent injury on April 9, 2010.

Petitioner's testimony and his treatment records are consistent with Dr. Carlson's opinion that Petitioner's work activities aggravated his hip arthritis and the April 9, 2010 injury was the proverbial last straw. Petitioner's work activities in tying down the vehicles and also in climbing, squeezing, and crawling into the vehicles was a factor in the aggravation of his underlying osteoarthritic condition. Further, Petitioner's injury of April 9, 2010 was also a causative factor. Petitioner experienced no symptoms relative to his right hip prior to the injury and his symptoms did not resolve thereafter until his hip arthroplasty.

The Arbitrator also relies upon Dr. Carlson's opinion regarding Petitioner's lower back pain. Following his initial injury to his back on November 16, 2009, Petitioner was provided physical therapy and returned to work after approximately three weeks. The MRI performed on June 16, 2010 revealed bilateral foraminal stenosis, protruding discs and nerve root displacement. Dr. Carlson opined that Petitioner's right hip injury, and his altered weight-bearing, caused an increase in Petitioner's lower back symptoms. This is confirmed by the treatment records which noted improvement in Petitioner's lower back symptoms following the hip surgery. (Px. 4). At the time of trial, Petitioner also testified that his hip and leg pain were significantly relieved with his surgical procedure. He continues to experience some back pain now and then that is aggravated by sitting for three to four hours and experiences discomfort in his hip with changes in weather. Petitioner noted that he continues to walk with a slight limp and he cannot fully squat. However, he has been able to return to his regular course of employment following his hip arthroplasty.

Therefore, the Arbitrator finds that Petitioner's current condition of ill-being is causally related to his injuries of November 16, 2009 and April 9, 2010 while working for Respondent.

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

Having determined that Petitioner's November 16, 2009 and April 9, 2010 injuries arose out of and in the course of Petitioner's employment with Respondent and the April 9, 2010 injury necessitated the July 20, 2010 surgical procedure, the Arbitrator finds that the Respondent is responsible for the unpaid medical bills submitted

as Petitioner's Exhibit 7. At hearing, Respondent agreed that the services provided to Petitioner were reasonable and necessary and objected only to liability.

Petitioner underwent treatment at Carlson Clinic from June 15, 2010 through November 7, 2011 relative to his right hip and lower back symptoms. As such, the medical bills from Carlson Clinic, totaling $54.00, submitted at Px. 7 are awarded.

Petitioner was prescribed a raised toilet seat following his surgical procedure. Having not disputed the reasonableness or necessity of the medical treatment, the bill from Integrated HomeCare Services, totaling $27.05, submitted at Px. 7 is awarded.

Petitioner's treatment with Dr. Hangan relative to treatment to the lower back and right hip following the injury of April 9, 2010 was reasonable and necessary. As such, the medical bills, submitted at Px. 7, totaling $1,083.00, are awarded.

The majority of Petitioner's medical bills following his April 9, 2010 injury, were paid by Central States Southeast and Soutwest Areas Health and Welfare and Pension Funds. The itemization from Central States, submitted at Px. 7, regarding medical bills paid correspond with Petitioner's treatment from April 10, 2010 through November 7, 2011. Having found that the treatment from April 9, 2010 through November 7, 2011 was reasonable and necessary and causally related to Petitioner's injury, Respondent is responsible for the medical bills paid by Central States, submitted at Px. 7.

K. ☒ What temporary benefits are in dispute?
☐ TPD ☐ Maintenance ☒ TTD

Respondent paid TTD in the amount of $3,603.96 from November 17, 2009 through December 11, 2009 while Petitioner was off work following his lower back injury of November 16, 2009. Respondent does not dispute the dates of temporary total disability alleged by Petitioner relative to the April 9, 2010 injury, having disputed liability only. Having found that Petitioner's April 9, 2010 injury arose out of and in the course of his employment and necessitated his July 20, 2010 surgical procedure, Petitioner is awarded temporary total disability benefits from June 14, 2010 through October 14, 2010, representing 17 & 3/7 weeks, at the rate of $742.78 per week. Petitioner was taken off work by Dr. Carlson on June 14, 2010 and released to return to work without restrictions on October 14, 2010 (Px. 4).

The Arbitrator notes that Petitioner was paid short term disability benefits by Central States from June 23, 2010 through October 13, 2010 in the amount of $4,765.21. As such, Respondent shall receive a credit of $4,765.21 for short term disability benefits paid to Petitioner.

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

The Arbitrator adopts the findings of fact and conclusions of law contained above with respect to the issues of accident and casual connection and incorporates them herein by this reference.

Having found Petitioner's work accidents of November 16, 2009 and April 9, 2010 caused his lower back and right hip conditions and that his current condition of ill-being as it relates to his right hip and lower back are causally related to his work accidents, the Arbitrator finds that Petitioner sustained permanent loss of use of the right leg and as a man as a whole. As a result of the November 16, 2009 accident, Petitioner suffered injury to his lower back (Px. 1). Petitioner was treated with physical therapy and work restrictions for approximately a month. His subsequent injury of April 9, 2010 resulted in symptomatic right hip arthritis and a labral tear and further aggravated the degenerative condition of his lower back. Petitioner underwent a right hip arthoplasty and physical therapy which significantly improved his hip and lower back pain (Px. 4, 5).

At trial, Petitioner testified to occasional discomfort in his right hip and lower back. He continued to experience some back pain aggravated by sitting for three to four hours at a time. He experienced discomfort in his hip mainly with changes in the weather or with attempting to ride a motorcycle. Petitioner continues to walk with a slight limp and is restricted in his ability to squat.

Based on the foregoing, the Arbitrator finds that Petitioner has sustained permanent partial disability to his lower back representing 2.5% loss of use of a man as a whole, pursuant to Section 8(d)(2) of the Act.

Based on the foregoing, the Arbitrator finds that Petitioner has sustained permanent partial disability to his right hip representing 40% loss of use of the leg, pursuant to Section 8(e) of the Act.

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

JOZEF KUKLA,

Petitioner,

vs.

NO: 09 WC 43101

14IWCC0784

RNF INSTALLATIONS,

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

The Commission finds that Petitioner is entitled to 37 weeks of maintenance benefits under Section 8(a) from November 16, 2010 through August 1, 2011, the date of Dr. Vender's final Section 12 examination when he opined that Petitioner could return to his previous work activities and there were no objective findings that would prevent him from going back to work as a carpenter.

Although the surveillance videos from 2010 suggest that Petitioner's abilities exceeded those that were indicated by the functional capacity evaluation (FCE) on November 16, 2010, these videos do not rise to the level of finding that Petitioner was capable of returning to his

previous occupation as a carpenter. However, the surveillance videos from August 2011 definitively show that Petitioner was capable of returning to work as a carpenter.

Petitioner testified that he was told by his attorney in August 2011, that he should try to get a job as a carpenter. T.101. Petitioner claimed that there had been four or five instances in the past year when he tried to work but the employers sent him home because he was not reliable and "would drop a hammer." Id. Petitioner claimed that he never even got paid for these "jobs." T.102. He testified that he can't do the job because of pain in his finger and hand, and that he cannot hit a hammer or use a drill or anything with vibrations. T.105. He claimed that he didn't have a good grip and could not climb a ladder. T.106-110.

On cross-examination, Petitioner testified that there were actually only three attempts at working as a carpenter. The first was in "summer or fall" of 2011 and he worked there for two days. The second attempt was two months prior to the hearing and it lasted a day. Petitioner testified that there was "maybe a third" attempt but it only lasted two hours.

The surveillance videos (Rx15-19) show Petitioner working at a construction site on August 4, 11, 17, 24, and 25, 2011. The location of the job site appears to be the same each time so Petitioner's testimony that he only worked for two days at the first "job attempt" is not true. The videos show Petitioner performing a variety of tasks using his right hand including using a hammer, carrying a long, large ladder with both hands, using a nail gun, climbing/up down a ladder while carrying a nail gun in his right hand, using an electric circular saw, carrying wood, and climbing along rafters and underneath them while using his right hand to support himself. The videos completely contradict Petitioner's testimony that he could not perform the job duties of a carpenter or use the necessary tools.

Petitioner argues that the FCE was determined to be valid, Dr. Ostric has restricted Petitioner from returning to work as a carpenter, and that the vocational rehabilitation counselor, Lisa Helms, testified that Petitioner needed vocational assistance to find a less demanding job. However, all of these are based on Petitioner's truthfulness about his condition and abilities. Since Petitioner was not truthful about his abilities, those opinions carry no weight.

We find that Petitioner is entitled to the Vocamotive charges prior to August 1, 2011, which would include the Vocational English classes in June 2011. The total amount awarded for these services is as follows:

12/20/10 through 1/27/11	Invoice #11808	$ 578.75
6/30/11	Vocational English Class	1,200.00
6/23/11	Phone call, e-mail, letter	76.50
7/1/11	Phone call	17.00
		$1,872.25

Petitioner is not entitled to vocational rehabilitation or maintenance benefits after August 1, 2011, based on his lack of credibility and our finding that he was capable of returning to his previous job as a carpenter.

The Commission also corrects two clerical errors in the decision. The second page of the decision states, under "Findings", that the date of accident was September 19, 2009. We correct this to reflect the accurate date of September 17, 2009. We also correct the period of temporary total disability in the "Order" section and change the ending date from November 12, 2010 to November 15, 2010 for a period of 60-4/7 weeks.

Finally, the Commission notes that Petitioner's Petition for Review includes "nature and extent" but this was a Section 19(b) hearing so permanency is not at issue.

All else is affirmed and adopted.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent shall pay to the Petitioner the sum of $400.00 per week for a period of 60-4/7 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 $400.00 per week for a period of 37 weeks, that being the period of maintenance under §8(a) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $1,872.25 for vocational rehabilitation expenses under §8(a) of the Act, subject to the fee schedule in §8.2.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay any unpaid medical bills for reasonable and necessary medical services charged to Central Medical Clinic of Chicago, Dr. Andrei Ostric and Midwest Plastic & Reconstructive Surgery, and Illinois Bone & Joint Institute, pursuant to the medical fee schedule after taking appropriate reductions to the charged amounts, as provided in §8(a) and §8.2 of the Act.

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

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

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

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $20,000.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: SEP 12 2014

Charles J. DeVriendt

Daniel R. Donohoo

Ruth W. White

SE/
O: 8/5/14
49

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

KUKLA, JOZEF
Employee/Petitioner

Case# **09WC043101**

RNF INSTALLATIONS
Employer/Respondent

14IWCC0784

On 6/21/2013, 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 0.07% 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:

1938 BELCHER LAW OFFICE
MATTHEW J BELCHER
350 N LASALLE ST SUITE 750
CHICAGO, IL 60654

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

14IWCC0784

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
AMENDED ARBITRATION DECISION
19(b)

Jozef Kukla
Employee/Petitioner

v.

RNF Installations
Employer/Respondent

Case # **09** WC **43101**

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 Simpson**, Arbitrator of the Commission, in the city of **Chicago**, on **July 24, 2012 and August 30, 2012**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. [ ] Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. [ ] Was there an employee-employer relationship?
C. [ ] Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. [ ] What was the date of the accident?
E. [ ] Was timely notice of the accident given to Respondent?
F. [x] Is Petitioner's current condition of ill-being causally related to the injury?
G. [ ] What were Petitioner's earnings?
H. [ ] What was Petitioner's age at the time of the accident?
I. [ ] What was Petitioner's marital status at the time of the accident?
J. [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 [x] Maintenance [ ] TTD
M. [ ] Should penalties or fees be imposed upon Respondent?
N. [ ] Is Respondent due any credit?
O. [x] Other **past and future vocational rehabilitation**

FINDINGS

On the date of accident, **September 19, 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 **$31,200**; the average weekly wage was **$600**.

On the date of accident, Petitioner was **46** years of age, ***married*** with **0** dependent children.

Respondent shall be given a credit of **$40,327.91** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$40,327.91**.

Respondent shall be given credit for $6,840.00 for permanency benefits paid under Section 8(e) of the Act.

Order

Respondent shall pay Petitioner temporary total disability benefits of $400/week for 60 3/7 weeks, commencing September 18, 2009 through November 12, 2010, as provided in Section 8(b) of the Act.

Respondent shall pay any unpaid medical bills for reasonable and necessary medical services charged to Central Medical Clinic of Chicago, pursuant to the medical fee schedule after taking appropriate reductions to the charged amount, as provided in Sections 8(a) and 8.2 of the Act.

Respondent shall pay for any unpaid medical bills for reasonable and necessary medical services charged to Dr. Andrei Ostric and Midwest Plastic & Reconstructive Surgery, pursuant to the medical fee schedule after taking appropriate reductions to the charged amount, as provided in Sections 8(a) and 8.2 of the Act.

Respondent shall pay for any unpaid medical bills for reasonable and necessary medical services charged to Illinois Bone & Joint Institute, pursuant to the medical fee schedule after taking appropriate reductions to the charged amount, as provided in Sections 8(a) and 8.2 of the Act

Respondent shall be given credit for any payments that have previously been paid.

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

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

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

Rebecah L. Simpson
Signature of Arbitrator

June 20, 2013
Date

JUN 21 2013

14IWCC0784

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

JOZEF KUKLA,	)	
	)	
Petitioner.	)	
	)	
vs.	)	**No. 09 WC 43101**
	)	
RNF INSTALLATIONS INC.,	)	
	)	
Respondent.	)	
	)	

AMENDED
FINDINGS OF FACTS AND CONCLUSIONS OF LAW

The parties agree that on September 17, 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. That on this date the petitioner sustained accidental injuries 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 which is the subject matter of this hearing within the time limits stated in the Act. The Petitioner is entitled to TTD from 9/18/2009 through 11/15/2010 representing 60 and 3/7 weeks.

At issue in this hearing is as follows: (1) is the petitioner's current condition of ill-being causally connected to the injury that the petitioner sustained on September 17, 2009; (2) is the respondent liable for the unpaid medical bills to Lake Forest Hospital in the amount of $1,706.00, the Illinois Bone & Joint Institute $13,910.00, Central Medical Clinic of Chicago $ $7,831.00 and Andrei Ostric M.D. $10,390.00; (3) is the petitioner entitled to maintenance from 11/16/2010 through 7/24/2012 representing 105 and 4/7 weeks; (4) did the respondent pay $40,327.91 for which credit should be allowed under Section 8(j) of the act; (5) has the petitioner lost his usual occupation and earning capacity(6) is the respondent responsible for payment of fees for past vocational rehab and future vocational rehab services; and (7) did the respondent pay the statutory amputation fee of $6,840.00.

On July 24, 2012, the Arbitrator heard the testimony of Lisa Helma, a Certified Rehabilitation Counselor; the Petitioner, Jozef Kukla; the Respondent's representative Katarina Karamitso, an adjustor for Pekin Insurance; Zarko Gligorevic, a case manager for Photofax, Jackson Strain; a private investigator for Photofax; and, Nick Boyd, a private investigator for Photofax. On August 30, 2012, the parties closed proofs offering the remaining exhibits into

evidence, which included the deposition testimony of Dr. Michael Vender, Dr. Richard Noren, and Dr. Srdjan Andrei Ostric.

The respondent's exhibits which are numbered 10, 20, 21, 22 and 23 were objected to by the petitioner and the objection was sustained. They are included with the file in the event the decision is appealed.

STATEMENT OF FACTS

In support of her Decision, the Arbitrator finds as follows:

The petitioner testified that he began working for RNF Installations as a carpenter approximately three weeks before he sustained the accidental injuries on September 17, 2009. He was making $15.00 an hour and worked at least 40 hours a week. He testified that on the date of the accident he and his supervisor were flipping over a bathtub and it was too heavy and he lost control of it, dropping the tub to the floor smashing his finger between the tub and the floor. He was wearing gloves and when he pulled his hand out of the glove, some of his finger stayed in the glove and he was taken to Lake Forest Hospital. He received stitches and was referred to an orthopedic surgeon, Dr. DeLeon. He later began seeing Dr. Ostric and on February 11, 2010 had another surgery and eventually underwent a functional capacity evaluation. They ended up removing part of the bone on the tip of his finger. Petitioner showed the arbitrator where the portion of his finger was missing.

The petitioner testified that there were four or five instances when he was taken on for work as a carpenter for a day or two. He said they were trials and they would just send me home he was not hired and he was not paid for his time or work. He testified that he was too weak and might cause an accident to someone and that even though he worked for a day or two, he was not paid by any of them for the work he did. The petitioner testified that he worked with Vocamotive and in his own independent job search but was unable to find employment.

With respect to his restrictions and limitations, the petitioner testified that he was having pain in his finger and could not hammer or drill or use anything that caused vibrations. He further testified that he doesn't have a grip as much as he wants to and demonstrated that he could not close his right hand completely. The petitioner claimed that if his hand worked okay, he would be interested in going back to work as a carpenter. He testified that because of pain, no one wanted to hire him and that they would keep him initially but let him go. He testified he was unable to use a hammer and that a wrench would fall out of his hand a crowbar would cause it to hurt. He also testified that he was unable to climb a ladder because he couldn't hold it and would have to grip it. Carrying anything up a ladder was impossible.

On cross-examination the petitioner agreed that the injury to the finger was at the tip from where it bends to the end. The petitioner admitted that he had surgery in October of 2009 by Dr. DeLeon for removal of necrotic tissue and 2 mm of the last bone of his finger. Petitioner admitted that he was paid the statutory amount of $6,840.00 for the loss of that bone by the

respondent. The petitioner also agreed with the notation by the evaluator at his functional capacity evaluation that the petitioner limited some of his participation in the evaluation because of his pain. The petitioner admitted that from 2009 through December of 2011 he never once made any complaints of his finger to his family physician, Dr. Jakimiec. The petitioner denied in October of 2010 that he told Dr. Jakimiec that he was doing "super good."

The petitioner admitted that prior to the finger injury he did not have any problem lifting weights, he testified that he had a prior right shoulder and arm injury and agreed that It is possible that a previous doctor told him he could not work in construction anymore because of that injury. The prior injury was the subject of a previous workers compensation claim and the petitioner admitted executing settlement contracts in that case eleven (11) months prior to his current injury. Petitioner claims he doesn't remember if the doctors released him to work in construction. He testified further that he received 83 weeks of total disability benefits as a result of that prior injury. The petitioner claims that there is a difference in the construction job he could no longer do because of the permanent restrictions placed upon him for it and the job he had with the respondent. He explained that the first job was new construction and the job which is the subject of this complaint was remodeling. He claims that even though the same tools are used in both types of work, they are used differently. He claimed that hammering was different; wrenches were used differently as were drills and other hand tools.

The petitioner testified that in November of 2010 he was unable to do any construction work at that time. He denied working when he saw Dr. Vender on August 1, 2011 for a Section 12 examination and was still collecting disability benefits at that time. He agreed that he did not tell Pekin that he had gone back to any type of work. He maintains that at that point he had not gone back to work. He admitted that in August of 2011 he was told by his attorney's office that he was to go look for work. At the same time he denied that he had been told by the same office that the benefits had been discontinued.

On cross-examination the petitioner testified that he had tried working construction but did not remember who he worked for. He said that he could only remember their first names. He testified that the first job was actually outside of town and may have been in the summer or fall and he only worked there for two days. He claimed he had difficulty with holding a hammer and a drill in his right hand.

The second time the petitioner tried to go back to work, in construction, according to his testimony was about two months prior to the trial. He did not remember where it was or the name of the company or what they were doing, he did remember it was for a man named Steven. He thought he only worked there for one day.

When questioned about a third attempt to go back to work he denied a third attempt at first but upon further questioning by counsel he stated that maybe there was a third time, but it was so short that I don't even know the name of the guy. When asked how short he answered maybe two hours.

On re-direct the petitioner explained that when he appeared at the job site the boss was watching him and when he tried to complete tasks, the boss realized right away that he was picking it up so weak.

The petitioner admitted that in the 11 months between when he had signed the contract settling his case with B&D indicating he had permanent restrictions and the time when he was injured at RNF Installations, he did not go to a doctor for any change in his work restrictions. The settlement contracts were admitted into evidence. They were executed by the petitioner on October 23, 2008 and indicate the petitioner had permanent restrictions which the employer was unable to accommodate. The petitioner received $225,000 as a wage differential in that case (R. Ex. 7).

The petitioner also presented the testimony of Lisa Helma, a certified vocational rehabilitation specialist with Vocamotive. She testified that she was retained by Mr. Belcher and conducted her initial evaluation on January 4, 2011. She testified that based upon her initial evaluation, if Dr. Vender, Dr. Ostric, Dr. Forys and the FCE were correct that the petitioner had lost his customary line of occupation as a carpenter and if Dr. Ostric was correct, the petitioner was totally disabled but was a qualified candidate for vocational rehabilitation. She testified that the functional capacity evaluation allowed Mr. Kukla to function at the light to medium level of physical demand. She was hesitant to say that the petitioner could use a hammer, a drill, a saw or almost any of the tools that would be required of a carpenter and that he would not be able to climb a ladder. Her expectation was that with vocational rehabilitation there was a chance of placement. She further testified that based upon the job log the petitioner presented, he was putting forth a good faith effort and continued to look for a job even after the vocational rehabilitation benefits were stopped and she was not surprised that he was not presently employed.

On cross-examination Ms. Helma testified that there was no indication that the initial evaluation done by her office was ever shared with the respondent despite the fact that she knew that the law required that rehabilitation plans were to be agreed plans between the parties. She admitted on cross-examination that her office indicated that Mr. Kukla had little interest based upon his attitude and approach during a job interview and did not ask any questions, even though he was advised to do so by a staff member at Vocamotive, and further that the petitioner told them that the finger had a pulsing pain and he couldn't touch anything with his finger. She agreed that that same staff member referred to the incorrect finger throughout the report

Ms. Helma testified further that the Vocamotive staff also noted the petitioner's failure to check off Saturdays and Sundays and his refusal to do so when asked by staff to do it, prompting the need for the staff member to actually check that off on his job availability. She initially testified that the petitioner was just beginning the job search process but admitted that it was several months into the vocational rehabilitation plan. She also admitted that the petitioner never advised her of any employment he had while her office was working with the petitioner or any failed attempts to obtain employment and in fact had reported that he did not have any employment. She agreed that the staff again questioned the petitioner's engagement in his job search and vocational rehabilitation process and questioned the actual extent that he was unable to understand English.

The testimony of Dr. Srdjan Ostric, was presented in the form of the transcript from his evidentiary deposition taken on March 15, 2012.(P. Ex. 8) Dr. Ostric testified that 60% to 75% of his practice was hand surgeries and that he is Board Certified as a plastic surgeon. He testified that the remainder of his practice was general reconstructive surgery including lower extremity, abdominal surgery, breast surgery and cosmetic surgery. (P. Ex. 8, p.5-7). Dr. Ostric testified that he first saw the petitioner on November 25, 2009 for a nail bed deformity and painful scar that was very stiff, and recommended physical therapy and a silicon digit tube. (P. Ex. 8, p. 12). Dr. Ostric continued the restrictions that were already in place for the petitioner and was of the belief that the petitioner was a construction carpenter. (P.Ex. 8, p.12-13). The doctor further testified that he last saw the petitioner before the hearing on March 7, 2012 and that the pain was essentially the same with reports of stiffness and limited use of the hand and no significant improvement. His work status was light duty and he was encouraged not to use the injured extremity because of the pain and stiffness he was reporting and the inability to use his hand functionally as a carpenter and heavy manual labor. (P. Ex. 8, p. 14-15). The doctor testified that because of the petitioner's very heavy manual labor position and use of power tools and hammers and lifting things, that he would not be able to tolerate it very well based upon the physical examination. (P. Ex. 8, p.16, 20). He further felt that the petitioner's condition had not changed during the course of treatment that he saw the petitioner. (P.Ex. 8, p. 16-17). Dr. Ostric testified that he agreed with the functional capacity evaluation findings but felt that the petitioner tended more toward the 0% of being able to do things with his finger. He didn't think the petitioner could tolerate it. (P. Ex. 8, p.19). Dr. Ostric testified that the petitioner needed a more intensive therapy which included a pain relieving cream and could include more invasive administrations of pain relieving medicines. (P. Ex. 8,p. 26). Dr. Ostric testified over objection of the respondent, that he felt the petitioner was a reliable patient and he had no reason to believe otherwise. (P. Ex. 8, p. 29).

On cross-examination Dr. Ostric testified that the original injury was a crush injury to the tip of the long finger. (P. Ex. 8, p. 34). The doctor admitted that the petitioner had excellent range of motion and the only complaint on March 22, 2010 and May 17, 2010, was pain. At that time Dr. Ostric also indicated that he did not believe the petitioner had Complex Regional Pain Syndrome (hereinafter "CRPS"). (P. Ex. 8, p. 38). He further admitted that by August 18, 2010 the petitioner had good clinical grip strength and that the main issue was pain. (P.Ex. 8, p. 39).

On April 21, 2011 Dr. Ostric felt the petitioner was at maximum medical improvement and the only limitation was pain. Petitioner had a "good" grip strength which Dr. Ostric felt meant it was more functional in daily use than daily work. (P. Ex. 8, p. 40) Dr. Ostric admitted on cross-examination that during the functional capacity evaluation the petitioner refused to do some of the testing complaining about the pain. (P. Ex. 8, p. 43). The doctor went on to testify that pain had an objective element to it. (P.Ex. 8, p. 43). He admitted that the pain was the big issue on the restriction of activities. (P. Ex. 8, p. 46). He further admitted that if the petitioner could tolerate construction work, then Dr. Ostric would allow it and that allodynia, which was reported to Dr. Noren, was pain out of proportion to the physical examination findings. (P. Ex. 8, p. 48).

In addition to the testimony of the above witnesses, the petitioner also presented medical evidence in the form of medical reports and deposition transcripts. Other than the objections made during the depositions the medical evidence was not challenged by the respondent and is not in dispute. The Arbitrator finds that the petitioner sustained a crushing injury to the tip of his right long finger which subsequently become necrotic and was debrided and later had excision of a distal phalanx osteophyte and joint manipulation under anesthesia. The petitioner was placed at maximum medical improvement on April 21, 2011 by Dr. Ostric and permanent restrictions were placed with occasional use of his hands within the limitations of pain and consistent with the functional capacity evaluation. The Arbitrator notes that the functional capacity evaluation completed at Vital Rehabilitation noted that the petitioner declined to test carry 50 pounds because of complaints of pain and that the therapist was unable to measure the right middle finger range of motion due to extreme sensitivity to touch reported by the petitioner. The evaluator did feel the petitioner could lift up to 41 pounds from the floor to the knuckle and 31 pounds from the knuckle to the shoulder and from the floor to the shoulder with high lifting of 21 pounds occasionally and 20 pounds of carry. The evaluator also felt that because of the over-sensitivity reported by the petitioner for the right middle finger that this severely affected his job performance and recommended that there was only occasional use of the right hand until the pain had resolved. (P. Ex. 4, FCE from Vital Rehabilitation p. 2-26 fax number designation)

The respondent offered the testimony of Katarina Karamitsos who was the workers' compensation specialist working for Pekin Insurance and adjusting the claim of Joseph Kukla. She testified that the petitioner was paid for temporary total disability benefits, medical benefits and permanency to the right middle finger of 50% of the finger. Benefits were paid through July 31, 2011 and issued on August 8, 2011 when they were stopped based upon the independent medical examination of Dr. Vender and surveillance showing Mr. Kukla actively engaged in construction. She testified that Dr. Vender felt the petitioner could work full duty and was at maximum medical improvement as of August 1. He had made recommendations for a surgical procedure if the petitioner chose, but no request had been made by the petitioner for the surgical procedure through the time of trial. Prior to ending benefits, she had not been notified by the petitioner or the petitioner's attorney that the petitioner had returned back to work. Ms. Karamitsos also testified that all of the medical treatments for bills that were submitted on proper claim forms with the exception of six weeks of physical therapy had been paid. The six weeks of physical therapy had been denied based upon Utilization Review. (R. Ex. 10)

Ms. Karamitsos explained the medical payment process and the review for Fee Schedule pricing. On cross-examination Ms. Karamitsos testified that it was her understanding that the basis for Dr. Vender's opinion of the petitioner's ability to return to work was through his examination and radiographs and diagnostic testing. Ms. Karamitsos further testified that the report of Dr. Vender itself encompassed a return to work and based upon that, as well as the surveillance depicting the petitioner very active doing construction work, was what she relied on. DVD's of the surveillance videos were admitted as Respondent's Exhibits 12 – 19. Ms. Karamitsos testified that it is Pekin's position that the physical condition of Mr. Kukla improved after the FCE because he was able to do his job. She admitted she doesn't know what changed between March and August of 2011 with respect to Mr. Kukla's ability. With respect to vocational rehabilitation, Ms. Karamitsos indicated that she didn't know that Vocamotive provided vocational services because she had not received a report from them. She did receive

an initial bill and payment was made. Ms. Karamitsos further testified that vocational services are owed when the petitioner is unable to return to work and that he should be reporting his earnings but that if there were no earnings, then there would be no credit. She also testified that RNF Installations was unable to return Mr. Kukla to a job full-time. Ms. Karamitsos clarified that in August of 2011 she was not contacted by the petitioner or the petitioner's attorney regarding the petitioner's work status. She learned that the petitioner was working on an active construction site at the end of July from the surveillance team.

The respondent submitted the evidence deposition testimony of Dr. Richard Noren, a Board Certified anesthesiologist with a subspecialty certificate in pain management. (R. Ex. 5). Dr. Noren examined the petitioner on June 3, 2010. He testified that the petitioner had allodynia, which is pain to a light touch. Dr. Noren described that as a subjective response which he described as asking someone does this hurt when I touch you and they say yes or no. And this could not be verified whether it is true or not that is why it is considered subjective. (R.Ex. 5, p. 8-9). He testified further that the examination found only allodynia as a symptom of CRPS and that no other symptoms were present. (R. Ex. 5, p. 11). He found no objective findings to support a diagnosis of CRPS. (R.Ex. 5, p. 9). Dr. Noren felt that the petitioner's complaints could be explained better by a possible sensory nerve damage to the finger as a result of the surgeries. (R.Ex. 5, p. 13). On cross-examination Dr. Noren admitted that he did not see an indication from Mr. Kukla that he was magnifying his pain or malingering. (R.Ex. 5, p. 14-15). He also agreed that use of a numbing cream would be reasonable if it was making the petitioner less symptomatic. (R. Ex. 5, p.16-17). He testified that the allodynia that the petitioner had was pathophysiological and consistent with the history and surgeries that could resolve within a short period of time and would likely improve over time. (R. Ex. 5, p. 21). On cross-examination Dr. Noren testified that he was 100% certain that in this case the petitioner did not have Reflex Sympathetic Disorder (hereinafter "RSD"). (R. Ex. 5, p. 24). Dr. Noren did not feel the petitioner needed any additional medical care, based upon his examination, except for possible Lidocaine or anesthetic cream. (R. Ex. 5, p. 34-35).

The respondent also offered the deposition testimony of Dr. Michael Vender that was taken on two different days. Respondent's exhibit number 3 was taken on October 25, 2011 and number 4 was on November 29, 2011. Dr. Vender testified that he is a Board Certified orthopedic surgeon and completed a fellowship in hand surgery in 1986. (R. Ex. 3, p. 5). Dr. Vender testified that he first examined the petitioner on December 14, 2009. He felt the petitioner was status post crush injury to the distal portion of the ring finger and had intrinsic tightness of the middle and ring fingers. The ring finger was not involved in the December of 2009 incident. (R. Ex. 3, p. 10-11). He did recommend intrinsic releases to improve the intrinsic tightness and discussed a possible revision to the end of the middle finger. This would involve making little cuts onto the sides of the extensor tendons at the finger to separate the muscles to allow a freer motion. At the same time he suggested a revision of the small bone protuberance could be completed while the petitioner was under anesthesia. At that time he testified that the petitioner should avoid any heavy lifting or forceful gripping and agreed he should not be doing carpentry work at that point.

The doctor testified that when he saw the petitioner on June 24, 2010. he felt the petitioner had a flexor sheath ganglion and probable flexor stenosing tenosynovitis of the middle

finger and arthritis at the distal interphalangeal joint. (R.Ex. 3, p. 15-16). Dr. Vender testified that the ganglion could be treated with an injection and that the A1 pulley could be injected with steroids. He also felt that desensitization could be provided to restore the normal sensation and normal sensitivity to the finger. (R. Ex. 3, p. 17). He further felt that the petitioner's symptoms were significantly improved and it was possible he could return to work but may have some difficulties. (R.Ex. 3, p. 18-19).

Dr. Vender saw Mr. Kukla for a third time on March 7, 2011 and reported that he did not have any significant treatment in the interim and none of the prior recommendations had been completed. The doctor noted that the arthritis in the joint had become symptomatic, but the findings and complaints were similar and the petitioner was reporting pain in the proximal finger with forceful use of the hand and in the distal portion of the finger. (R. Ex. 3, p. 20). He felt that the petitioner could still work, but should be limited with regards to heavy lifting on a repeated basis and testified that he did not feel the petitioner had RSD. (R. Ex. 3, p. 21-22).

August 1, 2011 Dr. Vender saw the petitioner, he testified that the petitioner was basically the same. He found a normal range of motion with some decreased motion isolated to the DIP joint and the tenderness and pain reported by the petitioner were still indicative of middle finger flexor stenosing tenosynovitis. He felt the cream was only a symptomatic masking type of phenomena and again recommended a release of the flexor tendon sheath. If the petitioner chose not to proceed with that, then he was free to resume his previous work activities and if symptoms increased he could get re-evaluated. (R. Ex. 3, p. 25). Dr. Vender found no objective findings that would prevent the petitioner from returning to work as a carpenter. (R. Ex. 3, p. 26).

On cross-examination Dr. Vender testified that the petitioner would be capable of operating a concrete saw or a circular saw and has no restrictions as it related to his work. (R. Ex. 3, p. 32). Dr. Vender further testified that there was no indication that the ganglion cyst was related to the trauma of September of 2009. (R. Ex. 3, p. 38). Dr. Vender further testified that working as a carpenter could increase diffuse pain with gripping activities. (R. Ex. 3, p. 40). He admitted that in June of 2010, based upon subjective complaints of the petitioner, the petitioner might have some difficulty returning to his previous work as a carpenter. (R. Ex. 3, p. 41). Dr. Vender testified that he was very comfortable saying that regardless of the work activities, whether he was a light carpenter or a heavy carpenter, that based on the limited findings the petitioner had, it was reasonable for him to move on and return to his normal work activities. (R. Ex. 3, p. 42-43). Dr. Vender testified that one explanation for the petitioner's complaints is flexor stenosing tenosynovitis and if the petitioner was treating, then restrictions could be reasonable but Dr. Vender would typically not provide restrictions for that type of condition. (R. Ex. 3, p. 44-45). Dr. Vender agreed further that if the petitioner's complaints on his finger were an impediment to work, then an arthrodesis could be considered. (R. Ex. 3, p. 45-46). In March of 2009 the doctor again recommended avoiding heavy lifting on a repetitive basis if he was to proceed with the treatment. He further testified that in retrospect he probably should have released the petitioner back to full duty at that point, but was giving the petitioner the benefit of the doubt. (R. Ex. 3, p. 47-48). Dr. Vender testified that a patient with RSD or CRPS would not present as the petitioner did who demonstrated a mechanical problem that explained their pain. (R. Ex. 3, p. 59-60).

On November 29, 2011 Dr. Vender testified that the intrinsic tightness that the petitioner had was consistent with his injury and would be the cause of the loss of motion involving the middle and ring fingers as a complication after an injury to the hand. (R. Ex. 4, p. 4-5). He testified that x-rays confirmed development of arthritis in the joint which may have been aggravated by the crush injury and could explain the petitioner's pain. (R. E x. 4, p. 8-9) and that should the petitioner go through with a fusion of the DIP joint to address the arthritis, he would not expect many ramifications for the hand itself, including loss of grip strength or loss of pinch strength. (R. Ex. 4, p. 16). Because of pain, the flexor stenosing tenosynovitis could significantly interfere with activities regarding the heavy lifting or forceful use of the hands and fingers. (R. Ex. 4, p.17).

Dr. Vender confirmed on re-direct that any need for any additional treatment of the petitioner is based solely on his subjective complaints of pain. (R. Ex. 4, p. 31).

The respondent also submitted CDs which contained surveillance video of the petitioner numbered as Exhibits 12 through 19. The videos were taken on four days in October, November and December of 2010 and 11 days in July and August of 2011. With respect to the videos the respondent called Zarko Gligorevic to testify. He stated that he was the case manager for Photofax, he oversees all surveillance being done by the team, he reviews their reports copy's CD's and informs clients of the status of the investigation. The investigators keep recording an individual for 30 minutes after they leave or are out of sight. The videos are sent to him and he puts them on a CD to send them out to the client. The videos are kept in a secured storage that only managers have access to. He testified that he received video footage from his investigators Nick Boyd and Jackson Strain with respect to this case. He transferred the videos to the CDs that are labeled Respondents Exhibits 12 through 19 he did not show the CDs or give a copy of them to the investigators to review and determine if they are true and accurate copies of the videos that were taken by them.

Jackson Strain and Nick Boyd they both testified that they were employed as investigators in worker's compensation cases. They were the investigators assigned to follow the petitioner and record his activities. With the exception of one small instance on the first day where Mr. Strain did not hit the record button fast enough he recorded everything he saw regarding the petitioner and his activities. They document claimant's lifestyle over 8 to 10 hours a day several different days. They each recorded videos of the petitioner on different days in various activities. The recordings were not edited by them, they were sent to the office with a written report documenting what they saw and recorded. Neither investigator has seen the video since sending it in to the office, nor have they seen the CD that was made from the videos. The petitioner did not object to the admission of the CDs when they were offered.

In August of 2011 almost 200 minutes of tape were obtained showing the petitioner actively engaged in construction work, working on an addition on a house. The video depicted the petitioner engaged in all normal activities of construction including carrying tools ladders of varying sizes and carrying a tool box. Petitioner is seen carrying a nail gun with his right hand while he climbed a ladder with his left. He does not appear to have any difficulty doing all of these activities. He does not display any indication that what he is doing is causing him pain.

The petitioner was observed regularly using his right hand. The surveillance noted that the petitioner was on the job site at least throughout the afternoon of August 4, all day on August 11, August 17, August 24 and August 25. All of these days were at the same job site and included the petitioner using power tools such as saws and nail guns, swinging a hammer and climbing in roof trusses to make the installation, all with his right hand showing no apparent difficulties. (R. Ex. 15-19)

In exhibits 12 and 13, in October and November 2010 the videos show the petitioner entering and exiting his vehicle and driving. He is carrying objects with his right hand without difficulty. The November 16, 2010 video showed the petitioner entering Vital Rehabilitation at 8:22 and exiting at 12:19. That afternoon the petitioner was observed carrying a long piece of lumber in his right hand and opening up the hatch of his vehicle with his right hand with no apparent difficulty. Later that afternoon the petitioner cleaned out his car. He is seen putting objects in and taking them out of the car. He regularly uses his right hand with no apparent difficulty. The following day the petitioner was loading building materials into his vehicle and then returning to his residence and unloading the same building material. He was later seen placing tool cases into the rear of his vehicle, along with other items, and replacing the building plywood into the rear of his vehicle, along with other items before departing his residence and traveling to another hardware store and then on to a separate residence where he remained for four hours. The petitioner's right middle finger was wrapped during this observation in 2010, but all of this activities were performed in a fluid and unrestricted manner with no pain behavior exhibited.

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).

"A claimant is generally entitled to vocational rehabilitation where he sustains a work-related injury which causes a reduction in his earning power and there is evidence that rehabilitation will increase his earning capacity." *Roper Contracting v. Industrial Commission*, 349 Ill. App. 3d 500 (2004).

The arbitrator finds as follows:

Is the petitioner's current condition of ill being causally related to the injury?

The parties agreed that the petitioner sustained a crush injury to the tip of his right middle finger. The injury was initially stitched and then after an infection developed, was debrided. Later when the petitioner continued to complain of symptoms, a revision surgery removing osteophytes at the end of the finger was performed. The Arbitrator finds the petitioner

does not have RSD or CRPS based on the opinions of Dr. Ostric, Dr. Vender and pain specialist Dr. Noren. The Arbitrator finds Dr. Forys' opinions to the contrary not credible.

Dr. Ostric did not feel the petitioner's condition had changed during the entire treatment period with Dr. Ostric from November 25, 2009 through his last date of treatment on April 21, 2011, according to Dr. Ostric's testimony. Additionally, Dr. Vender noted that the petitioner's condition had not changed at least from March 2011 through August 1, 2011. Both Dr. Ostric and Dr. Vender noted that the continued care was based upon the reports of pain by the petitioner and that there were no objective findings to support ongoing care, at least after March of 2011, besides those complaints.

The petitioner sustained a 2 mm bone loss to the tip of his right middle finger as a result of the injury and continues with intrinsic tightness and some pain complaints in that finger. The Arbitrator finds that these conditions are causally related to the work accident of September 17, 2009.

Were the medical services that were provided to the petitioner reasonable and necessary? Has respondent paid all appropriate charges for all reasonable and necessary medical services?

The Petitioner claims that the following medical bills are outstanding and the responsibility of the respondent to pay: Lake Forest Hospital in the amount of $1,706.00, the Illinois Bone & Joint Institute $13,910.00, Central Medical Clinic of Chicago $ $7,831.00 and Andrei Ostric M.D. $10,390.00;

The only testimony regarding outstanding medical bills was from Ms. Karamitsos offered by the respondent. Ms. Karamitsos testified that all properly submitted medical charges have been paid. The petitioner offered no testimony to rebut that evidence. Document exhibits were submitted by the petitioner's attorney, including medical charges from multiple providers and a list of all the bills paid and unpaid.

With respect to Lake Forest Hospital there does not appear to be any outstanding bills. The evidence indicates that the bill for Sept. 17, 2009 for emergency room services related to the injury to the finger has been paid according to the fee schedule.

With respect to Illinois Bone & Joint Institute the outstanding bills appear to be from September 21, 2009 through October 19, 2009 related to the debridement of the tissue on his injured finger. The petitioner has properly presented evidence that the he has incurred bills to the Illinois Bone & Joint Institute in the amount of $13,910.00, for treatment after his injury and that the respondent has paid $6,439.15. No evidence has been presented as to what the amount of the bills would be after adjustments for the application of the fee schedule. Respondent is responsible for any outstanding balance after application of the fee schedule and credit for the $6,439.15 already paid are made.

With respect to the Central Medical Clinic of Chicago, there appear to be charges outstanding of $5,851.00, prior to any reductions under the Fee Schedule as allowed under Section 8(a) and 8.2 of the Act. Respondent offered testimony that the only denied medical bills were for therapy based upon a Utilization Review, but the Utilization Review was denied admittance as hearsay. The petitioner has properly presented evidence that the bills to Central Medical Clinic of Chicago in the amount of $5,851.00 remain outstanding however, no information has been presented as to the appropriate balance after adjustments for the fee schedule. The Respondent is responsible for any remaining balance of the after the application of the fee schedule.

With respect to the services of Dr. Andrei Ostric at the Midwest Plastic and Reconstructive Surgery there appears to be charges of $10,390.00, which accrued between November 25, 2009 through June 16, 2010, prior to any reduction under the Fee Schedule as allowed under section 8(a) and 8.2 of the Act. The respondent has paid $ 4,477.25 to the Midwest Plastic & Reconstructive Surgery leaving a balance of $5,912.75 By agreement the parties agreed that the petitioner was disabled due to the accidental injury sustained until he was found to be at MMI on November 15, 2010. The petitioner has properly presented evidence that the bills to Dr. Andrei Ostric in the amount of $5,912.75, however it is not clear whether the fee schedule adjustments have been applied to that amount. The Respondent is liable for any outstanding amount after appropriate adjustments are made for the fee schedule.

What temporary benefits are in dispute? And Is the Petitioner entitled to past and future vocational rehabilitation services?

The parties stipulated that the petitioner was entitled to temporary total disability benefits through November 15, 2010, the date on which they stipulated he was at maximum medical improvement. The Arbitrator therefore awards 60-3/7 weeks of disability from the period of September 18, 2009 through November 15, 2010 pursuant to the stipulation of the parties. The Respondent presented undisputed evidence that it has paid $40,327.91 in weekly benefits to the petitioner. The respondent is awarded the credit for benefits paid.

The disputed issue was the maintenance period starting on November 16, 2010 through the date of trial. The Petitioner argues that he had permanent restrictions which prevented him from returning to work as a carpenter. Respondent argues that the evidence shows that the Petitioner is capable of working as a carpenter and therefore no maintenance benefits are due.

The Arbitrator notes that Dr. Ostric's restrictions are based upon the functional capacity evaluation performed at Vital Rehabilitation. The functional capacity evaluation indicated that the evaluator felt that this was a valid representation of the Petitioner's work abilities, but further notes that the evaluator specifically documented that the Petitioner refused to try to lift anything over 50 pounds due to his subjective reports of pain. Further, the Petitioner refused to allow the evaluator to test the Petitioner's right middle finger range of motion due to extreme pain complaints. However, the surveillance that was done on the afternoon of the functional capacity

evaluation and the following day showing the Petitioner regularly using his right hand while loading and unloading building materials and tool boxes without any apparent pain behavior or guarding of the right hand. The Arbitrator finds that the Petitioner's refusal based on his subjective reports, in light of the later activity that day and the next day shown on the surveillance tapes, was not reasonable and the restrictions do not represent a true measurement of the petitioner's work ability. The Arbitrator further finds that Dr. Ostric's reliance on this FCE is not supported in light of the demonstrated ability of the petitioner shown in all of the surveillance presented. Dr. Ostric was not provided with the facts by his patient and therefore his opinions on the work ability of the petitioner are not supported.

The Arbitrator finds persuasive the testimony of Dr. Michael Vender with respect to the work ability of the petitioner. Dr. Vender noted that he was giving the petitioner the benefit of the doubt when continuing restrictions of no heavy lifting on a repeated basis in March of 2011 when he saw the petitioner, based upon the petitioner's subjective pain complaints. Dr. Ostric also was noting at that point that the petitioner's only issue was his pain. Both Dr. Ostric and Dr. Vender agreed that the petitioner's condition did not change at least from March through August 1, 2011, and according to Dr. Ostric, not from November 16, 2010 through April 21, 2011. And both doctors agree that the main issue was the reports of pain by the petitioner.

The Arbitrator notes that the respondent continued to pay benefits and it authorized and paid some vocational services based upon the petitioner's subjective complaints prior to August 1, 2011. The Arbitrator finds persuasive Dr. Vender's opinion that the Petitioner was capable of working his full duty as of August 1, 2011. This opinion is more than amply supported by the Petitioner's own actions as depicted on the surveillance video showing him working at a job site over several days during the month of August performing all of the construction activities that he was telling his doctors he was unable to perform and that he testified at the hearing that he was unable to do. The surveillance showed him using the power tools that his vocational rehabilitation specialist felt he shouldn't be able to do and regularly swinging a hammer and using other tools that required him to grip with his right hand, also which Dr. Ostric and the vocational specialist felt the Petitioner was unable to do, based upon the Petitioner's subjective reports of pain.

The Arbitrator notes that the Petitioner himself was inconsistent with his testimony regarding his work activities. He claims he worked for such short periods of time over three occasions in 2011 and 2012 that he could not even remember the names of the employer. The petitioner further testified very specifically that he only worked for two days for the initial employer and that the initial employer sent him home because he was unable to hold tools and use them. The surveillance video confirms that the Petitioner worked several days at the same job site in August of 2011 and had no difficulty demonstrated on the surveillance in performing any of the carpentry tasks. The Arbitrator also notes that the petitioner previously executed a Lump Sum Settlement Contract indicating that he was unable to perform the job of a carpenter and received a sizable settlement as a result. The petitioner further testified that he had no changes in his restrictions from any doctors in the 11 months between when he executed that contract and when he was injured working for respondent. On cross examination regarding the permanent restrictions for working as a carpenter petitioner stated that there was a difference, the first job involved new construction and the current job that he was injured on involved

remodeling. He testified further that there were differences in using carpentry tools such as hammers, screw drivers and drills with new construction and remodeling. He did not elaborate further on that explanation. The Arbitrator finds this relevant to the petitioner's current assertion that he can no longer work as a carpenter for the injury to his right middle fingertip. The lack of any change in his condition between when he executed the contracts and when he was back working as a carpenter raise suspicion that he is not being upfront about his abilities, especially in light of his testimony that using a hammer etc. is different when engaged in remodeling rather than new construction. This casts doubt on the petitioner's current assertion again claiming he cannot work as a carpenter. When considering all of the inconsistencies together and the demonstrated ability shown on the surveillance, the Arbitrator finds the petitioner not credible with respect to his current complaints of pain as they relate to his ability to do his job as a carpenter.

Based upon the totality of the evidence, the Arbitrator hereby finds that the petitioner reached maximum medical improvement on November 15, 2010 as stipulated by the parties and that he is capable of performing his normal job activities as a carpenter, as he has demonstrated in his video. The Arbitrator therefore denies any request for maintenance benefits.

The Petitioner has presented evidence that the some of the medical bills for his treatment remain outstanding and further finds that they are reasonable and necessary and the responsibility of Respondent under the Act, and should be paid pursuant to the Fee Schedule.

The Petitioner has demonstrated the ability to complete the necessary functions of his job as carpenter and therefore is not entitled to vocational rehabilitation services and therefore the Arbitrator denies same.

ORDER OF THE ARBITRATOR

Respondent shall pay Petitioner temporary total disability benefits of $400/week for 60 3/7 weeks, commencing September 18, 2009 through November 12, 2010, as provided in Section 8(b) of the Act.

Respondent shall pay any unpaid medical bills for any reasonable and necessary medical services to Central Medical Clinic of Chicago, pursuant to the medical fee schedule after taking appropriate reductions to the charged amount, as provided in Sections 8(a) and 8.2 of the Act.

Respondent shall pay any unpaid medical bills for any reasonable and necessary medical services charged to Dr. Andrei Ostric and Midwest Plastic & Reconstructive Surgery, pursuant to the medical fee schedule after taking appropriate reductions to the charged amount, as provided in Sections 8(a) and 8.2 of the Act

Respondent shall pay any unpaid medical bills for any reasonable and necessary medical services charged to Illinois Bone & Joint Institute, pursuant to the medical fee schedule after taking appropriate reductions to the charged amount, as provided in Sections 8(a) and 8.2 of the Act

Respondent shall receive credit for all payments on medical bills that have been previously paid by Respondent.

Deborah L. Simpson
Signature of Arbitrator

June 20, 2013
Date

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

RANDY ALBRECHT,

Petitioner,

14IWCC0785

vs.

NO: 08 WC 44247
09 WC 02178

VEOLIA ENVIRONMENTAL SERVICES,

Respondent.

DECISION AND OPINION ON REVIEW

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

The Commission notes that counsel for the Petitioner made a plea for penalties during oral arguments. The record reveals that based on an agreement and stipulation of the parties, the Petition for Penalties was withdrawn during the arbitration hearing. Petitioner did not file a Petition for Review and did not advance an argument in his Statement of Exceptions advising the Commission as to why penalties were warranted in this matter. Based on the prior actions, the Commission declines to award penalties in this matter.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed on December 16, 2013 is hereby affirmed and adopted.

14IWCC0785

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 $75,000.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: SEP 1 2 2014

Michael J. Brennan

Thomas J. Tyrrell

Kevin W. Lamborn

MJB/tdm
O: 09-09-14
052

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

ALBRECHT, RANDY
Employee/Petitioner

Case# **09WC002178**

08WC044247

14IWCC0785

VEOLIA ENVIRONMENTAL SERVICES
Employer/Respondent

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:

0140 CORTI ALEKSY & CASTANEDA
MARK DePAOLO
180 N LASALLE ST SUITE 2910
CHICAGO, IL 60601

2337 INMAN & FITZGIBBONS LTD
JUDY NASH
33 N DEARBORN ST SUITE 1825
CHICAGO, IL 60602

141WCC0785

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

Randy Albrecht,
Employee/Petitioner

v.

Veolia Environmental Services,
Employer/Respondent

Case # **09** WC **2178**

Consolidated cases: **08 WC 44247**

An *Application for Adjustment 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 **9/16/13**. 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. [ ] Were the 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 [x] 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 **12/31/08**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$53,456.00**; the average weekly wage was **$1,028.00**.

On the date of accident, Petitioner was **44** 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. (Arb.Ex.#3).

Respondent shall be given a credit of **$71,124.00** for TTD, **$0.00** for TPD, **$92,563.32** for maintenance, and **$0.00** for other benefits, for a total credit of **$163,687.32**. (See Arb.Ex.#2).

Respondent is entitled to a credit of **$0.00** under Section 8(j) of the Act. The parties subsequently stipulated that all medical charges for reasonable and necessary medical services rendered to Petitioner on account of this injury have been paid by Respondent. (Arb.Ex.#3). As a result, Respondent is entitled to a credit for any and all amounts paid on account of this injury.

ORDER

Respondent shall pay Petitioner maintenance benefits of $685.33 per week for 130-6/7 weeks, commencing 12/14/10 through 6/16/13, as provided in §8(a) of the Act.

Respondent shall pay Petitioner temporary total disability benefits of $685.33 per week for 100-4/7 weeks, commencing 1/5/09 through 10/25/09 and from 10/30/09 through 12/13/10, as provided in §8(b) of the Act.

Respondent shall pay Petitioner the temporary total disability benefits that have accrued from 1/1/09 through 9/16/13, and shall pay the remainder of the award, if any, in weekly payments.

Respondent shall be given a credit of $71,124.00 for temporary total disability benefits and $92,563.32 in maintenance benefits that have been paid.

Respondent shall pay Petitioner permanent partial disability benefits, commencing 6/17/13, of $479.20 per week for the duration of the disability, because the injuries sustained caused a loss of earnings, as provided in §8(d)1 of the Act.

Respondent shall pay to Petitioner penalties of **$0.00**, as provided in §16 of the Act; **$0.00**, as provided in §19(k) of the Act; and **$0.00**, as provided in §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.

Signature of Arbitrator

12/11/13
Date

DEC 16 2013

STATEMENT OF FACTS:

Petitioner, a 44 year old waste hauler driver, testified that he had worked for the Respondent for about three years prior to the initial accident, having done the same job at Arc Disposal prior to that.

Petitioner testified that on August 25, 2008 (08 WC 44247) he was dumping a 10 yard dumpster weighing about 3,500 pounds empty when the safety failed, pinning him between the garbage truck and the dumpster. He was taken by ambulance to the Highland Park Hospital Emergency room where he was examined, x-rayed, given a CT scan, given medication, and prescribed off of work. (PX1;PX2).

Petitioner subsequently began treatment at Northbrook Occupational Medical Center and underwent a program of physical therapy. During this period Petitioner continued to complain of low back pain with numbness down his left leg. (PX3). Petitioner was eventually released to return to light duty work on September 12, 2008. He returned to light duty work for Respondent at that time and continued to drive a truck, although he was given someone to go with him on his route. However, Petitioner noted that the pain in his back got worse from all the bouncing around in the truck. He thereupon returned to the clinic and underwent an EMG on November 3, 2008 which showed early acute left lumbosacral radiculopathy at the L4 and L5 levels but was otherwise within normal limits. (PX5). Petitioner was eventually released to full duty work by the clinic's doctor, Dr. Osipovich, on November 12, 2008. (PX3).

Petitioner testified that on December 31, 2008 (09 WC 2178) he was told to do a special stop in Skokie to pick up a skid of boxes. He noted that after he picked up the boxes and got back to the truck he noticed sharp pain down his back. He indicated that he told his operation manager and eventually returned to the clinic on January 5, 2009.

On January 5, 2009, Petitioner was seen by Dr. Osipovich at Northbrook Occupational Medicine Center. Petitioner reported that on December 31, 2008, he was lifting 50 pound boxes when he developed sharp lower back pain that radiated down into his left leg. He noted that the pain had increased and he was unable to sleep at night. Petitioner indicated that his back had not improved 100% from his prior work related injury. However, he reported that he had been able to work until December 31, 2008, when the second injury occurred. X-rays of the lumbar spine revealed degenerative changes. Petitioner was diagnosed with a lumbosacral spine strain and a left S1 joint sprain. He was instructed to attend physical therapy and was referred for a lumbar spine MRI. He was also authorized off work at that time. (PX3;RX5).

Petitioner attended physical therapy on January 5th, January 7th, January 9th, January 12th and January 15th, 2009.

On January 12, 2009, an MRI of the lumbar spine was performed and revealed a left far lateral disk protrusion/early herniation with annular tear at L4-5, associated encroachment on the inferior aspect of the left neuroforamina, Grade 1 retrolithesis of L5 on S1 with uncovering of the disk margin and disk desiccation changes with minimal disk protrusion/early herniation at the right paracentral location at L2-3. (PX7;RX6).

On January 26, 2009, Petitioner was seen by Dr. Osipovich with complaints of constant soreness, discomfort and back pain as well as numbness. He was instructed to continue attending physical therapy and told to remain off work at that time. (PX3;RX5).

On February 2, 2009, Petitioner visited by Dr. Mark Levin for a §12 examination at Respondent's request. Dr. Levin reported that the x-rays from January 5, 2009 showed degenerative narrowing at the L5/S1 level and a

chronic wedging of the L1 vertebral body. The MRI from January 12, 2009, showed a far lateral disk protrusion at L4/5 that might have been impinging on the nerve root. Dr. Levin recommended two epidural steroid injections along with a formal physical therapy program with documentation of therapy modalities. Petitioner had reported that he was participating in PT. Dr. Levin could not determine when Petitioner would achieve maximum medical improvement. However, Dr. Levin did opine that Petitioner could return to light duty work with no repetitive bending, squatting or stooping and limited lifting while he continued with PT and the epidural steroid injections. (RX1).

On February 23, 2009, Petitioner was seen by Dr. Avi Bernstein pursuant to the referral of Dr. Osipovich. Dr. Bernstein reported that Petitioner was a 40-year old garbage collector who was involved in a work injury on August 25, 2008. He reported that he was injured by a 3,000 pound garbage can and was off work for a few months. He underwent physical therapy and was able to return to work. On December 31, 2008, he was lifting approximately 150 pamphlet boxes weighing about 50 lbs. each when he began to experience sharp pain radiating from his back down into his left leg He denied radicular symptoms and numbness or weakness into his lower extremities. Dr. Bernstein reported that the MRI scan showed degenerative disc changes at L5-S1 with a central to left sided disc bulge that appeared to impinge the left S1 nerve root. The report described a left lateral disc protrusion that Dr. Bernstein did not appreciate on his examination. Dr. Bernstein opined that Petitioner had symptoms of discogenic low back pain. He recommended a trial of lumbar epidural steroid injections and that he continue with physical therapy. If this did not help then he would consider a CT myelography or discogram. (PX7;RX6).

On March 13, 2009, Dr. Henry Kurzydlowski of Pain Care Consultants reported to Dr. Bernstein that he reviewed x-rays that showed lumbar degenerative disc disease, especially on the left side at L3-4. His physical examination showed decrease range of motion and tenderness to palpation. He recommended a lumbar epidural steroid injection at L3-4 under fluoroscopy. This was performed on March 25, 2009, April 15, 2009, and May 20, 2009. (PX7;RX5).

On August 3, 2009, Dr. Levin re-examined Petitioner at the request of Respondent. Dr. Levin reported that Petitioner had three epidural steroid injections that provided limited relief. Dr. Levin reviewed an EMG from Dr. Vatz from November 3, 2008 that described findings consistent with an L5 and/or L4 radiculopathy on the left. He opined that it was appropriate to proceed with a myelogram and post-myelogram CT study. (RX2).

On August 6, 2009, a CT lumbar myelogram demonstrated a far lateral herniated disc toward the left at L4-L5 level. There was moderate bony foraminal stenosis on the right at L5-S level. (PX7;RX6).

On November 19, 2009, Petitioner had a L3 through S1 lumbar diskogram (3 levels) performed at Advocate Lutheran General Hospital. The impression was negative diskogram and normal disk, L3-L4, positive diskogram with evidence of annular disruption, L5-5 and negative diskogram at L5-S1 with degenerative change. The CT lumbar spine post diskogram reported intervertebral disc degenerative changes present with associated tears within the respective disc annuluses at the L4-L5 and L5-S1 levels. (PX7;RX6).

In a letter to the adjustor dated October 5, 2009, Dr. Bernstein noted that he was in receipt of the former's September 29, 2009 letter "regarding a seasonal job which is available" to Petitioner. Dr. Bernstein indicated that he felt Petitioner could perform the work activity identified as a "leaf collector." (PX7;RX6).

Petitioner testified that he tried the position offered by Respondent but that the pain got worse and he lasted only four days. The specific dates that he worked were not given.

In a letter to the adjustor dated October 30, 2009, Dr. Bernstein noted that Petitioner "report[ed] that his pain is worsening and he is moving in the wrong direction. He feels he has been set back six months. This patient has chronic persistent low back pain. I am recommending that he discontinue physical therapy, that he remain off work and that we pursue an L3 to S1 lumbar discogram." (PX7;RX6).

On November 30, 2009. Dr. Bernstein reported that the November 19, 2009 lumbar discogram findings were completely normal at L3-4 and that L4-5 demonstrated degenerative change and evidence of an annular tear and was concordant with the patient's own complaints. L5-S1 demonstrated degenerative change but produced no pain reproduction. He believed the symptomatic disc was L4-5. He recommended a two level procedure given the findings were also at the L5-S1 level. (PX7;RX6).

On February 24, 2010, Dr. Avi Bernstein performed an L4-5 and L5-S1 anterior lumbar decompressive diskectomy, L4-5 total disk arthroplasty using Pro Disk L system, L5-S1 anterior spinal anterior spinal fusion, implantation of precision implant x1, implantation of infused bone morphogenic protein and application of integra titanium plate L5-S1. Petitioner was released from the hospital on February 26, 2010. (PX7;RX6).

By March 29, 2010, Petitioner was participating in physical therapy at Advocate Health Care. He wore a corset brace. Thereafter, Petitioner began a course of PT at NovaCare on May 12, 2010, 3X per week for six weeks. (PX7;RX6).

On July 8, 2010, Dr. Bernstein reported that Petitioner was doing well in PT and ordered six more weeks of same followed by a CT scan. (PX7;RX6).

On July 29, 2010, a CT of the lumbar spine showed postoperative changes involving L4-5 and L5-S1 disc levels without imaging complications. On August 23, 2010, Dr. Bernstein reported that a CT scan showed a completely healed fusion at the L5-S1 level. He was to continue with PT and progress to work hardening. By October 4,, 2010 Petitioner had participated in 52 PT sessions at NovaCare. (PX7;RX6).

On August 30, 2010, Petitioner was seen once again by Dr. Mark Levin at the request of Respondent pursuant to §12 of the Act. Dr. Levin reported that since his last visit in August of 2009 Petitioner had undergone a myelogram, post-myelogram CT, and surgery for an anterior lumbar fusion at L5/S1 with an artificial lumbar disk replacement at L4/5 on February 24, 2010. He was currently in physical therapy three times per week. He rated his current pain at 2-3/10 and 6-7/10 at times. Dr. Levin recommended that Petitioner proceed with a lumbar CT scan to confirm that the L5/S1 fusion was solid. If so, then he should proceed with a work hardening program for 4-6 weeks, followed by an FCE as he should be at MMI at that point. (RX2).

On October 14, 2009, Petitioner was advised by Dr. Bernstein that he could return to work in a modified job on October 26, 2009. (PX7;RX6).

On October 20, 2010, Petitioner had an initial work hardening evaluation at Select Physical Therapy. It was anticipated that Petitioner would return to work at the medium demand level. (PX7;RX6). On average his pain was 3 to 4 out of 10 and at worst 6-7/10. The plan was for Petitioner to participate in a program 3-5 times a week for 4 weeks. (PX7;RX6).

On November 30, 2010, Petitioner underwent a Functional Capacity Evaluation (FCE) at NovaCare which found that he demonstrated the ability to occasionally lift up to 65 lbs., floor to waist, 40 lbs, waist to shoulder, carry up to 55 lbs., push 87 lbs. of force and pull 112 lbs. of force. It also noted that he demonstrated the ability

to sit, stand and walk on a constant basis and the ability to complete all other positional tolerances on a frequent basis. (RX9).

In a letter to the adjustor dated December 13, 2010, Dr. Bernstein noted that Petitioner was "doing well", was "pleased with his results" and "has no significant residual complaints." Dr. Bernstein indicated that the aforementioned FCE was valid and that he "tested out to the medium physical demand level." Dr. Bernstein went on to state that "[b]ased on the findings of his FCE, and his good results from surgery, it is my opinion that he requires permanent restrictions consistent with the findings on the FCE. He is going to follow up with me for one year x-ray evaluation." (PX7;RX6).

Thereafter, Petitioner did not seek medical treatment from Dr. Bernstein until April 15, 2013 when he was seen in follow-up. At that time Dr. Bernstein noted that Petitioner was doing quite well but that he had some residual tingling in his legs from time to time. He had been relatively active without difficulty. He had good range of motion. X-rays showed a completely healed fusion at L5-S1 and that at the level of the disc replacement eh now has an auto-fusion with bridging bone anteriorly. An MRI was recommended to rule out any worrisome pathology. (RX6A).

On June 28, 2013, Petitioner underwent a MRI scan of the lumbosacral spine without contrast. The impression was anterior fusion at L4/5 and L5/S1. There were degenerative changes and no evidence of spinal stenosis. At L5/S1 there was no spinal or neural foraminal stenosis at that level. (RX6A).

On July 11, 2013, Petitioner returned to Dr. Bernstein in follow-up. At that time Dr. Bernstein noted that the MRI was benign and that the adjacent levels were unremarkable. He also reported that Petitioner had done well with surgery and was functioning well. Finally, Dr. Bernstein noted that "[i]n the future, this patient may have additional issues at the adjacent level requiring treatment. This is particularly true considering that his disc level has gone on to an auto-fusion." Petitioner was to follow up on an as needed basis in the future. (RX6A).

Respondent retained the Pagella Vocational firm to evaluate Petitioner's vocational prospects. Ms. Kari Seaver of the Pagella firm met with Petitioner for the first time in March of 2011 in the office of Petitioner's attorney. Following the evaluation, Ms. Seaver was of the opinion that Petitioner's physical restrictions prevented him from returning to his pre-accident job. Petitioner then began a job search under the guidance of Ms. Seaver in May of 2011. In September of 2011, Ms. Seaver recommended to Petitioner that he upgrade his CDL license to "A" Class to increase the potential job opportunities he could access. Petitioner immediately contacted his attorney to tell his attorney that he had a felony record and feared that any jobs requiring an "A" license would do an extensive background search and his criminal record would be discovered. Upon advice of his attorney, he then immediately informed Ms. Seaver of the criminal record. Ms. Seaver confirmed this in her testimony. She further testified that she had not been aware of Petitioner's felony record until he notified her in September 2011. Ms. Seaver could not recall asking Petitioner whether he had a criminal background during the initial March, 2011 interview, and her notes did not reflect that she had requested that information. Petitioner testified that he had not been asked about a criminal record during his initial interview, and that he did not volunteer the information until September of 2011, after he was asked to upgrade his CDL license. Ms. Seaver then contacted employment sources and determined that the Petitioner's past felony conviction would not be a complete bar to employment. Ms. Seaver then advised that Petitioner upgrade his license and pursue work as a truck driver.

Petitioner then attended classes and successfully took his test in order to obtain his "A" Class License in May of 2012. All during the interim period he continued to apply for jobs. Many of the job leads were provided by Ms. Seaver and many were generated by the Petitioner. Ms. Seaver required contact with at least 72 employers per month and Petitioner was in compliance. Ms. Seaver periodically verified Petitioner's compliance with the

potential employers. During the next several months, after upgrading his CDL license, Petitioner continued his job search under the guidance of Ms. Seaver.

Ms. Seaver wrote a report regarding Petitioner's job search activities approximately once per month. These reports were co-signed by Mr. Pagella. The reports, numbered one through 30, were admitted into evidence as Respondent # 8, and have been reviewed by the Arbitrator. Per the reports by Ms. Seaver, as well as her testimony, difficulties between Ms. Seaver and Petitioner began to arise in March of 2013. Ms. Seaver testified that in follow-up on one of Petitioner's job applications, a potential employer indicted that Petitioner had filled out an application which stated that Petitioner left his last job because "out on workers' compensation injury too long". Ms. Seaver testified that this was contrary to her instructions. Mr. Pagella testified that this answer was completely inappropriate and, in effect, sabotaged the job opportunity. Petitioner did not deny the statement made on the job application.

Ms. Seaver further testified that Petitioner obtained a job as a delivery driver for the Krez Group in Morton Grove, Illinois, in May of 2013, and that Petitioner "walked off" the job after part of one day. This job paid $13.00 per hour, and per Ms. Seaver's testimony, was appropriate for Petitioner. It was Ms. Seaver's opinion that Petitioner should have accepted the position. Petitioner testified the "Krez" job was well beyond his physical restrictions. He realized this only after taking a single run on the delivery truck and that was the reason he left the job.

In June of 2013, Petitioner turned down another delivery job with "Get Fresh Produce". Again, Petitioner testified that this job was beyond his physical capabilities. Again, Ms. Seaver testified that the job would have been appropriate for Petitioner and that he should have accepted the position. The job at "Get Fresh Produce" paid $13.00 per hour also.

Petitioner did accept a job and began work as a delivery driver on June 17, 2013 with the "Hospice" company. This job consisted of delivering wheel chairs, oxygen tanks, and hospital beds on wheels to various locations. Ms. Seaver testified that the job was appropriate for Petitioner as far as pay, but seemed to be in excess of his physical restrictions. Petitioner testified that there were no items that he had to deliver which were in excess of his capabilities which were not on wheels.

Copies of Petitioner's job logs which had been submitted to Ms. Seaver on an ongoing basis were admitted as Petitioner's #23. Petitioner testified that many, if not most of the jobs he applied for paid $13.00 per hour or less. The job logs were originated from leads generated from both Petitioner and Ms. Seaver.

It should be noted that Petitioner admitted on cross examination, that he has posted to on line social sites that he is the owner of a non-existent construction company. The Petitioner admitted that these postings were untrue.

The parties further stipulated that if Petitioner had been able to continue in his pre-accident occupation as a waste hauler, he would currently earn $30.97 per hour or $1,238.80 per week in the full performance of his former duties.

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

Petitioner testified that he sustained a work injury on August 25, 2008 when he was pinned up against a dumpster weighing about 3,500 pounds. As a result, Petitioner injured his left side and lower back. Petitioner was initially seen at Highland Park Hospital on the date of accident and received a course of medical treatment

until he returned to modified work on September 15, 2008 and his full duty job on November 12, 2008. (See decision in 08 WC 44247)

Thereafter, on December 31, 2008, Petitioner experienced sharp pains down his back after lifting approximately 75 boxes weighing between 40 to 50 pounds. Petitioner did not return to work following this injury until he accepted a job with Hospice Service on June 17, 2013.

Petitioner denied a prior history of back pain or medical treatment for same leading up to the undisputed accident on August 25, 2008 work injury and suffered no additional injuries leading up to the date of the second accident on December 31, 2008. The medical histories subsequent to the most recent accident on December 31, 2008 corroborate Petitioner's claim of increased back pain following the lifting of numerous boxes on the date in question, and reflect ongoing complaints and treatment for his lower back thereafter. Following the recommended course of epidural steroid injections and physical therapy, Petitioner proceeded with an anterior lumbar fusion at L5/S1 with an artificial lumbar disk replacement at L4/5 on February 24, 2010. There is no evidence that Petitioner sustained any other accidents involving his low back subsequent to December 31, 2008.

Therefore, based on the above, and the record taken as a whole, the Arbitrator finds that based on a chain of events theory Petitioner's current condition of ill-being relative to his lower back is causally related to the undisputed accident on December 31, 2008.

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:

Medical expenses were originally at issue in both claims at the commencement of trial. However, subsequent to the close of proofs, the parties agreed and stipulated that "... all medical charges for reasonable and necessary medical services rendered to Petitioner as a result of his injuries have been paid by Respondent. The issue of medical bill payment is hereby withdrawn." (Arb.Ex.#3).

WITH RESPECT TO ISSUE (K), WHAT AMOUNT OF COMPENSATION IS DUE FOR TEMPORARY TOTAL DISABILITY, TEMPORARY PARTIAL DISABILITY AND/OR MAINTENANCE. THE ARBITRATOR FINDS AS FOLLOWS:

The Arbitrator finds that Respondent shall pay to the Petitioner the sum of $685.33 per week for a total period of 101 weeks, that is from January 1, 2009 through October 25, 2009, when Petitioner was released to a light duty "leaf blower" job (42 weeks) and from October 30, 2009 through December 13, 2010 (58-4/7 weeks), when Dr. Bernstein released Petitioner to permanent restricted duty based upon Petitioner's valid FCE of November 30, 2010, for a period of 100-4/7 weeks. In so finding, the Arbitrator relies upon the valid FCE from NovaCare (PX13) and the record of Dr. Bernstein (PX7).

Furthermore, the Arbitrator finds that Respondent shall pay to the Petitioner the sum of $685.33 per week for maintenance, that is from December 14, 2010, the day after Dr. Bernstein pronounced Petitioner's restrictions permanent, through June 16, 2013, the day prior to Petitioner beginning his new employment, for a period of 130-6/7 wks. In so finding, the Arbitrator relies upon the testimony of Petitioner and Ms. Seaver, as well as the monthly reports of Ms. Seaver. (RX8). The evidence shows that Petitioner was in substantial compliance with his job search guidelines until at least March of 2013. At this time, Petitioner made an inappropriate response on a job application which may have caused him to be denied a job. The records also indicate that Petitioner

turned down two jobs in May and June of 2013, testifying that the jobs were beyond his restrictions. Though Petitioner's conduct in this regard was certainly questionable, it did not rise to the level of non-compliance, especially when viewed in context of Petitioner's entire job search, which encompasses over 1,000 contacts (PX23) and in light of the first 25 monthly reports from Ms. Seaver that show that Petitioner was in compliance with the job search guide lines. (RX8).

Finally, the Arbitrator notes that Petitioner's failure to disclose his past felony convictions during his initial vocational interview does not rise to the level of non-compliance. Ms. Seaver testified that she could not recall asking Petitioner whether he had a criminal record, and her notes did not reflect that she had asked. Petitioner testified that he was not asked about this. The Arbitrator further notes that upon disclosure of Petitioner's past felony convictions, Petitioner's job search plan was not altered.

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

Petitioner has requested a wage differential award pursuant to §8(d)1 of the Act.

The record shows that Petitioner is unable to return to his pre-accident occupation as a waste hauler/driver, based on the FCE and opinion of Dr. Bernstein. Specifically, the FCE performed on November 30, 2010 demonstrated the ability to occasionally lift up to 65 lbs., floor to waist, 40 lbs, waist to shoulder, carry up to 55 lbs., push 87 lbs. of force and pull 112 lbs. of force. It also noted that he demonstrated the ability to sit, stand and walk on a constant basis and the ability to complete all other positional tolerances on a frequent basis. (RX9). Thereafter, in a letter to the adjustor dated December 13, 2010, Dr. Bernstein noted that the aforementioned FCE was valid and that he "tested out to the medium physical demand level." Dr. Bernstein went on to state that "[b]ased on the findings of his FCE, and his good results from surgery, it is my opinion that he requires permanent restrictions consistent with the findings on the FCE." (PX7;RX6).

The parties stipulated that Petitioner could currently earn $30.97 per hour or $1,238.80 per week in the full performance of his previous duties. Currently, Petitioner earns $13.00 per hour (or $520.00 per 40 hour workweek). The Arbitrator notes that while Petitioner admittedly turned down two other jobs, which Ms. Seaver felt were appropriate (and which Petitioner did not think were within his restrictions), both jobs appear to have paid approximately $13.00 per hour, or the amount Petitioner is currently earning in his present job.

Therefore, Petitioner's weekly payment from Respondent is calculated as follows:

Current rate of pay for previous job.....	$1,238.80/week
Current earnings in present job.....	$ 520.00/week
Difference	$ 718.80/week
§8(d)1 payment ($718.80 X 2/3).....	$ 479.20/week

Based on the above, and the record taken as a whole, the Arbitrator finds that Petitioner is entitled to a wage differential award pursuant to §8(d)1 of the Act in the amount of $479.20 per week commencing June 18, 2013 and continuing for the duration of his disability. Along these lines, the Arbitrator finds that the injuries sustained caused permanent partial disability resulting in a partial loss of earnings that Petitioner would have been able to earn in the full performance of his pre-accident occupation, as of the date of the hearing.

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

Petitioner has requested additional compensation pursuant to §19(k) and §19(l) as well as attorneys' fees pursuant to §16 of the Act. However, the Arbitrator finds that legitimate issues of law and fact existed between the parties, particularly with respect to the sufficiency of Petitioner's cooperation in vocational rehabilitation efforts, and that as a result Respondent's conduct in the defense of this claim was neither unreasonable nor vexatious under the circumstances. As a result, Petitioner's claim for penalties is hereby denied.

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Courtney Bryson,

Petitioner,

14IWCC0786

vs.

NO: 11 WC 30426

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed December 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: SEP 12 2014

David L. Gore

DLG/gaf
O: 9/4/14
45

Stephen Mathis

Mario Basurto

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

BRYSON, COURTNEY
Employee/Petitioner

Case# **11WC030426**

14IWCC0786

CITY OF CHICAGO
Employer/Respondent

On 12/10/2013, 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 0.10% 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
DAVID HUBER
111 W WASHINGTON ST SUITE 1425
CHICAGO, IL 60602

0113 CITY OF CHICAGO LAW DEPT
MICHAEL GENTITHES
30 N LASALLE ST 8TH FL
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

ARBITRATION DECISION

14IWCC0786

COURTNEY BRYSON
Employee/Petitioner

Case #11 WC 30426

v.

CITY OF CHICAGO
Employer/Respondent

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable Robert Williams, arbitrator of the Workers' Compensation Commission, in the city of Chicago, on November 20, 2012. 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 April 12, 2011, the respondent was operating under and subject to the provisions of the Act.
- On this date, an employee-employer relationship existed between the petitioner and respondent.
- Timely notice of this accident was given to the respondent.
- In the year preceding the injury, the petitioner earned $64,327.12; the average weekly wage was $1,237.06.
- At the time of injury, the petitioner was 45 years of age, *married* with no children under 18.

ORDER:

- The petitioner's claim for benefits is denied.

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

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

Robert E. Williams

Signature of Arbitrator

December 10, 2013

Date

DEC 10 2013

FINDINGS OF FACTS:

On April 12, 2011, the petitioner, a sanitation laborer, performed her work duties of garbage removal. On April 13th, the petitioner sought treatment at MercyWorks and reported feeling an insect bite on her right posterior neck behind her ear. Two small elevated, 0.5 to 1 cm diameter skin lesions with no tenderness were noted.

The petitioner sought treatment with Dr. Emily Georgitis at the University of Chicago Medical Center on April 26th and reported feeling that she was stung by a sort of bug but did not feel a bug on her neck. She reported that later at her home, she noticed some large bumps that were oozing and productive of pus. Dr. Georgitis' assessment was skin lesions possibly due to furuncles related more to folliculitis than to an actual bite. Dr. Christopher Shea's at the University of Chicago Medical Center opinion on May 10th was neoplasm of uncertain behavior on the right post auricular area. The lesions were biopsied on May 11th and the dermatopathology report on May 13th indicated an inflamed follicular cyst, infundibular type. The petitioner's last follow-up was on September 13th. She testified that the only treatment she personally performs on this lesion is applying ice to the area occasionally during the summer.

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 she sustained an accident on April 12, 2011, arising out of and in the course of her employment with the respondent. The petitioner did not sufficiently establish that the lesions on her neck were due to an insect bite or sting. She did not know what caused the lesions on her neck and did not find an insect nor did she establish when the second

lesion occurred. Further, the medical evidence establishes a condition of furuncles due to folliculitis and not insect bites. Also, the petitioner did not establish that she was exposed to an increased risk of insect bite or sting due to her employment duties. The petitioner's claim for benefits is denied.

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Tina Jackson,

Petitioner,

14IWCC0787

vs.

NO: 10 WC 3941
10 WC 3942
10 WC 9918
10 WC 9919
10 WC 9920

Illinois Department of Human Services,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issue of the Arbitrator's refusal to reinstate the case, and being advised of the facts and law, affirms and adopts the Order of the Arbitrator.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Order of the Arbitrator dated December 30, 2013 is hereby affirmed and adopted.

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

DATED: SEP 12 2014

David L. Gore

Stephen Mathis

Mario Basurto

DLG/gaf
O: 9/4/14
45

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

Gregory Stavros,

Petitioner,

vs.

County of Cook,

Respondent.

14IWCC0788

NO: 13 WC 29745

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, temporary total disability, medical expenses, prospective medical expenses, and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed April 3, 2014 is hereby affirmed and adopted.

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

The party commencing the 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 12 2014

David L. Gore

Stephen Mathis

Mario Basurto

DLG/gaf
O: 9/4/14
45

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

STAVRES, GREGORY
Employee/Petitioner

Case# **13WC029745**

14IWCC0788

COUNTY OF COOK
Employer/Respondent

On 4/3/2014, 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:

0491 SOSTRIN AND SOSTRIN PC
BARRY LEVIN
33 W MONROE ST SUITE 1510
CHICAGO, IL 60603

0132 COOK COUNTY STATE'S ATTORNEY
KEVIN G WALLACH ASA
500 RICHARD J DALEY CENTER
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)

14IWCC0788

Gregory Stavros
Employee/Petitioner

v.

County of Cook
Employer/Respondent

Case # 13 WC 29745

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 **March 6, 2014**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

14IWCC0788

FINDINGS

On the date of accident, **8/20/13**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

ORDER

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

3/31/2014
Date

ICArbDec19(b)

APR 3 - 2014

FINDINGS OF FACT AND CONCLUSIONS OF LAW

The instant claim stems from a workplace altercation on August 20, 2013. Petitioner contends his claim is compensable, while Respondent contends the claim is barred because Petitioner was the aggressor.

Petitioner, a crew chief driver for Respondent's highway department, testified that his position was supervisory, akin to a laborer foreman. He worked for Respondent for 28 years. On August 20, 2013, Petitioner's work hours were 7 a.m. to 3:30 p.m. At approximately 2:30 p.m., Petitioner returned to the work yard to prepare equipment for the next day and speak with his supervisor, Marc Tudor. While Petitioner was speaking with Mr. Tudor in his office, Rick Walker, a driver on a different crew, came in. Petitioner stated that Mr. Walker "started yelling and accusing [him] of being a squealer on guys that are not working" and calling him "a no good son of a b****." Petitioner, in turn, called Mr. Walker a liar. According to Petitioner, Mr. Walker kept moving closer and yelling the same thing over and over. Petitioner got out of the chair and headed for the door to leave. While he was in the doorway, Mr. Walker grabbed his shirt in the chest area with both hands, dragged him into "that second office" and threw him against a wall. Petitioner's head and back struck the wall. Petitioner "got up off the floor and pushed [Mr. Walker] back." Petitioner then told Mr. Walker not to grab or push him again and tried to leave. However, Mr. Walker grabbed him again and "threw [him] into the next wall." Petitioner's neck and head struck the radios on the wall, and some of the radios fell on the floor. Petitioner fell down, and a small table broke his fall. As Petitioner was struggling to get up, Mr. Walker "threw [him] into the next office." Petitioner's low back struck a shelf in the third office. Mr. Walker then pinned Petitioner and threatened him with more violence if he continued talking. Finally, Mr. Walker let Petitioner go, and Petitioner walked out the door.

Petitioner was asked whether Mr. Tudor was present during the altercation. Petitioner stated the only thing he remembered was Mr. Tudor telling Mr. Walker to stop and leave him alone. According to Petitioner, no one else witnessed the incident. Petitioner stated that Mr. Walker had attacked him three or four years earlier, pushing him over a barrel.

Petitioner further testified that his neck and back hurt. He reported the incident to Respondent and the sheriff's police, called his doctor, and went home. The following morning, Petitioner had difficulty getting up because of severe pain in his neck and low back. He also had numbness in the last two fingers of the left hand and pain in his leg. Petitioner called in sick. On August 23, 2013, Petitioner saw Dr. Stamelos, an orthopedic surgeon with whom he had previously treated for injuries to the neck and low back. Petitioner stated that as a result of the altercation, his pain level increased from 2/10 to 10/10.

The medical records from Dr. Stamelos do not contain an original clinical note from August 23, 2013. Instead, the records contain a report dated August 23, 2013, addressed to Michael Drew, stating:

> "History: While at work, [the patient] was involved in an altercation with another employee on August 23, 2013 [*sic*]. In the ensuing days he was in severe

pain and discomfort and he sought medical attention with me at which time I evaluated him.

He had a history of both cervical and lumbar spine surgery. His pain was so severe and his x-rays did not show any significant pathology to verify the pain. So, MRIs were ordered according to the standard of care.

The MRI results show not only severe discogenic conditions, but impending worsening conditions due to what seemed to be discs at risk for further herniation or further damage since the patient's altercation had caused him considerable pain. He was thrown against walls and sidewalks resulting in blunt trauma.

Today, on August 23, 2013, the MRI results were so severe that the recommendation of excuse from work and treatments with injection therapy, medication, physical therapy and observation would be appropriate treatment.

In conclusion, please excuse [the patient] from work from August 23, 2013 until further notice. He will be sent back to work when his condition is improved and there is more stability in his cervical and lumbar spine."

In an addendum, Dr. Stamelos corrected the date of accident to August 20, 2013. The medical records further show that Petitioner complained of persistent, severe pain and stiffness, and underwent physical therapy and cervical and lumbar injections. Although Dr. Stamelos repeatedly stated the altercation aggravated preexisting conditions of the cervical and lumbar spine, he was opaque as to the nature of the pathology/aggravation and whether the MRIs showed any increased or new pathology. An MRI of the cervical spine, performed August 23, 2013, showed postoperative changes at C6-C7, a 3 mm posterior central disc protrusion at C7-T1, and cervical spondylosis. An MRI of the lumbar spine, also performed August 23, 2013, showed postoperative changes at L3-L4 and L4-L5, "with no significant interval changes *** compared with the previous study." Dr. Stamelos variously diagnosed "cervical syndrome," "[s]evere discogenic pain," "displaced lumbar discs," "cervical disc problems" and "lumbar disc problems," prescribed pain medication, and kept Petitioner off work because of his subjective complaints. Dr. Stamelos felt that surgery was not indicated.

Regarding his current condition, Petitioner testified the symptoms in his fingers had resolved. He rated his neck pain a 7/10 and back pain a 10/10, and also complained of severe pain in the hip. Petitioner testified the pain is constant and prevents him from doing anything.

On cross-examination, Petitioner testified that to get to Mr. Tudor's office, one had to pass through the third office and the second office (the radio room). Mr. Tudor's office did not have direct access to the hallway. During the altercation, a coworker, Ken Demann was in the third office, operating the base station radio. No one witnessed the incident, except Mr. Tudor and Mr. Demann. Petitioner denied that Mike Mungovan witnessed the incident.

Mr. Tudor, district engineer for the highway department, testified that at approximately 2:30 or 2:45 p.m. on August 20, 2013, he was speaking with Petitioner about the work that needed to be done in the fall. At one point, Mr. Walker came into Mr. Tudor's office and teased Petitioner about "snitching." Petitioner became defensive and annoyed, but Mr. Walker persisted in calling him a snitch. Petitioner then "walked towards" Mr. Walker, saying he was not a snitch, and Mr. Walker "defended himself," meaning the two men almost bumped chests, but did not lay hands on each other. Rather, they were speaking loudly and swearing at each other. Mr. Tudor asked them to stop. Then the phone rang, and the two men walked into the second office (the radio room). Mr. Tudor heard them speak loudly for a minute or so while he was talking on the phone about an emergency situation he needed to handle. After Mr. Tudor finished the phone call, which took approximately five minutes, he went outside and saw Mr. Walker sitting on a picnic bench. He did not see Petitioner, and went inside. At approximately 3:25 p.m., Mr. Tudor handed sign out sheets to the workers, and saw Petitioner and Mr. Walker sign out at the same time. Petitioner looked angry, but did not say anything. The two men then left for the day.

On cross-examination, Mr. Tudor stated that he "did not answer the phone call until [Petitioner and Mr. Walker] left [his] office, the office next to [him], and they walked into the hallway. [He] didn't touch the phone until they left." During that time, he could see "100 percent" into the second office. Both men were close to each other and using profane language. Mr. Tudor did not see what happened in the third office. Mr. Tudor was again questioned about what had transpired in his office:

> "Q. [W]hen [Petitioner] got up from his chair, he was walking toward the exit. Is that true?
>
> A. He was walking towards Walker, and Walker was at the exit.
>
> ***
>
> Q. When [Petitioner] got out of his chair, he walked toward the doorway. Is that true?
>
> A. I can give you one simple answer. It will be clear.
>
> Q. Did he walk toward the doorway?
>
> A. No, he walked towards Walker.
>
> Q. And was Walker in the doorway?
>
> A. Walker was in the doorway, yes."

On redirect examination, Mr. Tudor testified that after Petitioner and Mr. Walker had left his office, he observed them for approximately 20 to 25 seconds in the second office to make sure they stopped arguing "because [he] had to answer the phone call." During that time period,

the two men continued to argue, and Mr. Tudor firmly told them to stop. The two men then left the second office, and Mr. Tudor saw them turn toward the hallway while they were walking through the third office.

Mr. Tudor further testified it was not unusual for the workers to use profane language in the yard. Mr. Tudor affirmed that during the exchange in his office, Petitioner became offended and walked toward Mr. Walker. On re-cross examination, Mr. Tudor testified that he told Mr. Walker not to call Petitioner a snitch. Mr. Walker called Petitioner a snitch one more time and stopped.

Richard Walker, a motor vehicle driver, testified that he walked into Mr. Tudor's office between 2:30 and 3 p.m., and saw Petitioner there. Mr. Walker stated he did not recall the conversation, other than they were "laughing and joking for a little while." At one point, Petitioner got up and left Mr. Tudor's office. Mr. Walker then sat down and talked to Mr. Tudor for a while. Petitioner was "still in the general vicinity." The three of them were "laughing a little bit." Mr. Walker again stated he did not recall the subject of the conversation. He continued: "[Petitioner] had walked out and then came back in and wasn't happy about whatever and started a disagreement." Mr. Walker and Petitioner left Mr. Tudor's office and "continued [their] discussion." "[A]n altercation between the two of [them] ensued, which [Petitioner] came at [Mr. Walker] with his body, *** his body and his head." Mr. Walker stated he "flicked" Petitioner off with his body, clarifying that they bumped chests two or three times. He denied laying hands on Petitioner or pushing him into anything. After that, they disengaged and went outside through different doorways. On cross-examination, Mr. Walker vehemently denied calling Petitioner a snitch. Mr. Walker acknowledged that he might have sworn at Petitioner. Mr. Walker denied having an altercation with Petitioner several years earlier. Mr. Walker admitted he was suspended for 10 days as a result of the incident on August 20, 2013.

Kenneth Demann, base radio operator, testified that he was seated at his desk and performing dispatching duties when he heard "some yelling in the other room, some arguing, which is normal." When Petitioner and Mr. Walker came through the door, Mr. Demann "spun around, and *** saw both of them embraced with each other, yelling at each other. And they got to the other end of the room. And then they just stopped and let go. And both of them went their own way out the door." Mr. Demann denied seeing Mr. Walker push Petitioner into any objects or hearing a crashing noise indicating someone falling to the floor or striking a wall. On cross-examination, Mr. Demann testified the base radio was a headphone free device. During the incident, Mr. Demann was paying attention to answering calls and did not pay much attention to the altercation in the other room. He did hear Mr. Walker and Petitioner curse at each other, but not Mr. Walker calling Petitioner a snitch. Mr. Demann clarified that when Petitioner and Mr. Walker came through the door, they had their hands on each other's shirts and walked holding each other in that manner for approximately five feet before disengaging.

Michael Mungovan testified that at approximately 3 p.m. he was hanging up a radio in the middle office, when Petitioner came out of Mr. Tudor's office. He was aggravated and speaking loudly (although he always spoke loudly) about someone accusing him of turning people in. According to Mr. Mungovan, Mr. Walker was sitting at or leaning against a desk in the middle office. Petitioner and Mr. Walker exchanged words. Petitioner then walked up to

Mr. Walker. Mr. Walker stood up, and he and Petitioner bumped chests. At that point, Mr. Mungovan hung up his radio and left. On cross-examination, Mr. Mungovan testified that he considered Mr. Walker a "[w]ork friend," but did not socialize with him outside of work. Mr. Mungovan denied hearing the two men swear at each other, explaining that he only heard them talking loudly to each other.

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:

In Franklin v. Industrial Comm'n, 211 Ill. 2d 272, 279-80 (2004), the supreme court explained:

> "[F]ights arising out of disputes concerning the employer's work are risks incidental to the employment, and resulting injuries are compensable. Fischer v. Industrial Comm'n, 408 Ill. 115, 119 (1951). However, injuries to the aggressor in such a fight are not compensable. Container Corp. of America v. Industrial Comm'n, 401 Ill. 129, 133 (1948). We refer to the rule that an aggressor's injuries are not compensable as the 'aggressor defense.' "

The conduct of the parties must be examined in light of the totality of the circumstances. Franklin, 211 Ill. 2d at 281-82. Importantly,

> "A typical fight involving two employees has only one aggressor. When one employee escalates the dispute, he changes the circumstances and typically makes it reasonable for the other employee to respond in kind. This is not to condone answering violence with violence. It is to acknowledge that a claimant's conduct must be judged in light of the circumstances, and the circumstances include the conduct of others." Franklin, 211 Ill. 2d at 284.

It is an error to deny compensation on the basis that both the claimant and the other employee were aggressors. Rather, the Arbitrator must decide "whether claimant was *the* aggressor." (Emphasis in original.) Franklin, 211 Ill. 2d at 284.

Having carefully considered the entire record and viewed the demeanor of the witnesses, the Arbitrator finds only Mr. Demann's testimony credible. Regarding the remainder of the testimony, the Arbitrator finds that Petitioner and Mr. Walker did not truthfully and accurately describe the incident, and each blamed the other for being the aggressor. Mr. Walker was not candid about verbally provoking Petitioner. However, Mr. Walker's testimony as to the physical aspects of the altercation is more plausible than Petitioner's and more consistent with the rest of the record. The Arbitrator further finds Mr. Tudor's testimony inconsistent, defensive and downplaying the incident. Mr. Mungovan was reluctant to testify and also downplayed the incident.

The Arbitrator notes Petitioner and Mr. Walker are of similar height and build, although Petitioner seems to have a more powerful build. On the other hand, Mr. Walker is younger. The

weight of the evidence shows the two men bumped chests and grabbed each other's shirts before disengaging and leaving. The Arbitrator notes that on the stand, Petitioner was the least credible witness and had the most aggressive demeanor. Having carefully considered the entire record, the Arbitrator finds Petitioner was the aggressor. Accordingly, any injuries he might have sustained as a result of the altercation are not compensable.

In support of the Arbitrator's decision regarding (F), is Petitioner's current condition of ill-being causally related to the injury, the Arbitrator finds as follows:

Even had the Arbitrator found Petitioner's claim compensable in theory, the Arbitrator would still find Petitioner's alleged injuries are not causally connected to the altercation. As noted, the weight of the evidence shows Petitioner and Mr. Walker bumped chests and grabbed each other's shirts before disengaging and leaving. Petitioner did not seek emergency treatment on August 20, August 21 or August 22, 2013. Instead, Petitioner saw Dr. Stamelos on August 23, 2013, complaining of severe pain, which he attributed to the altercation. The medical records from Dr. Stamelos are exceedingly vague regarding Petitioner's diagnosis, while at the same time painstakingly connecting the symptoms to the altercation. Dr. Stamelos did not comment on Petitioner's obvious symptom magnification. The Arbitrator is unpersuaded the altercation caused any injuries to Petitioner.

For the foregoing reasons, the Arbitrator awards no 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

Charles Williams,

Petitioner,

14IWCC0789

vs.

NO: 10 WC 07221

City of Chicago,

Respondent.

DECISION AND OPINION ON REVIEW

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

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

14IWCC0789

The party commencing the 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 1 2 2014

David L. Gore

Stephen Mathis

Mario Basurto

DLG/gaf
O: 9/4/14
45

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

WILLIAMS, CHARLES
Employee/Petitioner

Case# **10WC007221**

09WC015239
10WC007222

CITY OF CHICAGO
Employer/Respondent

14IWCC0789

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:

0147 CULLEN HASKINS NICHOLSON ET AL
JOHN POWERS
10 S LASALLE ST SUITE 1250
CHICAGO, IL 60603

0010 CITY OF CHICAGO
NANCY J SHEPARD
30 N LASALLE ST SUITE 800
CHICAGO, IL 60602

STATE OF ILLINOIS)
)SS.
COUNTY OF Cook)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

14IWCC0789

Charles Williams
Employee/Petitioner

v.

City of Chicago
Employer/Respondent

Case # 10 WC 07221

Consolidated cases: 09 WC 15239 and 10 WC 07222

An *Application for Adjustment 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 **5/6/13**. 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 ___

14IWCC0789

FINDINGS

On **6/5/09**, 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 **$60902.40**; the average weekly wage was **$1171.20**.

On the date of accident, Petitioner was **49** years of age, ***single*** with **0** dependent children.

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

Respondent ***has*** 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 **$664.72**/week for **2.5** weeks, because the injuries sustained caused the **.50%** loss of the person as a whole, as provided in Section 8(d)2 of the Act.

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

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

Brian T. Cronin

Signature of Arbitrator

December 13, 2013
Date

DEC 16 2013

Charles Williams v. City of Chicago
09 WC 15239
10 WC 07221
10 WC 07222

14IWCC0789

STATEMENT OF FACTS

Mr. Charles Williams, Petitioner, is an employee of the City of Chicago, Respondent. He works as a laborer/refuse collector in the Department of Streets and Sanitation. Petitioner testified that his job duties include picking up trash cans and dumpsters, as well as picking up items left in alleys such as dressers, tables and beds.

Claim 09 WC 15239

On December 11, 2008, it is undisputed that Petitioner suffered an accident that arose out of and in the course of his employment with Respondent. He testified that he was working in an alley loading garbage cans when one of the garbage cans flew off the "flipper" and struck him in the face. He testified that he noticed pain and felt dizzy immediately after the impact.

Petitioner testified that he went to the emergency room at Mercy Hospital where he received stitches above his right eye. That same day, he followed up with his Primary Care Physician at Advocate Medical Group, Dr. Aruna Kandula. (Px. 1). At that visit, he gave a history of being struck in the facial area by a garbage can and suffering swelling and bleeding. He had an abrasion to the right side of his face and a laceration of his right eyelid. He reported no loss of consciousness and no blurred vision. He complained of a headache at that time. He had no new complaints of back pain or radicular leg pain. The Progress Notes list the following active problems: benign essential hypertension, lower back sprain and nicotine dependence. (Px. 1).

Petitioner went to Mercyworks on December 12, 2008, where he gave a similar history of accident. He was diagnosed with a contusion and abrasions to the right forehead, contusion to the right periorbital area and sutured laceration to the right infraorbital area. He was prescribed Ibuprofen and Bacitracin. He was taken off work from 12/12-12/13 and asked to return to the clinic on December 16, 2008. There was no complaint of back pain at this visit.

Petitioner followed up with Mercyworks on December 15, 2008. At that time, he indicated that he had also injured his lower back in the accident because of "the pressure of the garbage can from his head to his lumbar spine." He also had complaints of pain occasionally radiating to both legs. He had complaints of dizziness. (Px. 2) As he complained of dizziness, he was referred to the emergency room. Petitioner testified that he went to Mercy Hospital where he had a CT scan of his brain. The images revealed no acute intracranial process or hemorrhage. (Px. 2). Petitioner followed up with Mercyworks on December 17, 2008, where he continued to have complaints of lower

back pain. He was referred to physical therapy, which he underwent from December 31, 2008 through January 14, 2009.

At his Mercyworks follow-up visit on December 30, 2008, he was referred to the Mercy Eye Center for his continued dizziness and blurred vision. He was seen by Dr. Rubin at the Eye Center on January 26, 2009. At that time, he was diagnosed with an ocular contusion that was healing. He was told he could return to work with this condition. He did return to full-duty work on January 27, 2009.

On December 8, 2008, which was three days prior to his accident, Petitioner saw his Primary Care Physician, Dr. Kandula, with complaints of lower back pain. At that visit, he indicated he pulled his back and had not been to work. He was given a Toradol injection at this visit and a course of physical therapy was recommended. He was taken off work for two days, (Px. 1). There is no evidence he underwent any PT prior to his December 11, 2008 accident.

Petitioner testified on cross-examination that he had been taking Tramadol for back pain before the December 11, 2008 office visit. He testified that he felt sharp pain in his low back when he visited D. Kandula on December 8, 2008.

Petitioner testified that the lower back pain he experienced after December 11, 2008 was different than the pain he experienced when he went to see Dr. Kandula on December 8, 2008. He further testified that he was still having pain when he returned to work on January 27, 2009 and continued to have headaches. He did not follow up with a physician for either condition at that time.

Claim 10 WC 7221

Petitioner sustained an undisputed accidental injury to his lower back on June 5, 2009. He testified that he was pulling a cart and developed lower back pain. He was seen at Mercyworks on that same day, June 5, 2009. He denied any radiating pain. The doctor noted tenderness from L4 to S1. He was diagnosed with a lumbar strain, pre-existing secondary scoliosis and released to return to full-duty work, effective June 8, 2009. He did not follow up with any doctor with regard to this injury.

Claim 10 WC 7222

Petitioner testified that on January 8, 2010, he suffered a third injury to his lower back. At the arbitration hearing, it appeared that, initially, he could not remember the incident but after reviewing the incident report that he signed on January 8, 2010 (Px.11), he stated: "They got it wrong." He testified: "It was supposed to be a silver table that I picked up." He felt that the table weighed over 100 pounds and was four feet wide. He was lifting this table with a co-worker when the co-worker dropped the table, which forced Petitioner to throw it into the truck. He felt a snap in his lower back. He testified that he could not walk, he could not stand up and he could not sit down. Petitioner testified that prior to this incident he was fine and working full duty.

Petitioner went to Mercyworks on January 8, 2010 and gave a history of lifting a table that was approximately fifty pounds. At that time he denied any leg pain or numbness. He had a significant history of back scoliosis with a short right leg. He was found to have tenderness at levels L4 to S1 with the left greater than right. He did have some limited forward bending but negative straight leg raising. He was diagnosed with a lumbar strain. The treatment plan consisted of ice, and prescriptions for both Ibuprofen and Flexeril. He was told to come back on January 15, 2010 or sooner, if needed. He was released to return to work full duty as of January 11, 2010. (Px. 6).

Petitioner testified that he followed up with his Primary Care Physician on January 13, 2010. At that visit, his chief complaint was for lower back pain due to work-related injury. The notes say he had not been to work because he pulled his back. On exam, he was found to be stable with 5/5 strength and full range of motion. He had no swelling, no point tenderness, no crepitations nor any contractures. He was diagnosed with a lower back strain. He was told to apply ice and take medications as needed. He was advised to engage in "[a]ctivity as tolerated", but was not taken off work at that time. He was given a prescription for Tramadol. He was advised that if his condition did not improve, he was to follow up in two weeks. (Px. 7).

Petitioner did not attend the Mercyworks follow-up appointment on January 15, 2010. (Px. 6).

Petitioner did follow up with Mercyworks on January 21, 2010. He indicated that he had "stayed in bed all week." At that time, Steven Anderson, D.O., recommended physical therapy and released him to limited-duty, effective January 22, 2010. (Px 6). He attended physical therapy for four visits through February 3, 2010. On February 10, 2010, Petitioner was released from Mercyworks and returned to full-duty work due to Respondent's denial of the claim.

Petitioner did not follow up with his Primary Care Physician until February 23, 2010. He told his doctor that he had been off work since January 8, 2010. He came in for paperwork. On exam, there was tenderness to palpation. There was no swelling or muscle spasm. His PCP diagnosed him with a lower back sprain. She recommended continuation of physical therapy and pain meds. She felt if he did not improve in the next two weeks, she would consider an orthopedic referral. He was instructed to return to the office in ten days.

Petitioner did not return to his Primary Care Physician until April 9, 2010. At that visit, he indicated he needed a release back to work in ten days. The records indicate that he had not been back to work since January 8, 2010. His primary care doctor noted that he had not sought further management with a physical therapist or an orthopedic specialist. Petitioner returned to work on April 10, 2010.

Petitioner testified that upon returning to work he was still in pain but he had "no choice" but to return. He testified that he continued to have aching, could not sleep or bend and was in severe pain. He testified that he continues to have pain in his left leg. He

works full duty at this time in the same position he was in prior to the accident. He testified that he takes Ibuprofen for his pain. He no longer takes Tramadol. He testified on cross-examination that he takes Ibuprofen every day for this pain, and that he started this daily regimen approximately three weeks ago. He further testified that he needs a prescription to get this Ibuprofen.

CONCLUSIONS OF LAW

As to issue (C) , "Did an accident occur that arose out of and in the course of Petitioner's employment with Respondent?", the Arbitrator finds:

In claims # 09 WC 15239 and #10 WC 07221, the parties have stipulated that an accident occurred on the date in question.

In regard to claim #10 WC 07222, the Arbitrator finds that an accident did occur on January 8, 2010. Petitioner testified as to the nature of the accident. Petitioner offered the accident report into evidence, which shows that he completed the accident report on that date. Petitioner provided a consistent history of accident to Mercyworks that documented such accident occurred.

As to issue (E), "Was timely notice of the accident given to Respondent?", the Arbitrator finds:

In claims #09 WC 15239 and #10 WC 07221, the parties stipulated that Petitioner gave timely notice to Respondent.

In claim #10 WC 07222, the Arbitrator finds that notice was timely given as the accident report, which was admitted into evidence, documents that it was completed on the day of the occurrence and that Petitioner was sent to Mercyworks on that date. Despite the existence of such accident report, which indicates that Petitioner reported the accident to his supervisor ten minutes after it occurred, Respondent placed notice in dispute.

As to issue (F), "Is the Petitioner's current condition of ill-being causally related to the injury?", the Arbitrator finds:

In regard to claim number #09 WC 15239, Petitioner claims that he suffered an injury to his head, facial area and eye, as well as to his lower back. In regard to his head/face injury, there is no evidence of any prior injury to this area and no evidence of a subsequent injury occurred to this area. His accident is straightforward and he had consistent complaints with regard to this area from the date of the accident through the course of his treatment. Therefore, with regard to his head/face and eye injury, his current condition of ill-being is causally related to this injury.

In regard to his claim of a low back injury in this matter, it is clear that Petitioner had a non-work-related low back problem just three days before this date of accident for which he received an injection and was advised to take two days off work.

In the December 11, 2008 Progress Notes of Advocate Medical Group, his chief complaint consisted an abrasion to the face, a laceration of the eyelid and a headache. There was no complaint of a loss of consciousness or of a fall. Although the Progress Notes list his active problems as benign essential hypertension, lower back sprain and nicotine dependence, Petitioner voiced no new complaints of back pain and no complaints of radicular leg pain.

In the December 12, 2008 chart notes of Mercyworks, there were no documented complaints of low back pain.

However, when Petitioner visited Mercyworks on December 15, 2008, Dr. Diadula recorded, *inter alia*, the following: "He revealed that during the incident his lower back was also injured because of the pressure of the garbage cart from his head to his lumbar spine . . . Since the day of the accident, he revealed he has been complaining of low back pain, 10/10, occasionally radiating to both legs." Although Dr. Diadula diagnosed a back strain, there is no evidence that he was aware that on December 8, 2008, Dr. Kandula injected Petitioner's back with Toradol and kept him off work for two days.

Neither party offered a causation opinion.

Based on the foregoing, the Arbitrator finds that Petitioner's current condition of ill-being of his low back is not related to the December 11, 2008 accident.

In regard to claim #10 WC 07221, Petitioner suffered an accidental injury to his lower back on June 5, 2009. This injury required one visit to Mercyworks where he was released to full duty, effective June 8, 2009. The Arbitrator finds that his current condition of ill-being of his lower back is causally related to such injury.

In regard to claim #10 WC 07222, the Arbitrator notes that Petitioner did not offer a medical opinion that connects Petitioner's condition of ill-being to his accident. Yet, a chain of events that demonstrates a previous condition of good health, an accident and a subsequent injury that results in disability can be enough circumstantial evidence to prove a causal connection between the accident and the injury. Gano Electric Contracting v. Indus. Comm'n, 631 N.E.2d 724, 197 Ill. Dec. 502 (4th Dist. 1994).

For seven months prior to January 8, 2010, Petitioner was able to perform the full duties of a laborer/refuse collector. It is true that Petitioner did not follow up with the treatment recommendations of his Primary Care Physician and that Petitioner had previously been taking Tramadol for his back pain and that he now takes Ibuprofen. Notwithstanding, the Arbitrator finds that the January 8, 2010 accident destabilized Petitioner's condition of ill-being, which necessitated medical treatment and time off

work. The Arbitrator finds that there is a causal relationship between the accident of January 8, 2010 and Petitioner's current state of ill-being.

As to issue (J), "Were the medical services that were provided to Petitioner reasonable and necessary? Has respondent paid all appropriate charges for all reasonable and necessary treatment?", the Arbitrator finds:

In regard to claim numbers #09 WC 15239 and #10 WC 07221, the Arbitrator finds that all medical treatment was reasonable and necessary. Furthermore, as stipulated, all reasonable and necessary medical expenses have been paid by Respondent.

In regard to claim #10 WC 07222, the Arbitrator concludes that medical expenses in the amount of $1,243.08 that were incurred by Petitioner as a result of his January 8, 2010 accident are causally connected to and necessary to cure or alleviate Petitioner's condition of ill-being. The amount is to be paid pursuant to §8(a) and subject to §8.2.

Respondent has not paid for all reasonable and necessary claims as it appears there remains outstanding balances to Mercyworks on Pulaski for dates of service of January 8, 2010 and January 21, 2010; Advocate Medical Group for dates of service of January 13, 2010 and Mercyworks on Chatham for dates of service of January 25, 2010, January 27, 2010, January 28, 2010, February 1, 2010 and February 3, 2010. These dates of service should be paid by Respondent pursuant to the fee schedule.

As to issue (K), what temporary benefits (TTD) are in dispute?", the Arbitrator finds:

In regard to claim #09 WC 15239, the parties have stipulated to the time period of temporary total disability: 12/13/08 through 1/27/09. The parties have also stipulated that Respondent paid Petitioner for the entire period of time. No additional TTD is owed.

In regard to claim #10 WC 07221, there was no lost time so no temporary benefits are owed.

In regard to claim #10 WC 07222, the Arbitrator finds that Petitioner is entitled to TTD benefits from January 22, 2010 through April 8, 2010. This is a period of eleven weeks. On January 21, 2010, Steven Anderson, D.O., placed Petitioner on work restrictions as of January 22, 2010. Respondent declined to accommodate those restrictions. On February 23, 2010, when Petitioner followed up with Dr. Kandula, the doctor instructed him to work with "low back precautions." The Arbitrator interprets "precautions" to mean restrictions as no evidence exists that suggests Petitioner's condition of ill-being had improved since his January 27, 2010 exam at Mercyworks. The only evidence that shows Petitioner could return to full-duty work was Dr. Kandula's note of April 9, 2010.

As to issue (L), "What is the nature and extent of the injury?", the Arbitrator finds:

In regard to claim #09 WC 15239, the Petitioner suffered an injury to his head, face and eye areas. He testified that he does continue to have headaches at times. He did receive stitches for the laceration to his eye. There is no evidence that his eye injury had any lasting effect.

Therefore, the Arbitrator finds that Petitioner is entitled to 1% loss of use person as a whole for the injury to his head/face and eye area.

In regard to claim #10 WC 07221, the Arbitrator finds that Petitioner sustained a loss of use, man as a whole, of .5% for a low back strain.

In regard to claim #10 WC 07222, the Arbitrator finds that Petitioner has sustained a loss of use, man as a whole, of 2%, as a result of the back strain he sustained.

As to issue (M), " Should penalties or fees be imposed upon Respondent?", the Arbitrator finds:

Petitioner claims penalties and attorneys' fees for claim #10 WC 07222 only.

Although Petitioner has a history of low back problems, scoliosis and a short right leg, he was able to perform the full duties of a laborer/refuse collector for seven months prior to January 8, 2010.

Neither Petitioner nor Respondent offered a causation opinion.

Petitioner testified as to the nature of the accident that occurred on January 8, 2010. An accident report was entered into evidence that shows that on the date of accident, Petitioner completed the report. Petitioner provided a consistent history of accident to Mercyworks, which documented that such an accident did occur.

According to Respondent's own accident report, Respondent was put on notice of the accident within ten minutes after Petitioner alleged he was injured.

Such accident report, dated January 8, 2010, reveals that Respondent sent Petitioner to Mercyworks for treatment. On that date, the Mercyworks doctor, Steven Anderson, D.O., released Petitioner to perform his regular-duty work, effective January 11, 2010.

On January 13, 2010, Petitioner's doctor at Advocate advised him to perform "activity as tolerated."

Petitioner did not attend the January 15, 2010 appointment at Mercyworks.

On January 21, 2010, Petitioner returned to Mercyworks. He told Steven Anderson, D.O., that he did not go back to work on January 11, 2010 because of low back pain, and that he stayed in bed all week. After examining Petitioner, Dr. Anderson offered the following diagnosis: "Lumbar strain, scoliosis secondary to short right leg (pre-existing)." On this date, Dr. Anderson - - the physician at the provider to whom Respondent sent Petitioner - - advised Petitioner: "RTW limited duty 1/22/10."

Yet, Respondent refused to accommodate the limited-duty work restrictions and denied Petitioner the TTD benefits to which he was entitled.

At that time, no doctor advised Petitioner that he was capable of returning to full-duty work. At that time, no doctor opined that Petitioner's low back pain was unrelated to the lifting accident of January 8, 2010.

The February 10, 2010, Mercyworks note indicates that they received a letter of denial from the City. The case was closed and Petitioner was released to full-duty work.

Respondent did not provide a basis for denying the claim.

The Arbitrator concludes that Respondent's delay in payment of workers' compensation was unreasonable.

Section 19(l) of the Illinois Workers' Compensation Act states:

"A delay in payment of 14 days or more shall create a rebuttable presumption of unreasonable delay."

The record contains no evidence to rebut the presumption that Respondent's delay in payment of benefits from January 22, 2010 to the date of the arbitration hearing was unreasonable. Pursuant to Section 19(l), the Arbitrator awards $30.00 per day for 1,201 (from January 22, 2010 through May 6, 2013) up to the maximum of $10,000.00.

Therefore, the Arbitrator imposes 19(l) penalties in the amount of $10,000.00.

The Arbitrator further concludes that Respondent is liable to pay Petitioner additional compensation of $4,990.74, pursuant to Section 19(k) of the Act, for the unreasonable or vexatious delay in the payment of TTD and medical benefits. Respondent provided no basis for denying the claim. At arbitration, Respondent did not present any witnesses and did not offer any exhibits. Not only did Respondent refuse to pay compensation, they disputed that they were given notice of the accident within 45 days of its occurrence. Respondent's accident report, which Respondent's own employee completed, indicates Respondent was provided notice ten minutes after the accident. Respondent even sent Petitioner for medical treatment at Mercyworks the same day as the accident.

The Arbitrator notes Respondent did not pay any benefits pursuant to Section 8(j).

Based upon the above, the Arbitrator find Respondent is liable to pay Petitioner additional compensation in the amount $621.54, which represents 50% of the $1,243.08 in unpaid medical expenses (subject to §8.2), plus $4,369.20, which represents 50% of the unpaid 11 weeks of temporary total disability benefits, for a total of $4,990.74 (subject to §8.2).

Please see McMahan v. Indus. Comm'n, 683 N.E.2d 460, 225 Ill. Dec. 292 (1997).

Respondent is also liable to pay Petitioner an additional $998.15 as attorneys fees (20%) for the $4,990.74 in additional compensation awarded pursuant to Sections 19(k) (subject to §8.2).

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Charles Williams,

Petitioner,

14IWCC0790

vs.

NO: 10 WC 07222

City of Chicago,

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, prospective medical expenses, notice, accident, temporary total disability, penalties and fees, 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 December 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.

14IWCC0790

The party commencing the 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 1 2 2014

David L. Gore

Stephen Mathis

Mario Basurto

DLG/gaf
O: 9/4/14
45

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

14IWCC0790

WILLIAMS, CHARLES
Employee/Petitioner

Case# **10WC007222**

10WC007221
09WC015239

CITY OF CHICAGO
Employer/Respondent

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:

1250 CULLEN HASKINS NICHOLSON ET AL
JOHN POWERS
10 S LASALLE ST SUITE 1250
CHICAGO, IL 60603

0010 CITY OF CHICAGO
NANCY J SHEPARD
30 N LASALLE ST SUITE 800
CHICAGO, IL 60602

14IWCC0790

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

Charles Williams
Employee/Petitioner

v.

City of Chicago
Employer/Respondent

Case # 10 WC 07222

Consolidated cases: 09 WC 15239 and 10 WC 07221

An *Application for Adjustment 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 **5/6/13**. 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 ___

FINDINGS

14IWCC0790

On **1/8/10**, 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 **$61,963.20**; the average weekly wage was **$1,191.60**.

On the date of accident, Petitioner was **49** years of age, *single* with **0** dependent children.

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

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

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

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

ORDER

Temporary Total Disability Benefits

Respondent shall pay Petitioner temporary total disability benefits of **$794.40**/week for **11** weeks, commencing **1/22/10** through **4/8/10** as provided in Section 8(b) of the Act.

Medical Benefits

Respondent shall pay Petitioner **$1,243.08**, which is an amount equal to the charges for the reasonable and necessary medical services provided to Petitioner, pursuant to Section 8(a) and subject to Section 8.2 of the Act.

Respondent shall pay medical services rendered directly to the following facilities for these dates of services pursuant to the fee schedule: Mercyworks on Pulaski for dates of service of January 8, 2010 and January 21, 2010; Advocate Medical Group for dates of service of January 13, 2010 and Mercyworks on Chatham for dates of service of January 25, 2010, January 27, 2010, January 28, 2010, February 1, 2010 and February 3, 2010.

Permanent Partial Disability Benefits

Respondent shall pay Petitioner permanent partial disability benefits of **$664.72**/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.

Penalties and attorneys' fees

Respondent shall pay Petitioner penalties of **$10,000.00** for the unreasonable delay in the payment of temporary total disability benefits, as provided in Section 19(l) of the Act.

Respondent shall pay Petitioner penalties of **$4,990.74**, pursuant to Section 19(k) for the unreasonable or vexatious delay in the payment of benefits, and **$998.15** as attorneys' fees, pursuant to Section 16 of the Act, and all subject to Section 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

December 13, 2013
Date

DEC 16 2013

Charles Williams v. City of Chicago
09 WC 15239
10 WC 07221
10 WC 07222

14IWCC0790

STATEMENT OF FACTS

Mr. Charles Williams, Petitioner, is an employee of the City of Chicago, Respondent. He works as a laborer/refuse collector in the Department of Streets and Sanitation. Petitioner testified that his job duties include picking up trash cans and dumpsters, as well as picking up items left in alleys such as dressers, tables and beds.

Claim 09 WC 15239

On December 11, 2008, it is undisputed that Petitioner suffered an accident that arose out of and in the course of his employment with Respondent. He testified that he was working in an alley loading garbage cans when one of the garbage cans flew off the "flipper" and struck him in the face. He testified that he noticed pain and felt dizzy immediately after the impact.

Petitioner testified that he went to the emergency room at Mercy Hospital where he received stitches above his right eye. That same day, he followed up with his Primary Care Physician at Advocate Medical Group, Dr. Aruna Kandula. (Px. 1). At that visit, he gave a history of being struck in the facial area by a garbage can and suffering swelling and bleeding. He had an abrasion to the right side of his face and a laceration of his right eyelid. He reported no loss of consciousness and no blurred vision. He complained of a headache at that time. He had no new complaints of back pain or radicular leg pain. The Progress Notes list the following active problems: benign essential hypertension, lower back sprain and nicotine dependence. (Px. 1).

Petitioner went to Mercyworks on December 12, 2008, where he gave a similar history of accident. He was diagnosed with a contusion and abrasions to the right forehead, contusion to the right periorbital area and sutured laceration to the right infraorbital area. He was prescribed Ibuprofen and Bacitracin. He was taken off work from 12/12-12/13 and asked to return to the clinic on December 16, 2008. There was no complaint of back pain at this visit.

Petitioner followed up with Mercyworks on December 15, 2008. At that time, he indicated that he had also injured his lower back in the accident because of "the pressure of the garbage can from his head to his lumbar spine." He also had complaints of pain occasionally radiating to both legs. He had complaints of dizziness. (Px. 2) As he complained of dizziness, he was referred to the emergency room. Petitioner testified that he went to Mercy Hospital where he had a CT scan of his brain. The images revealed no acute intracranial process or hemorrhage. (Px. 2). Petitioner followed up with Mercyworks on December 17, 2008, where he continued to have complaints of lower

back pain. He was referred to physical therapy, which he underwent from December 31, 2008 through January 14, 2009.

At his Mercyworks follow-up visit on December 30, 2008, he was referred to the Mercy Eye Center for his continued dizziness and blurred vision. He was seen by Dr. Rubin at the Eye Center on January 26, 2009. At that time, he was diagnosed with an ocular contusion that was healing. He was told he could return to work with this condition. He did return to full-duty work on January 27, 2009.

On December 8, 2008, which was three days prior to his accident, Petitioner saw his Primary Care Physician, Dr. Kandula, with complaints of lower back pain. At that visit, he indicated he pulled his back and had not been to work. He was given a Toradol injection at this visit and a course of physical therapy was recommended. He was taken off work for two days, (Px. 1). There is no evidence he underwent any PT prior to his December 11, 2008 accident.

Petitioner testified on cross-examination that he had been taking Tramadol for back pain before the December 11, 2008 office visit. He testified that he felt sharp pain in his low back when he visited D. Kandula on December 8, 2008.

Petitioner testified that the lower back pain he experienced after December 11, 2008 was different than the pain he experienced when he went to see Dr. Kandula on December 8, 2008. He further testified that he was still having pain when he returned to work on January 27, 2009 and continued to have headaches. He did not follow up with a physician for either condition at that time.

Claim 10 WC 7221

Petitioner sustained an undisputed accidental injury to his lower back on June 5, 2009. He testified that he was pulling a cart and developed lower back pain. He was seen at Mercyworks on that same day, June 5, 2009. He denied any radiating pain. The doctor noted tenderness from L4 to S1. He was diagnosed with a lumbar strain, pre-existing secondary scoliosis and released to return to full-duty work, effective June 8, 2009. He did not follow up with any doctor with regard to this injury.

Claim 10 WC 7222

Petitioner testified that on January 8, 2010, he suffered a third injury to his lower back. At the arbitration hearing, it appeared that, initially, he could not remember the incident but after reviewing the incident report that he signed on January 8, 2010 (Px.11), he stated: "They got it wrong." He testified: "It was supposed to be a silver table that I picked up." He felt that the table weighed over 100 pounds and was four feet wide. He was lifting this table with a co-worker when the co-worker dropped the table, which forced Petitioner to throw it into the truck. He felt a snap in his lower back. He testified that he could not walk, he could not stand up and he could not sit down. Petitioner testified that prior to this incident he was fine and working full duty.

Petitioner went to Mercyworks on January 8, 2010 and gave a history of lifting a table that was approximately fifty pounds. At that time he denied any leg pain or numbness. He had a significant history of back scoliosis with a short right leg. He was found to have tenderness at levels L4 to S1 with the left greater than right. He did have some limited forward bending but negative straight leg raising. He was diagnosed with a lumbar strain. The treatment plan consisted of ice, and prescriptions for both Ibuprofen and Flexeril. He was told to come back on January 15, 2010 or sooner, if needed. He was released to return to work full duty as of January 11, 2010. (Px. 6).

Petitioner testified that he followed up with his Primary Care Physician on January 13, 2010. At that visit, his chief complaint was for lower back pain due to work-related injury. The notes say he had not been to work because he pulled his back. On exam, he was found to be stable with 5/5 strength and full range of motion. He had no swelling, no point tenderness, no crepitations nor any contractures. He was diagnosed with a lower back strain. He was told to apply ice and take medications as needed. He was advised to engage in "[a]ctivity as tolerated", but was not taken off work at that time. He was given a prescription for Tramadol. He was advised that if his condition did not improve, he was to follow up in two weeks. (Px. 7).

Petitioner did not attend the Mercyworks follow-up appointment on January 15, 2010. (Px. 6).

Petitioner did follow up with Mercyworks on January 21, 2010. He indicated that he had "stayed in bed all week." At that time, Steven Anderson, D.O., recommended physical therapy and released him to limited-duty, effective January 22, 2010. (Px 6). He attended physical therapy for four visits through February 3, 2010. On February 10, 2010, Petitioner was released from Mercyworks and returned to full-duty work due to Respondent's denial of the claim.

Petitioner did not follow up with his Primary Care Physician until February 23, 2010. He told his doctor that he had been off work since January 8, 2010. He came in for paperwork. On exam, there was tenderness to palpation. There was no swelling or muscle spasm. His PCP diagnosed him with a lower back sprain. She recommended continuation of physical therapy and pain meds. She felt if he did not improve in the next two weeks, she would consider an orthopedic referral. He was instructed to return to the office in ten days.

Petitioner did not return to his Primary Care Physician until April 9, 2010. At that visit, he indicated he needed a release back to work in ten days. The records indicate that he had not been back to work since January 8, 2010. His primary care doctor noted that he had not sought further management with a physical therapist or an orthopedic specialist. Petitioner returned to work on April 10, 2010.

Petitioner testified that upon returning to work he was still in pain but he had "no choice" but to return. He testified that he continued to have aching, could not sleep or bend and was in severe pain. He testified that he continues to have pain in his left leg. He

works full duty at this time in the same position he was in prior to the accident. He testified that he takes Ibuprofen for his pain. He no longer takes Tramadol. He testified on cross-examination that he takes Ibuprofen every day for this pain, and that he started this daily regimen approximately three weeks ago. He further testified that he needs a prescription to get this Ibuprofen.

CONCLUSIONS OF LAW

As to issue (C), "Did an accident occur that arose out of and in the course of Petitioner's employment with Respondent?", the Arbitrator finds:

In claims # 09 WC 15239 and #10 WC 07221, the parties have stipulated that an accident occurred on the date in question.

In regard to claim #10 WC 07222, the Arbitrator finds that an accident did occur on January 8, 2010. Petitioner testified as to the nature of the accident. Petitioner offered the accident report into evidence, which shows that he completed the accident report on that date. Petitioner provided a consistent history of accident to Mercyworks that documented such accident occurred.

As to issue (E), "Was timely notice of the accident given to Respondent?", the Arbitrator finds:

In claims #09 WC 15239 and #10 WC 07221, the parties stipulated that Petitioner gave timely notice to Respondent.

In claim #10 WC 07222, the Arbitrator finds that notice was timely given as the accident report, which was admitted into evidence, documents that it was completed on the day of the occurrence and that Petitioner was sent to Mercyworks on that date. Despite the existence of such accident report, which indicates that Petitioner reported the accident to his supervisor ten minutes after it occurred, Respondent placed notice in dispute.

As to issue (F), "Is the Petitioner's current condition of ill-being causally related to the injury?", the Arbitrator finds:

In regard to claim number #09 WC 15239, Petitioner claims that he suffered an injury to his head, facial area and eye, as well as to his lower back. In regard to his head/face injury, there is no evidence of any prior injury to this area and no evidence of a subsequent injury occurred to this area. His accident is straightforward and he had consistent complaints with regard to this area from the date of the accident through the course of his treatment. Therefore, with regard to his head/face and eye injury, his current condition of ill-being is causally related to this injury.

In regard to his claim of a low back injury in this matter, it is clear that Petitioner had a non-work-related low back problem just three days before this date of accident for which he received an injection and was advised to take two days off work.

In the December 11, 2008 Progress Notes of Advocate Medical Group, his chief complaint consisted an abrasion to the face, a laceration of the eyelid and a headache. There was no complaint of a loss of consciousness or of a fall. Although the Progress Notes list his active problems as benign essential hypertension, lower back sprain and nicotine dependence, Petitioner voiced no new complaints of back pain and no complaints of radicular leg pain.

In the December 12, 2008 chart notes of Mercyworks, there were no documented complaints of low back pain.

However, when Petitioner visited Mercyworks on December 15, 2008, Dr. Diadula recorded, *inter alia*, the following: "He revealed that during the incident his lower back was also injured because of the pressure of the garbage cart from his head to his lumbar spine . . . Since the day of the accident, he revealed he has been complaining of low back pain, 10/10, occasionally radiating to both legs." Although Dr. Diadula diagnosed a back strain, there is no evidence that he was aware that on December 8, 2008, Dr. Kandula injected Petitioner's back with Toradol and kept him off work for two days.

Neither party offered a causation opinion.

Based on the foregoing, the Arbitrator finds that Petitioner's current condition of ill-being of his low back is not related to the December 11, 2008 accident.

In regard to claim #10 WC 07221, Petitioner suffered an accidental injury to his lower back on June 5, 2009. This injury required one visit to Mercyworks where he was released to full duty, effective June 8, 2009. The Arbitrator finds that his current condition of ill-being of his lower back is causally related to such injury.

In regard to claim #10 WC 07222, the Arbitrator notes that Petitioner did not offer a medical opinion that connects Petitioner's condition of ill-being to his accident. Yet, a chain of events that demonstrates a previous condition of good health, an accident and a subsequent injury that results in disability can be enough circumstantial evidence to prove a causal connection between the accident and the injury. Gano Electric Contracting v. Indus. Comm'n, 631 N.E.2d 724, 197 Ill. Dec. 502 (4th Dist. 1994).

For seven months prior to January 8, 2010, Petitioner was able to perform the full duties of a laborer/refuse collector. It is true that Petitioner did not follow up with the treatment recommendations of his Primary Care Physician and that Petitioner had previously been taking Tramadol for his back pain and that he now takes Ibuprofen. Notwithstanding, the Arbitrator finds that the January 8, 2010 accident destabilized Petitioner's condition of ill-being, which necessitated medical treatment and time off

work. The Arbitrator finds that there is a causal relationship between the accident of January 8, 2010 and Petitioner's current state of ill-being.

As to issue (J), "Were the medical services that were provided to Petitioner reasonable and necessary? Has respondent paid all appropriate charges for all reasonable and necessary treatment?", the Arbitrator finds:

In regard to claim numbers #09 WC 15239 and #10 WC 07221, the Arbitrator finds that all medical treatment was reasonable and necessary. Furthermore, as stipulated, all reasonable and necessary medical expenses have been paid by Respondent.

In regard to claim #10 WC 07222, the Arbitrator concludes that medical expenses in the amount of $1,243.08 that were incurred by Petitioner as a result of his January 8, 2010 accident are causally connected to and necessary to cure or alleviate Petitioner's condition of ill-being. The amount is to be paid pursuant to §8(a) and subject to §8.2.

Respondent has not paid for all reasonable and necessary claims as it appears there remains outstanding balances to Mercyworks on Pulaski for dates of service of January 8, 2010 and January 21, 2010; Advocate Medical Group for dates of service of January 13, 2010 and Mercyworks on Chatham for dates of service of January 25, 2010, January 27, 2010, January 28, 2010, February 1, 2010 and February 3, 2010. These dates of service should be paid by Respondent pursuant to the fee schedule.

As to issue (K), what temporary benefits (TTD) are in dispute?", the Arbitrator finds:

In regard to claim #09 WC 15239, the parties have stipulated to the time period of temporary total disability: 12/13/08 through 1/27/09. The parties have also stipulated that Respondent paid Petitioner for the entire period of time. No additional TTD is owed.

In regard to claim #10 WC 07221, there was no lost time so no temporary benefits are owed.

In regard to claim #10 WC 07222, the Arbitrator finds that Petitioner is entitled to TTD benefits from January 22, 2010 through April 8, 2010. This is a period of eleven weeks. On January 21, 2010, Steven Anderson, D.O., placed Petitioner on work restrictions as of January 22, 2010. Respondent declined to accommodate those restrictions. On February 23, 2010, when Petitioner followed up with Dr. Kandula, the doctor instructed him to work with "low back precautions." The Arbitrator interprets "precautions" to mean restrictions as no evidence exists that suggests Petitioner's condition of ill-being had improved since his January 27, 2010 exam at Mercyworks. The only evidence that shows Petitioner could return to full-duty work was Dr. Kandula's note of April 9, 2010.

As to issue (L), "What is the nature and extent of the injury?", the Arbitrator finds:

In regard to claim #09 WC 15239, the Petitioner suffered an injury to his head, face and eye areas. He testified that he does continue to have headaches at times. He did receive stitches for the laceration to his eye. There is no evidence that his eye injury had any lasting effect.

Therefore, the Arbitrator finds that Petitioner is entitled to 1% loss of use person as a whole for the injury to his head/face and eye area.

In regard to claim #10 WC 07221, the Arbitrator finds that Petitioner sustained a loss of use, man as a whole, of .5% for a low back strain.

In regard to claim #10 WC 07222, the Arbitrator finds that Petitioner has sustained a loss of use, man as a whole, of 2%, as a result of the back strain he sustained.

As to issue (M), " Should penalties or fees be imposed upon Respondent?", the Arbitrator finds:

Petitioner claims penalties and attorneys' fees for claim #10 WC 07222 only.

Although Petitioner has a history of low back problems, scoliosis and a short right leg, he was able to perform the full duties of a laborer/refuse collector for seven months prior to January 8, 2010.

Neither Petitioner nor Respondent offered a causation opinion.

Petitioner testified as to the nature of the accident that occurred on January 8, 2010. An accident report was entered into evidence that shows that on the date of accident, Petitioner completed the report. Petitioner provided a consistent history of accident to Mercyworks, which documented that such an accident did occur.

According to Respondent's own accident report, Respondent was put on notice of the accident within ten minutes after Petitioner alleged he was injured.

Such accident report, dated January 8, 2010, reveals that Respondent sent Petitioner to Mercyworks for treatment. On that date, the Mercyworks doctor, Steven Anderson, D.O., released Petitioner to perform his regular-duty work, effective January 11, 2010.

On January 13, 2010, Petitioner's doctor at Advocate advised him to perform "activity as tolerated."

Petitioner did not attend the January 15, 2010 appointment at Mercyworks.

On January 21, 2010, Petitioner returned to Mercyworks. He told Steven Anderson, D.O., that he did not go back to work on January 11, 2010 because of low back pain, and that he stayed in bed all week. After examining Petitioner, Dr. Anderson offered the following diagnosis: "Lumbar strain, scoliosis secondary to short right leg (pre-existing)." On this date, Dr. Anderson - - the physician at the provider to whom Respondent sent Petitioner - - advised Petitioner: "RTW limited duty 1/22/10."

Yet, Respondent refused to accommodate the limited-duty work restrictions and denied Petitioner the TTD benefits to which he was entitled.

At that time, no doctor advised Petitioner that he was capable of returning to full-duty work. At that time, no doctor opined that Petitioner's low back pain was unrelated to the lifting accident of January 8, 2010.

The February 10, 2010, Mercyworks note indicates that they received a letter of denial from the City. The case was closed and Petitioner was released to full-duty work.

Respondent did not provide a basis for denying the claim.

The Arbitrator concludes that Respondent's delay in payment of workers' compensation was unreasonable.

Section 19(l) of the Illinois Workers' Compensation Act states:

"A delay in payment of 14 days or more shall create a rebuttable presumption of unreasonable delay."

The record contains no evidence to rebut the presumption that Respondent's delay in payment of benefits from January 22, 2010 to the date of the arbitration hearing was unreasonable. Pursuant to Section 19(l), the Arbitrator awards $30.00 per day for 1,201 (from January 22, 2010 through May 6, 2013) up to the maximum of $10,000.00.

Therefore, the Arbitrator imposes 19(l) penalties in the amount of $10,000.00.

The Arbitrator further concludes that Respondent is liable to pay Petitioner additional compensation of $4,990.74, pursuant to Section 19(k) of the Act, for the unreasonable or vexatious delay in the payment of TTD and medical benefits. Respondent provided no basis for denying the claim. At arbitration, Respondent did not present any witnesses and did not offer any exhibits. Not only did Respondent refuse to pay compensation, they disputed that they were given notice of the accident within 45 days of its occurrence. Respondent's accident report, which Respondent's own employee completed, indicates Respondent was provided notice ten minutes after the accident. Respondent even sent Petitioner for medical treatment at Mercyworks the same day as the accident.

The Arbitrator notes Respondent did not pay any benefits pursuant to Section 8(j).

Based upon the above, the Arbitrator find Respondent is liable to pay Petitioner additional compensation in the amount $621.54, which represents 50% of the $1,243.08 in unpaid medical expenses (subject to §8.2), plus $4,369.20, which represents 50% of the unpaid 11 weeks of temporary total disability benefits, for a total of $4,990.74 (subject to §8.2).

Please see McMahan v. Indus. Comm'n, 683 N.E.2d 460, 225 Ill. Dec. 292 (1997).

Respondent is also liable to pay Petitioner an additional $998.15 as attorneys fees (20%) for the $4,990.74 in additional compensation awarded pursuant to Sections 19(k) (subject to §8.2).

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 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: 11 WC 02078

State of Illinois/Pinckneyville Correctional Center, 14IWCC0791

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by Respondent herein and notice given to all parties, the Commission, after considering the issues of accident/repetitive trauma, notice, causal connection, medical expenses and prospective medical care, and being advised of the facts and law, reverses the Decision of the Arbitrator for the reasons stated below.

Petitioner, a 39 year old correctional lieutenant at the time of the arbitration hearing, testified that he began working as a correctional officer in 1992 at Respondent's Joliet Correctional Center (Joliet), a maximum security prison built around 1880. He worked at Joliet for approximately two years. His job duties at Joliet included daily "bar rapping," which involved striking the cell bars with a piece of metal rebar to test structural integrity of the cell doors. Petitioner tested 80 cells a day in that manner. Petitioner testified that bar rapping caused the feelings of "[v]ibration, numbness, basically your hands tingle for several hours afterward." The cell doors were sliding bar doors, which required force to slide open and rarely opened smoothly. The door keys were big brass keys, called Folger Adams keys. The doors were hard to unlock because the locks were over 100 years old. Petitioner described the daily unlocking process: "[There were] two locks on the door, one of them is called a deadlock. You would have to undeadlock each of 80 cells, to begin the day. And to open the cell, you actually put in the second lock, and you basically hit it three or four times with your wrist until the door unlatched.

The way those locks worked, it turned a mechanism which [is] underneath the door, there was a device that would come up and it took a lot of force to pull that device up to unlock the door." Petitioner stated while performing the unlocking duties "your hand and arms go numb. You find yourself switching from one hand to the other." Petitioner's job duties also included cuffing and uncuffing inmates.

In 1994, Petitioner transferred to Dwight Correctional Center (Dwight), built in the 1930s. He worked in the maximum security, mental health and death row facilities at Dwight. His job duties at Dwight included daily bar rapping in a similar manner to bar rapping at Joliet. Older units at Dwight had sliding bar doors and newer units, built in the 1950s and 1960s, had sold steel doors. The locks and keys were identical to those used at Joliet. Petitioner's daily unlocking duties were similar to his duties at Joliet.

Petitioner further testified that he was a tactical team member when he worked at Joliet and Dwight. Approximately 30 percent of the tactical team training consisted of striking and blocking with a baton. Petitioner described the resulting sensation: "[I]t's extremely painful, normally in the palm of your hand and into your wrist. Whenever you strike somebody or you're struck and you block another baton at full force *** the force has to go somewhere." The training took place once or twice a month for three hours. Petitioner remained on a tactical team through 2006.

In 1998, Petitioner transferred to Pinckneyville Correctional Center (Pinckneyville). In 1999, he was promoted to correctional lieutenant and assigned to the segregation unit. He worked the day shift, from 7 a.m. until 3 p.m. Petitioner testified that although correctional lieutenant is a supervisory position, the post description required supervisors to work side by side with subordinate staff. Petitioner worked side by side with correctional officers to lead by example. Thus, he continued to perform bar rapping and unlocking doors, in addition to his supervisory and administrative duties. Petitioner admitted he did bar rapping infrequently at Pinckneyville, and it took only 30 seconds when he did bar rap. However, he did a lot of locking and unlocking, using Folger Adams keys, as well as other, smaller keys to unlock locks, padlocks and handcuffs. The doors at Pinckneyville were steel, hinged doors. Petitioner estimated he opened 100 to 120 doors and performed from several dozen to 200 cuffings and uncuffings a day. Petitioner also periodically checked the cell doors were secure by pulling on them. Petitioner agreed with the job analysis of a correctional officer at Pinckneyville, prepared by CorVel, that a correctional officer uses his hands for forcible gripping and pinching up to two thirds of the workday on a frequent basis.

In 2005 and 2006, Petitioner sought treatment for numbness and tingling in his arms, hands and fingers. The medical records in evidence show in 2006 Petitioner consulted Dr. Fakhre Alam, a neurologist, complaining of numbness and tingling in the fingers. He underwent an EMG/NCV, which was normal. Dr. Alam diagnosed nonspecific paresthesia. Petitioner testified he did not file a workers' compensation claim because there was no work-related

diagnosis. He continued to work as a correctional lieutenant and did not miss any time from work. His symptoms worsened, especially over the past couple of years.

Petitioner further testified that in 2009 and 2010 Pinckneyville was on lockdown approximately 25 percent of the time, which "exponentially" increased the locking, unlocking, cuffing, uncuffing, lifting, carrying, pushing and pulling job activities. Petitioner explained that during lockdown the number of segregations wings doubled. Petitioner continued to work alongside correctional officers. Amongst his many duties, he opened "chuckholes" (food/mail slots in the door) and put in a food tray. The chuckholes were hard to open because of accumulation of food and waste.

Petitioner further testified he participated in special operations training for seven years, from 1999 through 2006, which almost exclusively consisted of weapons training. During the first couple of years, Petitioner trained during two months out of the year. Beginning in the third year, he trained four or five 12 to 16 hour days a month, every month. In all, he fired tens of thousands rounds from high velocity assault rifles. Petitioner stated he loaded ammunition into the magazine rapidly and forcefully. At the end of a training session, he felt tingling, numbness and pain in his hands and arms. Petitioner stopped participating in special operations training because of the pain in the hands and arms, which made firing a rifle difficult.

In December of 2010, Petitioner returned to Dr. Alam and underwent further diagnostic testing. The medical records from Dr. Alam show that on December 20, 2010, Petitioner complained of numbness and tingling in the little and ring fingers bilaterally. Dr. Alam suspected ulnar neuropathy. On December 21, 2010, Dr. Alam performed an EMG/NCV study, which showed mild to moderate bilateral ulnar neuropathy at the elbow. On January 3, 2011, Dr. Alam referred Petitioner to Dr. Robert Golz, an orthopedic surgeon. Petitioner testified that after receiving the test results on January 3, 2011, he notified Respondent of the symptoms in his hands and arms and filed an application for adjustment of claim on January 20, 2011.

On February 7, 2011, Petitioner consulted Dr. David Brown, complaining of numbness and tingling in his hands, wrists and forearms, and summarizing is job duties consistently with his testimony. Dr. Brown diagnosed bilateral cubital tunnel syndrome, prescribed splints and medication, and released Petitioner to return to work full duty.

On March 4, 2011, Petitioner consulted Dr. Golz, complaining of worsening symptoms in the bilateral upper extremities, which he attributed to his job duties. Dr. Golz diagnosed bilateral cubital tunnel syndrome and very early carpal tunnel syndrome, and prescribed medication. On May 6, 2011, Petitioner followed up with Dr. Golz, reporting no lasting improvement. Dr. Golz recommended bilateral ulnar nerve transposition and an injection into the carpal tunnel. Petitioner testified that in October of 2011, he transferred from the segregation unit to the boot camp because it is much easier on the hands and arms.

Jason Thompson, a correctional lieutenant at Pinckneyville, testified that he had known Petitioner since 1998. Lt. Thompson heard Petitioner's entire testimony and thought it was truthful and accurate. Lt. Thompson further testified that he had observed Petitioner's work and noticed Petitioner "do more work" compared to other, less motivated individuals. Lt. Thompson stated Petitioner was an exceptional employee.

Dr. James Williams, a hand and upper extremity surgeon and Respondent's expert, testified via evidence deposition on October 10, 2012. At Respondent's request, Dr. Williams performed a records review, but did not examine Petitioner. He reviewed the post description for correctional lieutenant, the job analysis and videos from CorVel, the accident reports, and the medical records from Petitioner's physicians. Dr. Williams also visited Pinckneyville in July of 2011. During the visit, he opened and closed a chuckhole, cuffed and uncuffed an officer, and opened and closed cell doors. Dr. Williams observed that opening a chuckhole or a cell door required mild to moderate degree of force. Dr. Williams thought a correctional lieutenant's job was very similar to that of correctional officer, "just somewhat more supervisory in role." Dr. Williams opined Petitioner "definitely had cubital tunnel syndrome." Dr. Williams was unsure whether Petitioner also had early carpal tunnel syndrome. Dr. Williams opined Petitioner's job duties at Pinckneyville did not cause or aggravate his cubital tunnel or carpal tunnel syndrome because the opening and closing of locks and pulling of doors was "done with rest in between doing it. It's not something which is sustained for a prolonged period of time." Dr. Williams also did not think repeated turning of the wrists or pulling on cell doors could cause or aggravate cubital tunnel or carpal tunnel syndrome.

Dr. Brown, a hand and upper extremity surgeon, testified via evidence deposition on December 4, 2012, that Petitioner was referred by his attorney. Dr. Brown diagnosed bilateral cubital tunnel syndrome and disagreed with Dr. Golz's diagnosis of early carpal tunnel syndrome. Dr. Brown opined Petitioner's bilateral cubital tunnel syndrome was work-related based on: Petitioner's description of his job duties; the job site analysis from December of 2010 and February of 2011; the key usage study; and the evidence depositions (see below) of Robert Schuchert, Donna Jones, Jaelene Bryan, Jimmy Phillips, Jason Thompson and Melanie Welch. Dr. Brown opined: "[B]ased on all the information I have, which is a young healthy gentleman with no identifiable risk factors for this condition, has a 20-year exposure to performing activities that both I and Dr. Williams acknowledge increases [*sic*] cubital tunnel pressure—in my opinion, the 20 years of work exposure to these activities would be considered at least an aggravating factor to the cubital tunnel and to his condition."

Petitioner introduced into evidence five evidence depositions taken in the case of Jimmy Phillips v. State of Illinois/Pinckneyville Correctional Center, claim No. 10WC23567 (the Phillips case), and one evidence deposition taken in the case of Donna Jones v. State of Illinois/Pinckneyville Correctional Center, claim No. 10WC38807 (the Jones case).[1] Robert Schuchert testified via evidence deposition in the Phillips case on October 5, 2011, that in 2004 he began working as a locksmith at Pinckneyville. Mr. Schuchert admitted filing a workers'

[1] Respondent did not object to the admission of evidence depositions from other cases.

compensation claim against Respondent for repetitive trauma to the elbows. Regarding the condition of the locks at Pinckneyville, Mr. Schuchert testified the locks had gotten worse over the years because of wear and tear, especially the chuckhole locks in the segregation unit. Chuckhole locks often became jammed because food or drink spilled on them. Several years earlier, Respondent replaced "a lot" of the chuckhole locks because of their poor condition. The keys also showed signs of wear and tear.

Jimmy Phillips testified via evidence deposition in his case on October 5, 2011, that he worked as an R5 A segregation wing officer at Pinckneyville since 1998. He had difficulty unlocking and locking chuckholes. Mr. Phillips explained that although the keys were good quality, some of the chuckhole locks did not work well because the inmates "do things to it to not make it work."

Donna Jones testified via evidence deposition in the Phillips case on October 5, 2011, that she worked as a correctional officer at Pinckneyville since 1998. Petitioner's attorney, Thomas Rich, was also representing Ms. Jones in her workers' compensation claim against Respondent. Ms. Jones testified some doors at Pinckneyville were difficult to open and sometimes the cuff locks did not work well. Ms. Jones worked in the segregation unit on and off for two years. The Folger Adams keys used in the segregation unit were difficult to use. Chuckholes were unlocked with the Folger Adams key. Ms. Jones often had difficulty unlocking the chuckholes. Also, the doors became stuck quite often.

Jaelene Bryan testified via evidence deposition in the Phillips case on October 5, 2011, that she worked as a correctional officer at Pinckneyville for the past 13 years. Ms. Bryan had also filed a workers' compensation claim against Respondent for repetitive trauma. Petitioner's attorney, Thomas Rich, was also her attorney. Ms. Bryan testified that some chuckholes were very difficult to open, explaining: "You have to repeatedly jerk the key as hard as you can until you finally can get it to click just right so you can open it." Ms. Bryan used her hands a lot to perform her job duties. On cross-examination, Ms. Bryan admitted she had not been diagnosed with carpal tunnel or cubital tunnel syndrome.

Lt. Thompson testified via evidence deposition in the Phillips case on October 5, 2011, that he worked at Pinckneyville since 1998. A correctional lieutenant supervises correctional officers and does not do as much key turning as the officers. Lt. Thompson, as a correctional lieutenant, usually did more paperwork than physical work. On cross-examination, Lt. Thompson testified he sometimes had difficulty with locks and keys, explaining: "Chuckholes stick all the time, and the reason they stick is because food and stuff gets—you're passing trays through it, so food would drip down on it and get in the lock and gum it up. On top of that, every now and then, you get an inmate try to sabotage a unit." By comparison, brand new chuckholes are easy to use. Occasionally, cell door locks are difficult to open because of the condition of the locks.

Melanie Welch, a vocational rehabilitation counselor with CorVel, testified via evidence deposition in the Jones case on July 8, 2011, that at Respondent's request she performed a job site analysis of the duties of correctional officer at Pinckneyville and videotaped her observations. She visited Pinckneyville on December 13, 2010, and January 20, 2011, and met with the warden, the assistant warden, the union coordinator, the workers' compensation coordinator, and several correctional officers. Ms. Welch stated she visited the segregation unit and saw cell doors with chuckholes, which are opened with a Folger Adams key. Ms. Welch observed correctional officers repeatedly open doors, turn keys and perform grasping activities. She did not observe an officer have any difficulty opening locks.

Petitioner disagreed with the video and the job analysis of Ms. Welch, stating: "[S]he does not show the magnitude of what we actually do. She does not show the frequency of what we do. And to be honest with you, it's grossly understated, grossly underestimated."

Respondent introduced into evidence several job analysis videos from Pinckneyville, none of them showing any difficulty opening cell door, chuckhole or padlock locks. The videos show a correctional officer does a great deal of locking, unlocking, cuffing and uncuffing, and an officer assigned to a segregation unit wing does more locking, unlocking, cuffing and uncuffing.

Petitioner claims repetitive trauma going back to 1992, which manifested itself on January 3, 2011. The medical records show mild to moderate bilateral ulnar neuropathy at the elbow, of approximately equal severity on both sides. There is no medical evidence showing Petitioner sustained repetitive trauma as a result of performing his job duties at Joliet or Dwight. An EMG/NCV study performed in 2006 was normal.

Petitioner transferred to Pinckneyville in 1998 and became a correctional lieutenant in 1999. Petitioner maintains his job duties as a correctional lieutenant were as physically demanding as the job duties of correctional officer. Petitioner testified he did a lot of locking and unlocking of locks, padlocks and handcuffs. Petitioner admitted he did bar rapping infrequently at Pinckneyville, and it took only 30 seconds when he did bar rap. Petitioner was a tactical team member through 2006. However, the training took place only once or twice a month for three hours. Petitioner further testified he participated in special operations training from 1999 through 2006, which almost exclusively consisted of weapons training. However, none of the doctors opined the weapons training could have caused or aggravated his bilateral cubital tunnel syndrome. Furthermore, as noted, an EMG/NCV study performed in 2006 was normal.

Petitioner repeatedly compares himself to a correctional officer and heavily relies on the evidence depositions of correctional officers at Pinckneyville who claimed repetitive trauma injuries. Petitioner has been a correctional lieutenant since 1999. He only relies on the testimony of Lt. Thompson to the extent it corroborates his testimony. However, in his evidence deposition, Lt. Thompson testified a correctional lieutenant supervises correctional officers and does not do as much key turning as the officers. Lt. Thompson usually did more paperwork than

physical work. In light of Lt. Thompson's testimony and in light of Petitioner's bilateral ulnar neuropathy being approximately equal on the dominant and non-dominant sides, the Commission adopts the opinion of Dr. Williams that Petitioner's condition of ill-being is not work-related.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed April 8, 2013, is hereby vacated and Petitioner's claim is denied.

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

Pursuant to §19(f)(1) of the Act, this Decision and Opinion on Review of a claim against the State of Illinois is not subject to judicial review.

DATED: SEP 16 2014
SM/sk
o-08/28/2014
44

Stephen J. Mathis

Mario Basurto

David L. Gore

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

ROBINSON, KENNETH
Employee/Petitioner

Case# **11WC002078**

SOI/PINCKNEYVILLE CORRECTIONAL CENTER
Employer/Respondent

14IWCC0791

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:

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

1350 CENTRAL MGMT SERVICES RISK MGMT
WORKERS' COMPENSATION CLAIMS
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0558 ASSISTANT ATTORNEY GENERAL
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0502 ST EMPLOYMENT RETIREMENT SYSTEMS
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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

APR 8 2013

KIMBERLY B. JANAS Secretary
Illinois Workers' Compensation Commission

STATE OF ILLINOIS)SS.

COUNTY OF MADISON)

14IWCC0791

- [ ] 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)

Kenneth Robinson
Employee/Petitioner

v.

State of Illinois/Pinckneyville Correctional Center
Employer/Respondent

Case # 11 WC 02078

Consolidated cases: _____

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable William R. Gallagher, Arbitrator of the Commission, in the city of Collinsville, on January 31, 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. [x] Was timely notice of the accident given to Respondent?

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

G. [ ] What were Petitioner's earnings?

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

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

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

K. [x] Is Petitioner entitled to any prospective medical care?

L. [ ] 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 (manifestation), January 3, 2011, Respondent was operating under and subject to the provisions of the Act.

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

On this date, Petitioner did 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 $78,972.00; the average weekly wage was $1,518.69.

On the date of accident, Petitioner was 39 years of age, married with 2 dependent child(ren).

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

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

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

Respondent shall authorize and make payment for prospective medical treatment as recommended by Dr. Golz, including, but not limited to the upper extremity surgeries.

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

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

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

William R. Gallagher, Arbitrator
ICArbDec19(b)

April 2, 2013
Date

APR 8 - 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 January 3, 2011, and that Petitioner sustained repetitive trauma to the right and left hands and the right and left arms/elbows. Respondent disputed liability on the basis of accident, notice and causal relationship. This case was tried as a 19(b) proceeding and Petitioner sought an order for payment of medical bills and prospective medical treatment.

Petitioner began working for the Department of Corrections in 1992 and was initially employed as a Correctional Officer at Joliet Correctional Center where he worked for two years. During his two years at Joliet, Petitioner did a substantial amount of bar rapping, cuffing/uncuffing inmates and using Folger-Adams keys. While performing these activities, Petitioner experienced numbness and tingling in his hands; however, he did not seek any medical treatment at that time.

In 1994, Petitioner was transferred to Dwight Correctional Center and his job duties were essentially the same as at Joliet. Petitioner again experienced the same hand symptoms that he experienced while at Joliet and, again, he did not seek any medical treatment. At both Joliet and Dwight, Petitioner was a member of the tactical unit. The primary duty of the tactical unit was to do cell extractions of uncooperative inmates. This required the training with and usage of a baton. When the members of this unit trained with these batons, they would use them to block each other's blows and this caused a painful sensation to the palm of the hand.

In September, 1998, Petitioner was transferred to Pinckneyville Correctional Center as a Correctional Officer. Approximately one year later, Petitioner was promoted to the rank of Correctional Lieutenant. Petitioner testified that, as a Correctional Lieutenant, he worked side by side with the Correctional Officers under his supervision and would lead them by example. Petitioner stated that at Pinckneyville, there is very little bar rapping; however, there is still a substantial amount of use of Folger-Adams keys, keying of padlocks and cuffing/uncuffing inmates. Petitioner testified that he has performed the aforementioned functions thousands of times over the years. Petitioner also performed clerical duties which included performing annual evaluations of the Correctional Officers that work under his supervision, review logs to ensure that they are accurate, deal with grievances and responses, etc.

Petitioner testified that he had reviewed the deposition testimony of Melanie Welch (the ergonomics person from Corvel hired by Respondent) and that he disagreed with her job analysis of his duties because it failed to show either the magnitude or frequency of the repetitive tasks that he was required to perform. In Petitioner's words it was "grossly underestimated."

In addition to his job duties as a Correctional Lieutenant, Petitioner served as a member of a unit called Special Operations for approximately seven years. This is a team of 24 officers that have the task of providing security and protection for the Correctional Directors. While Petitioner was a member of this unit, he received special weapons training one week out of every month. This entailed the use of M-16 automatic assault rifles, Glock pistols, 12 gauge shotguns and all other department firearms. Included in Petitioner's training was his being trained to quickly draw, fire

and reload whatever weapon he was using at the time. These tasks did require the repetitive and forceful use of both of his upper extremities.

Petitioner also watched a video which purportedly depicted the usual activities of a Correctional Officer. He stated that it was also inaccurate because it did not show any of the difficulties encountered when keying, opening chuckholes, and further, it did not show any of the weapons training or discharge.

Petitioner also testified that in 2009 and 2010, Pinckneyville Correctional Center was on lockdown approximately 25% of the time. When a lockdown occurred, virtually all of Petitioner's job duties that required the repetitive use of his upper extremities increased "exponentially." This included cuffing/uncuffing inmates, keying cell locks, shakedowns, etc. In October, 2011, Petitioner sought a transfer to the boot camp to ease the stress on his hands and arms; however, he is still called back to the main facility to perform his regular duties on an as needed basis.

Petitioner tendered into evidence several deposition transcripts of individuals who testified about the conditions at Pinckneyville Correctional Center. This included the deposition testimony of Robert Schuchert, who was deposed on October 5, 2011. Schuchert previously worked at Pinckneyville Correctional Center as a Correctional Officer from 1998 to January, 2004. Since that time he has been the locksmith at Pinckneyville Correctional Center. He confirmed that Correctional Officers have to open and closed chuckholes, cell doors, locked cabinets, etc. and, because of the age and extensive use of the locks, he described them as being fair to poor. Specifically, he noted that the chuckholes are difficult to operate because of the continual usage and the fact that food gets spilled in them on a regular basis.

The deposition testimony of Jimmy Phillips was obtained on October 5, 2011, and was also received into evidence at trial. Phillips has been a Correctional Officer at Pinckneyville Correctional Center and he testified that the officers experience difficulties when locking/unlocking the chuckholes on a daily basis. He also watched the video and stated that it did not show the extent of the difficulties encountered by the officers in using the keys nor did it show the officers having to pull on the cell doors.

The deposition of Donna Jones was taken on October 5, 2011, and it was also received into evidence at trial. Donna Jones has been a Correctional Officer at Pinckneyville Correctional Center since July 1, 1998, and she also reviewed the video and Job Site Analysis. In regard to the video, she acknowledged that it did show cuffing/uncuffing of an inmate; however, it did not show a situation when there was resistance by the inmate. The video also failed to show the difficulties Correctional Officers experience when opening and closing cell doors. In respect to the keying, she testified that Folger-Adams keys are difficult to use and that the video did not accurately show the fast pace at which the work had to be performed.

The deposition testimony of Jaelene Bryan was taken on October 5, 2011, and was also received into evidence at trial. Bryan has been a Correctional Officer at Pinckneyville Correctional Center for approximately 13 years and she also reviewed the video and Job Site Analysis. She stated that the video did not show the difficulties Correctional Officers encounter when

cuffing/uncuffing inmates, locking/unlocking the chuckholes, use of keys, pulling and forcing doors to open especially during the summer months when they tend to stick more and that the leisurely pace that was depicted in the video was not accurate either. She further testified that the Job Site Analysis did not accurately indicate the repetitive nature and volume of what Correctional Officers are required to do.

The deposition testimony of Jason Thompson was taken on October 5, 2011, and was also received into evidence at trial. Thompson holds the rank of Correctional Lieutenant and has worked at Pinckneyville Correctional Center since July 1, 1996, and has been a Correctional Lieutenant since October, 1998. Lieutenant Thompson testified that keying cells and chuckholes, opening/closing doors, cuffing/uncuffing inmates, turning keys, opening doors, opening/closing chuckholes, weapons training, restraining and guiding inmates, and performing various amounts of paperwork were all duties of a Correctional Officer. He agreed that all of these activities involve using both upper extremities.

Lieutenant Thompson was also present at the trial of this case and was called to testify by Petitioner's counsel. Thompson has known Petitioner since 1998 and testified that Petitioner was an "exceptional employee." He confirmed that Petitioner's testimony was truthful and accurate. Thompson performed the key estimation study submitted by Respondent and testified that, while it was accurate, it only described the minimum requirement. Specifically he stated "The way I was instructed to do the study was to look at what is required of everybody at Pinckneyville, and that's what I did. Some employees do what's required, and some employees do what's right. So, therefore, what Lieutenant Robinson has reported as his usage is, in my opinion, probably closer to what he actually did than what my report is."

Melanie Welch was deposed on July 8, 2011, and her deposition testimony was also received into evidence at trial. Welch is an employee of Corvel and she performed the Job Site Analysis and obtained the video at the request of Respondent. Welch acknowledged that the video did not show difficulties in the use of locking/unlocking, cuffing/uncuffing inmates or opening/closing of cell doors.

In 2005/2006, Petitioner again began to experience numbness and tingling in his hands. On January 3, 2006, Petitioner was seen by Dr. Fakhne Alam, who had nerve conduction studies performed of both upper extremities on January 13, 2006. These studies were normal and there was no diagnosis of either cubital tunnel or carpal tunnel syndrome made at that time nor was there a workers' compensation claim filed on behalf of Petitioner. Over time, Petitioner's hand symptoms worsened and he returned to Dr. Alam in December, 2010. Dr. Alam had nerve conduction studies performed again on December 21, 2010, which were positive for mild to moderate bilateral ulnar neuropathy at the elbows. They were negative for carpal tunnel syndrome. When Dr. Alam saw Petitioner on January 3, 2011, he informed him of his condition and stated that he was going to refer him to Dr. Golz. The following day, January 4, 2011, Petitioner reported to Respondent that he may have sustained a work-related repetitive trauma injury to both wrists and elbows. A Workers' Compensation Employee's Notice of Injury was completed and signed by Petitioner on that day, January 4, 2011.

On February 7, 2011, Petitioner was seen by Dr. David Brown. Dr. Brown obtained a history of Petitioner's work duties and examined him. Dr. Brown opined that Petitioner had symptoms and findings consistent with bilateral cubital tunnel syndrome. Dr. Brown recommended conservative care. In that initial medical note, Dr. Brown did not provide an opinion as to whether or not there was a causal relationship between this condition and Petitioner's work activities.

On March 4, 2011, Petitioner was seen by Dr. Robert Golz. Dr. Golz also obtained a history of Petitioner's work activities and examined him. Dr. Golz's diagnosis was bilateral cubital tunnel syndrome, more on the right than the left with early carpal tunnel syndrome. Initially, Dr. Golz recommended a course of conservative treatment. Dr. Golz saw Petitioner on May 6, 2011, and Petitioner's symptoms and condition had not improved. At that time, Dr. Golz recommended surgery on both elbows, initially on the right. When seen by Dr. Golz on December 21, 2011, Petitioner's symptoms and findings on examination were essentially the same as what they were previously. Petitioner was still awaiting approval from workers' compensation before proceeding with any surgery.

At Respondent's request, Dr. Robert Williams reviewed Petitioner's medical records, the video, the Job Site Analysis and key use data. Dr. Williams did not examine the Petitioner. Dr. Williams also had previously visited Pinckneyville Correctional Center and personally open/closed a chuckhole, use a Folger-Adams key, cuffed/uncuffed a Correctional Officer, closed a cell door and lifted a property box. Dr. Williams agreed with the diagnosis of cubital tunnel syndrome; however, he opined that the job duties were not highly repetitive and that Petitioner's job was more of a supervisory role. He thereby concluded that Petitioner's job duties were neither an aggravating nor causative factor of Petitioner's condition of cubital tunnel syndrome.

Dr. Williams was deposed on October 10, 2012, and his deposition testimony was received into evidence at trial. Dr. Williams' testimony was consistent with his medical report and he reaffirmed his opinion as to causality. Dr. Williams acknowledged that Petitioner did not have any risk factors that would have contributed to the development of carpal or cubital tunnel syndromes; however, he still opined that Petitioner's job duties at Pinckneyville Correctional Center did not cause or aggravate the condition. Dr. Williams did not have a substantial amount of information regarding Petitioner's job duties and acknowledged that he had not reviewed any of the depositions of the other witnesses noted herein. Further, Dr. Williams did not know about the duties Petitioner had regarding his use of the firearms. In regard to Dr. Williams' personal tour of the Pinckneyville Correctional Center, was able to open a chuckhole that was apparently in good order and while he encountered no particular difficulty, he still stated that it could require moderate force.

Dr. Brown was deposed on December 4, 2012, and his deposition testimony was received into evidence. Dr. Brown stated that he declined to provide an opinion as to causality in his initial note because he was waiting to receive more information about Petitioner's job duties so as to render a well informed opinion. When asked to opine as to causality, Dr. Brown stated that Petitioner's 20 year exposure to the work duties which required performing intensive arm/hand activities with no other risk factors would be considered an aggravating factor to the development of the cubital tunnel syndrome.

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 a repetitive trauma injury arising out of and in the course of his employment for Respondent that manifested itself on January 3, 2011.

In support of this conclusion the Arbitrator notes the following:

Petitioner credibly testified about the job duties that he performed as a Correctional Officer and Correctional Lieutenant. There was no appreciable difference between Petitioner's job duties as a Correctional Officer and Correctional Lieutenant because, as a Correctional Lieutenant, Petitioner worked side-by-side with his subordinates and performed the same job tasks.

The deposition testimony of Schuchert, Phillips, Jones, Bryan and Thompson in regard to the job duties of either a Correctional Officer or Correctional Lieutenant was consistent with that of Petitioner. Further, when Lieutenant Thompson testified at trial, he stated that the key estimation study performed by him only described a minimum requirement and that Petitioner performed this duty not in a "minimum" manner, rather, Petitioner performed the task in the way that it should be performed.

The Arbitrator is not persuaded by the testimony of Welch, the Job Site Analysis or the video. As previously noted herein, various witnesses testified in detail how there were inaccuracies in both.

The Arbitrator finds the opinion of Dr. Brown to be more credible than that of Dr. Williams in respect to the issue of causal relationship. Dr. Brown had a more thorough knowledge of Petitioner's job duties than Dr. Williams and Dr. Brown personally examined Petitioner. The fact that Dr. Williams personally visited Pinckneyville Correctional Center and performed some of the job duties of Petitioner under very controlled or ideal circumstances is not persuasive. Further, Dr. Williams was not well informed in respect to all of Petitioner's job duties and agreed that Petitioner did not have any other possible contributing risk factors.

Petitioner was not informed that he had positive nerve conduction studies and a diagnosis of bilateral cubital tunnel syndrome until January 3, 2011, and that this condition may have been work-related. The Arbitrator thereby finds that this is the date of manifestation.

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

The Arbitrator concludes that Petitioner gave notice to Respondent within the time required by the Act.

In support of this conclusion the Arbitrator notes following:

As is noted herein, the date of manifestation was January 3, 2011, and Petitioner reported the injury to Respondent of the following day and the Workers' Compensation Employee's Notice of

Injury was completed on that date, January 4, 2011. This is well within the time period required by the Act for Petitioner giving notice to Respondent.

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

The Arbitrator concludes that the medical services provided to Petitioner were reasonable and necessary and Respondent is liable for 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 support of this conclusion the Arbitrator notes the following:

There is no dispute as to reasonableness and necessity of any of the medical treatment that has been provided to Petitioner.

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

The Arbitrator concludes that Respondent is liable for providing perspective medical treatment to Petitioner including, but not limited to, the surgery recommended by Dr. Golz.

In support of this conclusion the Arbitrator notes the following:

Dr. Golz has recommended surgery on both upper extremities and there is no medical opinion to the contrary.

William R. Gallagher, Arbitrator

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Kenneth Folkers,

Petitioner,

14IWCC0792

vs.

NO: 09 WC 45952

Chicago Sun-Times,

Respondent.

DECISION AND OPINION ON §8(a) PETITION

Timely Petition for medical benefits pursuant to §8(a) having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of additional medical treatment and being advised of the facts and law, awards the surgery prescribed by Dr. Seymour. Petitioner was 51-years-old on the date of accident, July 28, 2009. He worked in Respondent's shipping department for over twenty years and had no prior left knee problems. His job duties included driving a forklift, sitting for long periods of time, and occasionally standing. He sustained an undisputed accident on July 28, 2009 when he slipped and twisted his left knee, sustaining a complex tear of the posterior horn of the medial meniscus. Dr. Seymour performed surgery on October 13, 2009. Surgery, along with postoperative physical therapy and cortisone injections, was unsuccessful in relieving Petitioner's knee pain. Petitioner attempted to return to his regular work duties on November 30, 2009 but experienced so much pain that Dr. Seymour took him back off of work. Petitioner was eventually able to return to work with restrictions against bending, twisting, kneeling and squatting. Respondent accommodated the restrictions and Petitioner continued to work for Respondent.

An arbitration hearing on the nature and extent of permanent partial disability was held on November 1, 2010. The Arbitrator found that Petitioner sustained 20% loss of use of the left leg. Petitioner timely petitioned for review of the Arbitrator's November 22, 2010 decision and argued that the permanency award was too low to appropriately reflect Petitioner's condition of ill being as a result of the accident. Petitioner argued that given the failed surgery, restrictions,

and daily symptoms of pain and swelling, the award should be increased. In a decision dated September 8, 2011, the Commission modified the Arbitrator's award to 27.5% of the left leg, noting the nature of the left knee injury, Petitioner's failed treatment, his daily pain and disability and the expectation that he will need a knee replacement in the future. Commissioner Lindsay dissented from the Majority's Decision because Petitioner's testimony about a future knee replacement was not corroborated by Dr. Seymour's records, Petitioner's restrictions were accommodated by Respondent, he was no longer on prescription medications and he had no treatment for six months preceding arbitration.

Section 8(a) proceedings were held on January 23, 2014 in front of Commissioner White and Petitioner testified that since the arbitration hearing on November 1, 2010, he returned to Dr. Seymour for further treatment. On December 13, 2010 he had another injection of cortisone and was told to use over-the-counter medications as necessary and follow up as needed. Respondent's plant closed almost two years later on October 1, 2011. At the time of closure Petitioner was working full duty and he immediately began looking for a new job. He did not have any treatment between December 13, 2010 and February 23, 2012. Petitioner returned to Dr. Seymour on February 23, 2012 and was prescribed a series of viscosupplementation injections and anti-inflammatory medication. The injections were performed in May of 2012 and did not provide any lasting relief. On August 23, 2012 Dr. Seymour performed another cortisone injection for pain relief, prescribed medication and told Petitioner to return as needed. Petitioner returned on September 27, 2012 and Dr. Seymour recommended an MRI, which was performed on October 5, 2012. On October 8, 2012 Dr. Seymour recommended arthroscopic surgery; he believed that the MRI showed a "progression of arthritis, especially in the medial compartment with frayed irregular cartilage and possibly some tearing of the residual meniscus." Petitioner testified that he has not returned to Dr. Seymour since October 8, 2012.

On December 27, 2012 Petitioner began working at Source Interlink Merchandise. Petitioner testified that he was hired as a forklift driver and performed the same duties that he performed for Respondent, although he testified that he moved to the returns department so that he would not have to climb ladders as frequently. Petitioner testified that his knee is very sore and his pain increases with any amount of walking. He notices that his knee swells over the course of his eight hour shift. Petitioner testified that on a "good day" his pain is a "two" on a scale from zero to ten; "good days" are days that he is not working. During the §8(a) hearing, his pain was a "six" after walking several blocks to the hearing site. He takes Tylenol and aspirin and soaks in the hot tub for pain management.

The depositions of Dr. Seymour and Respondent's medical experts, Dr. Verma and Dr. Nelson, were admitted into evidence at §8(a) hearing. Dr. Nelson, an orthopedic surgeon who examined Petitioner at the request of Respondent, testified via deposition on August 9, 2013. Dr. Nelson's opinion is that Petitioner's diagnosis is medial compartment arthritis. He does not agree that arthroscopic surgery is appropriate treatment because he does not believe that arthroscopic surgery can improve articular cartilage loss. He believes that studies have shown that when the primary complaint is pain, arthroscopic surgery does not usually relieve that symptom. On July 9, 2013 when Dr. Nelson examined Petitioner, Petitioner rated his pain at a level "two" and that his symptoms were aggravated by sitting and stair climbing. Petitioner was at the time working forty hours per week as a forklift driver for Source Interlink Merchandise and taking Meloxicam,

an anti-inflammatory medication. Petitioner believed that the medication made him tired and he did not take it regularly despite the fact that it offered some relief. On examination, Petitioner's left knee showed signs of swelling but had normal alignment and range of motion. Dr. Nelson found no instability or tenderness along the joint line but some diffuse dull pain on the medial femoral condyle. Dr. Nelson concluded that Petitioner's symptoms of degenerative arthritis were mild to occasionally moderate; he recommended Petitioner take his medication on a regular basis for pain control, rather than subject himself to another surgery.

On cross-examination, Dr. Nelson agreed that he was not aware of any left knee treatment prior to the accident. The fact that arthritis was found in the knee at the time of arthroscopy only three months after the accident was strong evidence that Petitioner had preexisting arthritis in the knee, however Dr. Nelson agreed that there was no indication that Petitioner was symptomatic prior to the accident. Dr. Nelson testified that arthritis can become symptomatic as it progresses, or "trauma can create a situation where a patient does not have symptoms before the trauma and has some symptoms after the trauma." He agreed that work activities could contribute to a worsening of symptoms. He understood that Petitioner's job with Respondent was a forklift driver but he did not review a job description, videos or photos. He did not know Petitioner's specific duties at Source Interlink other than also operating a forklift. He believed it was not clear whether Petitioner had really had continuous symptoms because of the gap in treatment. We note that Dr. Nelson answered "yes" when asked whether degenerative arthritis might or could have become symptomatic as a result of the July 28, 2009 accident. Dr. Nelson was asked whether the accident likely caused the onset of symptoms, and Dr. Nelson answered that he did not believe so but he did not know the cause.

Petitioner's treating orthopedic surgeon, Dr. Scott Seymour, testified via deposition on October 25, 2013. Dr. Seymour testified that Grade 2 chondromalacia on the medial femoral condyle and Grade 3 chondromalacia on the patella and the trochlea were incidental findings at the time of the October 13, 2009 surgery. This "unstable degenerative torn cartilage" on the patella and the trochlea was removed at that time. The surgery lessened but did not eliminate Petitioner's symptoms and within six weeks Dr. Seymour began injecting Petitioner's knee for further treatment. Petitioner's pain and discomfort remained fairly consistent through the spring of 2010. On December 13, 2010 he once again injected Petitioner's knee and in May of 2012 viscosupplementation was attempted. Dr. Seymour explained that "the idea is if you have someone with arthritis or degenerative changes, you'd do these injections into the knee, or whatever the affected joint is, and it provides some pain relief, reestablishing some normal synovial fluid in the knee." He ordered a new MRI in August of 2012 because Petitioner was still having pain complaints. The MRI showed "some mild fraying of the free margin of the body of the medial meniscus. Then he had severe diffuse cartilage chondromalacia in the medial compartment, small knee effusion, mild arthritic changes with chondromalacia in the lateral and patellofemoral compartments." Dr. Seymour recommended another knee arthroscopy because he believed by that point conservative treatment had failed. "A lot of times when patients have arthritis and have mechanical symptoms in the knee, we'll do a scope to more or less clean it out or remove some of the fragmented, unstable cartilage." Dr. Seymour believed that Petitioner had had the same problems on an intermittent basis for the duration of his treatment history; he could not say if Petitioner's symptoms necessarily worsened. Dr. Seymour testified that the surgery he recommends is intended to address the symptoms of Petitioner's arthritis. Dr. Seymour testified

that he understood that Petitioner works as a forklift driver. He released Petitioner to return to his regular duties on February 8, 2010 and he has not imposed any restrictions through his last examination on October 8, 2010.

Dr. Verma, an orthopedic surgeon who examined Petitioner at the request of Respondent testified via deposition on November 6, 2013. Dr. Verma examined Petitioner on June 8, 2011 without the benefit of medical records to review. He subsequently issued an addendum report when the medical records were reviewed. Dr. Verma diagnosed persistent pain post left knee arthroscopy and pre-existing degenerative disease that was not causally related to the accident. Dr. Verma examined Petitioner again on February 7, 2013 and reviewed additional records. Dr. Verma testified that he disagreed with Dr. Seymour's recommendation of an arthroscopy because he did not see any indication of medical necessity; this was based on a lack of evidence of mechanical symptoms or a recurrent tear. He believed that that the medical literature was fairly clear that the use of arthroscopy in the treatment of degenerative arthritis was found to be unpredictable and did not generally result in clinical benefit to patients. He did not expect improvement if Petitioner underwent the surgery. Dr. Verma believed that Petitioner was at maximum medical improvement for the accident by the time he first examined Petitioner.

On cross-examination Dr. Verma testified that his opinion is that osteoarthritis is generally a naturally occurring condition due to degeneration of the cartilage. He does not believe that work activities contribute to it. He is aware that some literature suggests otherwise, but he does not agree with those conclusions and he does not believe that a link between arthritis and work activities is generally accepted. Dr. Verma explained that there are four levels of chondromalacia – softening, fissuring, partial thickness and full thickness loss. Dr. Verma testified that meniscal tears increase the risk of developing chondromalacia because of increased contact area and increased contact load on the articular cartilage. Dr. Verma took x-rays on June 8, 2011 and noted trace joint space narrowing with three to four millimeters of joint space remaining and peripheral osteophyte formation; he testified that he would grade the arthritic changes at grade three. He opined that there was no way to tell how long the arthritis found during arthroscopy had been present but he testified that it was probably multiple years.

Dr. Verma testified that findings of arthritis are not generally significant unless they are accompanied by symptoms. According to all of the information available to Dr. Verma, Petitioner's degenerative condition prior to the accident was not symptomatic. Dr. Verma agreed that as a result of the initial surgery, Petitioner was at an increased risk for arthritic changes in his knee in the future over an extended time. Dr. Verma does not believe that Petitioner's return to work exacerbated the pathology present in the knee, although it increased his symptom of knee pain. He agreed that there was no indication that Petitioner had any resolution of knee pain after the initial surgery, but he does not believe performing another procedure will help either. Dr. Verma believed that a total knee replacement could be necessary in the future but would be related to Petitioner's arthritis and not the accident. Dr. Verma did not review Dr. Nelson's deposition or reports. He opined that all of Petitioner's treatment has been reasonable and necessary although he does not agree with the arthroscopy recommendation. On cross-examination, Dr. Verma agreed that chondromalacia can develop over time due to the removal of a meniscus. He explained that during the original surgery, however, grade three chondromalacia was already present before the meniscus was removed.

14IWCC0792

The medical witnesses are in agreement that some degree of left knee arthritis pre-existed the accident of July 28, 2009. We find that Petitioner testified credibly that his condition was asymptomatic prior to the accident, and that since the accident he has had continued pain despite treatment. We note that in twenty years of employment history with Respondent, no evidence of prior complaints has been offered. The recommended arthroscopic surgery would address Petitioner's arthritic condition, which was worsened by the accident. We find that the recommended arthroscopy surgery is reasonable and necessary to treat Petitioner's progression of arthritis, despite the difference in opinion between Drs. Nelson and Verma and Dr. Seymour. Where the medical testimony is conflicting, it is for the Commission to determine which testimony is to be accepted. After considering our prior decision and the entire record on Petitioner's §8(a) petition, we find that Petitioner is entitled to additional treatment for his left knee and we award the surgery recommended by Dr. Seymour.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent authorize and pay for the left knee arthroscopy prescribed by Dr. Seymour.

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $12,200.00. 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: SEP 16 2014
RWW/plv
o-7/2/14
46

Ruth W. White

Charles J. DeVriendt

Daniel R. Donohoo

STATE OF ILLINOIS)
) SS.
COUNTY OF KANE)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Craig Sennett,

Petitioner,

14IWCC0793

vs.

NO: 10 WC 44933

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed July 8, 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 $73,400.00. 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 17 2014
o8/5/14
RWW/rm
046

Ruth W. White

Charles J. DeVriendt

Daniel R. Donohoo

14IWCC0793

STATE OF ILLINOIS)
)SS.
COUNTY OF KANE)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
SUPPLEMENTAL ARBITRATION DECISION
19(b)

CRAIG SENNETT
Employee/Petitioner

v.

HYDRALIFT, INC.
Employer/Respondent

Case # **10** WC **44933**

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 **April 10, 2013**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

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

SENNETT, CRAIG
Employee/Petitioner

Case# **10WC044933**

HYDRALIFT INC
Employer/Respondent

14IWCC0793

On 7/8/2013, 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 0.08% 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:

0657 TURNER LAW OFFICES
RICHARD L TURNER
107 W EXCHANGE ST
SYCAMORE, IL 60178

1120 BRADY CONNOLLY & MASUDA PC
RAYMOND C PERSIN
ONE N LASALLE ST SUITE 1000
CHICAGO, IL 60602

14IWCC0793

FINDINGS

On the date of accident, **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* 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 **$100,000.00**; the average weekly wage was **$1,923.08**.

On the date of accident, Petitioner was **43** years of age, *single* with **0** dependent children.

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

Respondent shall be given a credit of **$115,473.02** for TTD and maintenance, and **$9,944.00** for advances paid, for a total credit of **$125,417.02**.

ORDER

Temporary Total Disability

Respondent shall pay Petitioner temporary total disability benefits and maintenance benefits of $1,243.00/week for 158 weeks, commencing March 31, 2010, through April 10, 2013, as provided in Sections 8(a) and 8(b) of the Act. Respondent shall be given total credit of $125,417.02 for temporary total disability benefits and maintenance benefits that have been paid, and advances paid to-date.

Respondent shall pay reasonable and necessary medical services, pursuant to the medical fee schedule of $1,148.08 to Midwest Sports Medicine, and $389.22 to Northwest Neurology, Ltd., as provided in Sections 8(a) and 8.2 of the Act. Respondent shall further pay for reasonable and necessary medical treatment related to Petitioner's cubital tunnel surgery and post-operative care.

Respondent shall pay to Petitioner penalties of $768 65 as provided in Section 19(k) of the Act; and $00 as provided in Section 19(l) of the Act. Respondent shall further pay no attorney's fees to Petitioner as provided in Section 16 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.

Carl Lee
Signature of Arbitrator

7/8/13
Date

ICArbDec19(b)

JUL 8 - 2013

CRAIG SENNETT

v.

HYDRALIFT, INC.

Case No. 10 WC 44933

FINDINGS OF FACT

This matter returned for hearing before the Arbitrator on remand from the Illinois Workers' Compensation Commission in its decision in 12 IWCC 0469, in which the Commission, after considering evidentiary issues when this matter was initially tried before the Arbitrator on April 22, 2011, reversed the decision to exclude Petitioner's tax returns for 2006, 2007, and 2008, and remanded the case to the Arbitrator for "further proceedings pertaining to those tax returns" as well as for a determination of any further temporary total compensation or of compensation for permanent disability pursuant to *Thomas v. Industrial Commission.* In so doing, the Commission indicated that there was evidence that the Petitioner's 2009 tax return, and, in particular, the earnings he claimed on that return, differed significantly from tax returns filed in the years immediately proceeding 2009, and for that reason, the Commission found it reasonable to allow Respondent the opportunity to have Petitioner's prior tax returns evaluated by a forensic tax expert. The Commission remanded the case to the Arbitrator for admission of additional evidence and expert testimony pertaining to the prior tax returns. The Commission deferred consideration of further issues in dispute until after the parties had a chance to address the 2006 through 2008 tax returns. The remaining findings of fact are supplemental to the Arbitrator's findings in the initial decision in this matter entered July

12, 2011, and the findings in the initial decision of the Arbitrator are expressly incorporated herein.

The Arbitrator heard further evidence from Respondent on remand on April 10, 2013, consisting of further testimony from the Petitioner (called as an adverse witness by Respondent) with respect to his personal tax returns for 2006 through 2008, and the tax returns for the Respondent, HYDRALIFT, INC., for the years 2006 through 2008. In addition, the Arbitrator considered further testimony from Respondent's tax expert, Mark Thomas, concerning his interpretation of the tax returns of both the individual and corporate returns for the years 2006 through 2008.

On rebuttal, the Petitioner offered further testimony of Petitioner concerning the use of the corporate tax account for HYDRALIFT for his personal expenses, and offered evidence which was admitted as PX 20, PX 21 and PX 22, consisting of copies of checks issued from the corporate account for his personal expenses, along with spreadsheet summaries, for the respective years of 2006, 2007 and 2008. The Arbitrator has taken into consideration those exhibits. The Arbitrator notes that these three exhibits are substantially similar to the prior exhibits admitted into evidence as PX 16 and PX 17, which also consisted of copies of check stubs and summary itemizations of personal expenses of the Petitioner paid for out of the corporate checking account for the years 2009 and the first quarter of 2010.

In addition, in rebuttal the Petitioner presented his expert tax accountant, Robert Kleeman, to testify as to his review of the additional information consisting of both the corporate and

individual tax returns for the years 2006 through 2008, as well as the itemization of the payments of personal expenses from the corporate account for the years 2006 through 2008, contained in PX 20, PX 21 and PX 22.

It was the opinion of Mark Thomas on behalf of the Respondent, that his prior opinions as testified to in the initial proceeding in this matter were not changed but were supported by the tax returns for 2006 through 2008. It was Mr. Kleeman's opinion on behalf of the Petitioner that the evidence submitted, and in particular the evidence of payment of personal expenses from the corporate account as contained in the records of PX 20 through PX 22, establishes that the Petitioner was again using his corporate account to pay individual expenses and those payments constituted "income" for purposes of the Internal Revenue Code in the years 2006 through 2008. Mr. Kleeman noted that the Petitioner's personal expenses paid from the HYDRALIFT corporate account in the year 2006 amounted to $218,193.00; and in the year 2007, they amounted to $232,068.00; and in the year 2008, they amounted to $163,208.00. It remains the opinion of Mr. Kleeman, pursuant to the Internal Revenue Code and the decisions in *Joly* and *Veterinary Surgical Consultants* that the Petitioner earned in excess of $100,000.00 for each and every year from 2006 through 2009. His opinions were set forth in his written supplemental report of August 17, 2012, which was admitted as PX 19.

Also admitted on rebuttal was the draft 2010 HYDRALIFT corporate tax return, as PX 15. The Petitioner testified that the 1120S for 2010 for HYDRALIFT was never filed as he did not have the money to pay the tax preparer to file this return. However, he indicated that the information contained in the draft return, for compensation of officers in the amount of

$25,000.00, represented the payments to him for the first quarter of 2010, through his date of injury of March 30, 2010, in his capacity of President of the corporation.

The Arbitrator finds no reason to change his findings of fact with respect to any of the issues in dispute. The Arbitrator enters the same findings of fact with respect to accident, date of accident, notice, causal relationship, medical services/charges, prospective medical care, and credit as itemized under the prior decision entered in this cause.

With respect to earnings, temporary total disability/maintenance, and penalties/fees, the Arbitrator supplements the original decision as follows. The prior findings for each of the issues discussed below are expressly adopted in this supplemental decision and supplemental findings are set forth as follows.

With respect to "G", what were the Petitioner's earnings in the 52 weeks before the injury, the Arbitrator supplements his initial findings of fact as follows:

The additional testimony which the Arbitrator has taken into consideration, including the testimony of the Petitioner and the accountant/tax experts presented by both sides, does not change the findings of the Arbitrator with respect to average weekly wage under Section 10 of the Act. Section 10 of the Act clearly provides that "average weekly wage" shall mean the actual earnings of the employee in the employment in which he was working at the time of injury during the period of 52 weeks ending with the last day of the employee's full pay period immediately preceding the date of injury, divided by 52. All the evidence received in this case, including the evidence received on remand, points to the fact that the Petitioner was consistently using his Subchapter S corporation as, in the

testimony of Robert Kleeman, his "personal piggy bank": using corporate funds to pay his personal expenses to the extent of earnings of at least $100,000.00 per year in not only the 52 weeks before the injury date of March 30, 2010, but in the prior years from 2006 through 2008. In particular, the Arbitrator has reviewed, again, PX 16 and PX 17, which consist of photocopies of checks written off the corporate account for personal expenses along with spreadsheet summaries; as well as the additional exhibits received from Petitioner on review, PX 20, PX 21 and PX 22, which consist of photocopies of checks and summary spreadsheets for the years 2006, 2007 and 2008, respectively. In each of those years, the Petitioner withdrew in excess of $100,000.00 from the corporate account to pay his personal expenses and there is no contrary evidence from the Respondent to establish that these checks were not used for personal expenses.

Rather, Respondent relies upon the testimony of its tax expert, Mark Thomas, whose opinions the Arbitrator does not find credible. This is particularly true in light of not only the testimony of Robert Kleeman, but the rulings from the tax courts with respect to what constitutes "taxable income" attributable to a sole shareholder in a Subchapter S corporation. *Joly v. Commissioner*, 211 Fed.3d 1269 (2006), is determinative with respect to "income" for purposes of the Internal Revenue Code.

The Petitioner testified that he changed his tax accounting procedures in 2009 and 2010, in light of some difficulties that he experienced in prior personal injury litigation in demonstrating income. Both his personal and corporate returns showed income in 2009, and the first quarter of 2010, at the equivalent of $100,000.00 per year or $25,000.00 per

quarter. These tax returns accurately reflected actual income attributable to him in the nature of W-2 wages, in compliance with tax law.

Finally, the Petitioner accepts the testimony of Robert Kleeman, as noted in the Arbitrator's prior decision in this cause, that "the W-2 is sacrosanct". The Petitioner filed the W-2 listing income of $100,000.00 for the tax year 2009 and all of his tax records point to that. The fact that the Petitioner did not file similar tax returns in 2006 through 2008 (and thereby may not have been in compliance with tax law) does not change the fact that he was still taking the equivalent in excess of $100,000.00 worth of income in each of those prior tax years from the corporation. The additional evidence received in the nature of the 2006 through 2008 tax returns does not change the Arbitrator's opinion with respect to the average weekly wage in the 52 weeks before the injury. His earnings in the 52 weeks prior to March 30, 2010, were $100,000.00, or $1,923.08 per week.

With respect to "L", what temporary benefits are in dispute and "N" what credits are due Respondent, the Arbitrator supplements his initial findings of fact as follows:

The Petitioner testified that he remains off of work for his injury incurred on March 30, 2010, and is now in vocational rehabilitation pursuant to Section 8(a) of the Act, and receiving maintenance payments. As instructed by the Commission pursuant to *Thomas v. Industrial Commission*, 78 Ill.2d 327 (1980), the Arbitrator finds that additional temporary total disability and maintenance benefits have accrued to the Petitioner to the extent of a total of 158 weeks from the time period from March 31, 2010, through April 10, 2013, and that there is no evidence presented that the Petitioner has not been entitled to TTD or maintenance in that time period.

The evidence also establishes that the Petitioner continues to receive, at this time, benefits of $762.22 per week, and his unrebutted testimony was that a total of credit to-date for TTD and maintenance are $115,473.02, and the total credit for advances (see the prior findings of the Arbitrator in the prior decision) stand at $9,944.00, for a total credit through the date of hearing of $125,417.02.

With respect to "M", whether penalties or fees should be imposed upon Respondent, the Arbitrator supplements his initial findings of fact as follows:

The Petitioner has received from the Respondent through the hearing date TTD, maintenance, and advances totaling $125,417.02. According to RX 8 the Petitioner also received post accident from the Respondent's checking account checks amounting to at least $16,572.64.

Therefore, the Arbitrator finds the Respondent was not unreasonable or vexatious and accordingly, awards no 19 L or K penalties or attorney fees for late payment of TTD or maintenance. However, the 19 K penalty for non payment of medical bills stands at $768.65.

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 up	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Dorhn Ganson,
Petitioner,

vs. 10 WC 18385

14IWCC0794

Dynergy Midwest Generation,
Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by Petitioner and Respondent herein and notice given to all parties, the Commission, after considering the issues of causal connection, medical expenses, and permanent disability, and being advised of the facts and law, modifies the November 20, 2013 decision of Arbitrator Fratianni as stated below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

Petitioner argued in her Statement of Exceptions and Brief in Support that Respondent's Petition for Review was untimely. The Respondent's Petition for Review was file stamped by the Commission after the New Year holiday on January 2, 2014. Respondent marked on its Petition for Review that it received a copy of the Decision of the Arbitrator on November 29, 2013. The completed Proof of Service stated that the form was mailed, with proper postage paid, on December 27, 2013 to Petitioner's counsel and the Commission. Petitioner acknowledges that the Petition for Review is considered filed with the Commission when placed in the mail within the statutory period per *Norris*. As such, the Commission finds that the Respondent's Petition for Review was timely filed within 30 days of receipt of the Decision of the Arbitrator, pursuant to Section 19(b) of the Act.

Petitioner submitted outstanding medical expenses in Petitioner's Exhibit 8. The Arbitrator ordered Respondent to pay to Petitioner outstanding medical bills of Springfield MRI ($1,275.00), Premier Physical Therapy ($204.40), Sangamon Anesthesiologist ($161.40), Reliable ($127.00) and Blue Cross/Blue Shield ($7,330.26) totaling $9,098.06. The Commission finds, in addition to the $9,098.06 awarded by the Arbitrator, reasonable, related and outstanding medical expenses in PX8 in the amount of $21,839.68 incurred at St. John's Hospital for left knee surgery performed on May 18, 2011. Respondent argues the St. John's surgery bill was paid by Blue Cross and is noted as such in the Blue Cross statement contained in PX8. The Commission notes that the Blue Cross statement clearly states that the bill was submitted, however $0.00 was remitted. The St. John's outstanding bill for $21,839.68 is contained in Petitioner's Exhibit 8 and Respondent's only objection to this exhibit was causation. Having found causation, the Commission orders that Respondent pay to Petitioner $30,937.74 for reasonable, necessary and related medical expenses contained in Petitioner's Exhibit 8, pursuant to Sections 8(a) and 8.2 of the Act.

The Arbitrator found that the injuries sustained by Petitioner on January 25, 2008 caused Petitioner to sustain a 20% loss of use of the left leg, referable to the knee. The Arbitrator noted that the condition of the left knee was now permanent. After review of the record as a whole, the Commission modifies the Arbitrator's finding related to permanent partial disability and finds that Petitioner sustained a 25% loss of use of the left leg under Section 8(e) of the Act.

The Commission notes that Petitioner was a 54 year old union electrician at the time of the January 25, 2008 accident. She sustained an injury to her left knee when she attempted to enter a three and a half foot square passageway approximately three feet off the ground. She testified she experienced immediate pain, swelling and instability in the left knee and immediately reported the incident. She continued to work full duty for a period of time but experienced episodes of her left knee giving way. Petitioner testified that she was tired of her knee giving out and went to see her primary physician for treatment on August 28, 2008. At that visit, Petitioner was diagnosed with a left knee strain. Petitioner continued to work full duty and did not seek treatment again until October 9, 2009. At that visit, she gave a consistent history of accident and strengthening exercises were ordered. Petitioner followed up with Dr. Watson on May 19, 2010 and gave a consistent history of accident in January 2008 and persistent complaints since that time. An MRI of the left knee was performed on May 26, 2010, and Dr. Watson confirmed a complete tear of the ACL as well as a torn medial meniscus. Petitioner underwent a diagnostic arthroscopy with partial medial meniscectomy and allograft reconstruction of the ACL on May 18, 2011. She participated in post-surgery physical therapy and was noted on July 27, 2011 to have minimal discomfort and no instability. Petitioner was released to full duty work by Dr. Watson on August 31, 2011. Petitioner testified at arbitration that she currently experiences swelling of the left knee with walking and standing which she treats with over-the-counter pain medication and rest. She no longer experiences "giving way" episodes and is working full duty as an electrician for Respondent.

All else is affirmed and adopted.

IT IS THEREFORE ORDERED BY THE COMMISSION that the November 20, 2013 Decision of the Arbitrator is hereby modified.

14IWCC0794

IT IS FURTHER ORDRED BY THE COMMISSION that Respondent pay to Petitioner the sum of $636.15 per week for a further period of 53.75 weeks, as provided under Section 8(e) of the Act, because the injuries sustained caused the loss of use of 25% of the left leg.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner $30,937.74 for reasonable, necessary and related medical expenses contained in Petitioner's Exhibit 8, pursuant to Sections 8(a) and 8.2 of the Act.

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

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

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $65,300.00. 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: SEP 17 2014

Daniel R. Donohoo

Charles J. DeVriendt

Ruth W. White

o-07/23/14
drd/adc
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ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

GANSON, DORHN
Employee/Petitioner

Case# **10WC018385**

DYNERGY MIDWEST GENERATION
Employer/Respondent

14IWCC0794

On 11/20/2013, 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 0.10% 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:

1727 LEE & WENDT
DAN JOHNSON
1101 S SECOND ST
SPRINGFIELD, IL 62704

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

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

DORHN GANSON,
Employee/Petitioner

v.

DYNERGY MIDWEST GENERATION,
Employer/Respondent

Case # 10 WC 18385

Consolidated cases: NONE.

14IWCC0794

An *Application for Adjustment 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 **August 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: _____

14IWCC0794

FINDINGS

On **January 25, 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 **$70,720.00**; the average weekly wage was **$1,360.00**.

On the date of accident, Petitioner was **54** years of age, ***married*** with **no** dependent children.

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

Respondent ***has 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 **$0.00** under Section 8(j) of the Act.

ORDER

Respondent shall pay Petitioner permanent partial disability benefits of **$636.15**/week for **43** weeks, because the injuries sustained caused the **20%** loss to the **left leg,** as provided in Section 8(e) of the Act.

Respondent shall pay reasonable and necessary medical services of **$9,098.06,** 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.

JOANN M. FRATIANNI
Signature of Arbitrator

November 18, 2013
Date

ICArbDec p. 2

NOV 20 2013

14IWCC0794

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

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

Petitioner works for Respondent as a union electrician. Petitioner testified her job duties require her to maintain and repair equipment and she is generally responsible for the operation of the power plant equipment. Petitioner testified that prior to January 25, 2008, she never had any health issues with her left knee, nor sought treatment for same.

Petitioner testified that on January 25, 2008, while attempting to enter an area, she stepped in a hole trying to enter a contained space. The passageway was 3-1/2 feet off the ground and 3-1/2 feet square. When she did so, she experienced immediate pain, swelling and instability to her left knee. Petitioner testified she thought it was a strain or sprain and that rest, ice, elevation, and over the counter pain medication would relieve her symptoms.

On January 25, 2008, Petitioner also filled out an incident report (Px1) that stated: "while trying to enter B preccp through hole in perf plate wall my left knee popped and gave out. Attempted to enter a second time, the left knee popped again & gave out. Bruise to inner shin and achey left knee."

Petitioner testified her symptoms remained consistent thereafter and her left knee had giving out episodes while walking on uneven surfaces. Petitioner testified she had scheduled time off prior to the accident, and she was able to rest her left leg during her vacation.

Petitioner testified she then experienced another giving out episode to her left knee in August, 2008. Petitioner testified she was walking her dog around her yard when she walked into a dip in the ground, causing her knee to give out and she fell to the ground. Petitioner testified at that point in time she was sick of her knee giving out and wanted to see what could be done about it.

Introduced into evidence were medical records of treatment of Havana Medical Association for the period of October 9, 2001 through August 29, 2008. There is no indication that Petitioner underwent treatment to her left knee prior to the incident of January 25, 2008. On August 28, 2008, Petitioner sought medical treatment for a left knee condition. A history of injury was recorded of an incident involving her stepping into a hole. Petitioner indicated that she thought her left knee was getting better a few days after the episode, but that she was still experiencing knee instability and decided to pursue treatment at that time. X-rays revealed no fractures or significant arthritic changes.

Following that doctor visit, Petitioner continued working full time at her regular job.

On October 9, 2009, Petitioner sought treatment Dr. Lydia Villafuerte. Dr. Villafuerte recorded a history of left knee pain and instability, which she related to the January 25, 2008 work accident. Petitioner complained of giving out episodes of the knee and that she treated herself conservatively by keeping herself active. Dr. Villafuete following examination prescribed knee strengthening exercises and an MRI if her condition did not improve. (Px6)

Petitioner then saw Dr. Michael Watson on May 19, 2010. Dr. Watson testified by evidence deposition in this matter. (Px2) Dr. Watson recorded a history of injury occurring in January of 2008. Examination revealed stable collateral ligaments and some mild effusion around the left knee. His impression was an anterior cruciate ligament tear that he felt was consistent with the mechanism of injury. Dr. Watson prescribed an MRI. The MRI was performed on May 26, 2010, and revealed a small joint effusion, an anterior cruciate ligament tear, and medial meniscus tear. (Px2)

Following this MRI, Petitioner returned to see Dr. Watson, who prescribed arthroscopic surgery.

On May 18, 2011, Petitioner underwent arthroscopic surgery with Dr. Watson, for reconstruction of the anterior cruciate ligament and repair of the medial meniscus tear. Post surgery, Dr. Watson prescribed physical therapy. (Px2, Px4) On August 31, 2011, Dr. Watson released Petitioner to full duty work with no medical restrictions. (Px2)

Dr. Watson testified that it was his opinion that a causal relationship existed between the January 25, 2008 work accident, the anterior cruciate ligament tear and medial meniscus tear, and the surgical procedure to repair same. Dr. Watson testified that he believed Petitioner to be honest, straightforward and exceptionally stoic, as she did not realize the magnitude of the injury until it was diagnosed.

Dr. Watson further testified it was apparent Petitioner wanted to work even though her left knee symptoms persisted. Dr. Watson did admit that he was the first physician in this case to diagnose an anterior cruciate ligament tear and medial meniscus tear, and prescribe a course of treatment for it.

Petitioner saw Dr. George Paletta. This examination was at the request of Respondent. Dr. Paletta testified by evidence deposition in this matter. (Rx2) Dr. Paletta testified that he agreed with the diagnosis of Dr. Watson, and his recommendations for various treatment options. Dr. Paletta felt that Petitioner's history of injury was not consistent and felt "it is certainly unusual and probably unlikely that she would be able to continue for so long as she did if she did in fact had an unstable knee secondary to ACL tear."

Dr. Paletta indicated that he could not testify within a reasonable degree of medical certainty when the ACL injury occurred, thus he could not render an opinion as to when the ACL was torn. Dr. Paletta did testify that his opinion as to causal relationship would be the same as Dr. Watson's if Petitioner's history events is believed to be true.

Dr. Paletta further testified that instability, or giving way, was the symptom most consistent with an ACL tear.

Ms. Jan Michaels was called to testify on behalf of Respondent. Ms. Michaels testified she knows Petitioner personally. Ms. Michaels testified she could not recall the exact dates or times of events but prior to January, 2008, Petitioner had no knee complaints and no problems performing her usual and customary duties. Ms. Michaels testified that after January of 2008, Petitioner began experiencing consistent knee complaints and episodes of instability that did not resolve until the time of her surgery.

Petitioner testified to complaints of pain and swelling to her left knee with walking and standing. She is now working full duty at her regular job for Respondent.

Petitioner testified and maintains that her left knee became unstable and she was experiencing giving out episodes consistently since the January 25, 2008 accident. Petitioner admitted during her testimony that she did not seek any medical attention following this accident until August 28, 2008, and continued working full time with the exception of the vacation period noted above. Petitioner testified that although there are gaps in treatment, her symptoms remained the same until after she had the surgery with Dr. Watson on May 18, 2011. Respondent disputes Petitioner's assertions.

Based upon the above, including the testimony of Petitioner, Ms. Michaels and Dr. Watson, the Arbitrator finds that the conditions of ill-being as diagnosed above are causally related to the accidental injury. The Arbitrator finds that Petitioner presented herself in person as a credible witness and so did Ms. Michaels. The testimony of both, along with the histories of injury provided to the medical providers, and the accident report in evidence, all clearly corroborate that an accidental injury occurred and the condition to the left knee as diagnosed was causally related to that accident.

14IWCC0794

Based further upon the above, the Arbitrator finds the condition to the left knee as indicated above to now be permanent in nature. The Arbitrator notes that the accident date in this matter is January 25, 2008, which predates the changes to the Illinois Workers' Compensation Act effective September 1, 2011, as amended, that reflects the need for an AMA Guideline and other factors in determining permanent disability. As such, the Arbitrator is following the law in determining permanency that predated the amendments to the Act noted above.

J. Were 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 certain outstanding medical bills and charges that were incurred after this accidental injury:

Springfield MRI & Imaging Center	$1,275.00
Premier Physical Therapy	$ 204.40
Sangamon Associated Anesthesiologist	$ 161.40
Reliable	$ 127.00
Blue Cross/Blue Shield	$7,330.26

These charges total $9,098.06. Respondent did not dispute any of the incurred charges, including reasonableness and necessity for such treatment, other than disputing causation. Having found causation in this matter in "F" and "L" above, the Arbitrator further finds the above charges to be the liability of Respondent to Petitioner, subject to the medical fee schedule as created in Section 8.2 of the Act.

STATE OF ILLINOIS)
) SS.
COUNTY OF SANGAMON)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Gloria Burcham,

Petitioner,

vs. NO: 12 WC 39052

Governor's State University,

14IWCC0795

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 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 accidental injuries that arose out of and in the course of her employment with Respondent on August 13, 2012.

The Petitioner testified that she was employed by the Respondent as a Statewide trainer. She travels around the State training new staff. She also has an office in Springfield. While in the office she is responsible for floor work and office work. (Transcript Pgs. 11-13)

On August 13, 2012, she testified that she was working in her office. Her office is a cubicle with a desk, swivel chair and a plastic mat underneath the swivel chair. There were shelves on her desk and she reached for some paperwork on the shelf and went to sit back down in her chair. When she sat back down, her back end hit the chair and the chair slid back "real fast" and her buttocks hit the ground. (Transcript Pgs. 13-17)

The Arbitrator found that the Petitioner's accident of standing and reaching for a folder and then sitting back down on a rolling chair that moved when she hit it with her buttocks was

not an accident. The Arbitrator held that the risk of injury must be particular to that employment and that the Petitioner failed to prove that she was exposed to a risk to a greater degree than the general public.

We disagree with the Arbitrator.

In **Sisbro, Inc.** v. **Industrial Commission**, 207 Ill. 2d 193, 797 N.E. 2d 665 the supreme court held that "To obtain compensation under the Act, a claimant bears the burden of showing, by a preponderance of the evidence, that he suffered a disabling injury which arose out of and in the course of his employment." The parties in this matter do not dispute that the Petitioner was injured during the course of her employment. Per the **Sisbro** case the "arising out of" component is primarily concerned with causal connection. This is satisfied when Petitioner has shown that the injury had its origin in some risk connected with or incidental to the employment.

Petitioner has successfully shown that she was performing acts the Respondent might reasonably have expected her to perform in regard to her assigned duties. Petitioner was at her desk and stood up to get a folder she needed to perform her work. She went to sit down and struck her buttocks on a swivel chair causing it to roll on the plastic mat and resulting in her striking her buttocks on the ground. The Petitioner sustained accidental injuries arising out of and in the course of her employment with Respondent.

The Arbitrator's decision is hereby reversed.

Petitioner complained of back pain in her lower back after this fall. She did have prior complaints of lower back pain but never received any treatment for them. (Transcript Pgs. 19-20)

Dr. O'Leary's testimony at deposition was that there was a clear causal connection between Petitioner's current condition of ill-being and the accident on August 13, 2012.The fall aggravated the pre-existing condition of degenerative disc disease that was asymptomatic prior to accident. Based on a reasonable degree of medical certainty her condition is now symptomatic and thus the accident of August 13, 2012 aggravated that condition. (Petitioner Exhibit 6 Pgs. 18-21, Pgs. 55-58)

The Petitioner was 58 years old at the time of her injury. Her job as a trainer does not require heavy lifting or frequent stooping or bending. The injury to her lower back should not affect her future earning capacity.

Petitioner's current complaints consist of random pain that is "jabbing." There is an "aching soreness" on both sides of her back. She experiences this back pain two to three times a week. Dr. Leary released Petitioner to work without restrictions. (Transcript Pgs. 33-39)

Both Dr. Hoffman and Dr. O'Leary refer to Petitioner's injury as a Lumbar Sacral strain. (Petitioner Exhibit 1 and 4)

The Commission finds that Petitioner sustained a loss of use to the extent of 2 1/2 % of the person as a whole.

14IWCC0795

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $656.39 per week for a period of 12 1/2 weeks, as provided in §8 (d) (2) of the Act, for the reason that the injuries sustained caused the loss of use to the person as a whole to the extent of 2 1/2%

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum for medical expenses related to Petitioner's lower back from August 13, 2012 until October 9, 2013 under §8(a) of the Act and subject to 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: SEP 19 2014

Charles J. DeVriendt

Daniel R. Donohoo

Ruth W. White

HSF
O: 7/23/14
049

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

BURCHAM, GLORIA
Employee/Petitioner

Case# **12WC039052**

GOVERNOR'S STATE UNIVERSITY
Employer/Respondent

14IWCC0795

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:

4707 LAW OFFICE OF CHRIS DOSCOTCH
2708 N KNOXVILLE AVE
PEORIA, IL 61604

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

4993 ASSISTANT ATTORNEY GENERAL
ANDREW SUTHARD
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

DEC 6 2013

KIMBERLY B. JANAS Secretary
Illinois Workers' Compensation Commission

STATE OF ILLINOIS)
)SS.
COUNTY OF SANGAMON)

14IWCC0795

☐ 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

GLORIA BURCHAM
Employee/Petitioner

v.

GOVERNOR'S STATE UNIVERSITY
Employer/Respondent

Case # 12 WC 39052

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 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 _____

FINDINGS

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

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

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

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

In the year preceding the injury, Petitioner earned **$56,887.56**; the average weekly wage was **$1,093.99**.

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* 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 failed to prove she sustained an accident on August 13, 2012 that arose out of her employment with Respondent. Petitioner's claim for compensation is denied and no benefits are awarded.

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

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

Signature of Arbitrator

December 3, 2013
Date

ICArbDec p. 2

DEC 6 - 2013

GLORIA BURCHAM v. GOVERNOR'S STATE UNIVERSITY, *12 WC 39052*

Findings of Fact and Conclusions of Law

The Arbitrator finds:

Petitioner has been employed by Respondent as an instructor and state-side trainer with DCFS. Petitioner trains new staff at DCFS for their roles as placement workers or investigators and she also does specialty training. Petitioner has an office in Springfield but her job also requires travel throughout the State of Illinois. Petitioner described her job as involving both floor work and office work as she trains in a classroom setting and does paperwork at her desk located in her office/cubicle. As will be more particularly discussed herein, on August 13, 2012, Petitioner was working in her cubicle, stood up to grab a piece of paper and fell to the ground while sitting back down in her chair. Petitioner reported the incident to her supervisor and complained of back pain. (RX 1)

Following the fall Petitioner sought care with her family physician, Dr. Hoffman, on August 16, 2012. Petitioner completed an "Injury Patient" form in which she stated she injured herself on August 13, 2012 when she was standing to reach some files and went to sit back onto a chair that rolls and it went out from her and she fell to the floor onto her bottom. Petitioner complained of lumbar sacral pain. Petitioner's physical examination revealed tenderness along the lower back. Dr. Hoffman prescribed medication and ordered therapy. Petitioner was advised she could continue working. (PX 1)

Benjamin McDaniel completed a "Worker's Compensation Witness Report" on September 11, 2012. In it he indicated that he did not actually witness the accident but he did hear a loud thud shortly after Petitioner entered her cubicle. He asked Petitioner if she was okay and she told him that her chair simply slipped out from under her seat and she slipped to the floor. McDaniel observed Petitioner picking herself up and the chair was still some distance away spinning slightly. Petitioner resumed her duties thereafter. (PX 8; RX 3)

Petitioner's supervisor, Michelle Grove, completed an injury report on September 12, 2012. In it, she described the accident as follows:

> While seated at her desk, [Petitioner] stood to reach at some papers and when she went to sit back in to her desk chair, it rolled backwards and she landed on [the] floor.
> (PX 7)

In the section where Ms. Grove was asked about the cause of the accident, she noted there were rollers on the chair and a plastic mat underneath. The chair rolled backward when she sat backwards on it and she fell to the floor and the chair turned over. Ms. Grove stated that the plastic mat was removed thereafter. (PX 7)

By letter dated October 2, 2012 Petitioner was advised by the State of Illinois Department of Central Management Services that her claim had been reviewed/investigated and deemed not compensable under the Workers' Compensation Act. (PX 4)

Petitioner next saw Dr. Hoffman on November 23, 2012. When she returned to Dr. Hoffman on November 23, 2012, Dr. Hoffman renewed the prescription for the physical therapy and also ordered a MRI. (PX 1)

Petitioner attended one physical therapy session on November 26, 2012 at Accelerated Rehab. Petitioner gave a history of having experienced the onset of low back pain after a chair rolled out from under her at work. Petitioner reported minimal pain at the beginning which worsened over the next couple of days. Petitioner was scheduled to undergo an MRI. According to the Initial evaluation report Petitioner reported increased pain with working 8-9 hours per day, driving, laying in a prone positing, lifting, and pushing. Petitioner denied any leg pain or tingling or numbness in her lower extremities. Petitioner was scheduled to be seen two times per week for the next six weeks. (PX 1)

After attending that visit, Petitioner was informed that she was not "certified" and could no longer attend therapy.

On January 18, 2013 Petitioner underwent an MRI for her lumbar spine. It revealed: (1) desiccation of the discs at L3-4, L4-5, and L5-S1; (2) mild eccentric disc bulges to the left at L3-4 and L4-5 without displacement of the neural elements; and (3) mild facet arthropathy at L3-4 through L5-S1 without significant compromise of the central canal or neural foramina. (PX 3)

Petitioner returned to Dr. Hoffman on January 22, 2013. At that point Dr. Hoffman referred Petitioner to see an orthopedic surgeon at Midwest Orthopedics – Dr. Patrick O'Leary. (PX 1)

Dr. Hoffman examined Petitioner on two occasions between January 22, 2013 and February 12, 2013. Petitioner's condition remained unchanged. An orthopedic referral was pending. She was to continue her medications. (PX 1)

On February 28, 2013 Petitioner was examined by Dr. Patrick O'Leary at Midwest Orthopedics in Peoria. Dr. O'Leary inquired how the accident occurred and Petitioner advised him she had reached up to get something from a shelf, sat down thinking the chair was behind her but it flipped back and over and she landed on her buttocks. Petitioner also showed him a picture of the chair and her mat. Dr. O'Leary stated, "I think the reason this occurred is because the chair is on [a] plastic mat which allows it to roll but unfortunately sometimes allows it to roll too easily and, thus, probably caused the situation here." (PX 1) Dr. O'Leary reviewed the MRI concluding it showed degenerative disc disease at L3-4 and l4-5 and a bulging disc with a possible annular tear at L5-S1. He described it as a "work-related" injury as it aggravated an underlying condition. Petitioner was still complaining of low back pain at a level of 7 out of 10. Dr. O'Leary's diagnosis was lumbosacral degenerative disc disease and a possible L5-S1 annular tear related to her fall. Dr. O'Leary recommended 6 to 8 weeks of therapy and felt she could continue working full duty. (PX 1)

Petitioner returned to see Dr. Hoffman on March 12, 2013. Her condition and treatment recommendations remained the same. (PX 1)

Dr. Hoffman referred Petitioner to a pain clinic when he examined her on April 5, 2013. She was to continue her therapy and medications. (PX1)

Dr. Hoffman saw Petitioner on April 26, 2013. Her diagnosis and complaints remained the same. He recommended ongoing therapy, pain clinic management, and anti-inflammatory medication. (PX 1)

The evidence deposition of Dr. O'Leary was taken on April 30, 2013. Dr. O'Leary diagnosed underlying degenerative disc disease and an L5 -S1 annular tear with low back pain. Dr. O'Leary testified to a reasonable degree of medical certainty that the fall and mechanism of injury described by the Petitioner aggravated the foregoing pre-existing conditions. Dr. O'Leary's final diagnosis was degenerative disc disease and an L5- S1 annular tear aggravated by fall at work. Dr. O'Leary further testified that Petitioner's treatment was related to the August 13, 2012 fall and that Petitioner had a good prognosis.
(PX 9)

Petitioner participated in physical therapy at Professional Therapy Services in March, April and May of 2013. She was discharged from therapy on May 3, 2013 because her certification had expired for treatment. At that time Petitioner's condition was improved. (PX 4; PX 6; RX 4)

On May 7, 2013 Petitioner returned to see Dr. O'Leary. Dr. O'Leary's office notes reflect Petitioner's description of the accident – to wit, Petitioner was sitting in her cubicle and she had a rolling chair with four wheels situated on a plastic mat to allow it to roll easier than on the carpeted areas. Petitioner thought the chair was behind her but it slipped out when she went to sit down. Petitioner reported that she had completed therapy and was feeling better However, she was still experiencing some aches and pains albeit they were improved since prior to therapy. Petitioner also reported that she had been told by insurance that she could no longer pursue therapy as she had completed the maximum number of visits. Dr. O'Leary believed Petitioner was reaching maximum medical improvement (MMI). Petitioner was told to continue working full duty, that conservative management of her condition was recommended, and that she should continue her home exercises. Petitioner was to return in four weeks. Petitioner was given a Return to Work slip indicating she needed no restrictions or limitations as of May 7, 2013. (PX 4; RX 5)

Petitioner was then referred to pain specialist Dr. Yibing Li by her family physician, Dr. Hoffman. She was examined by Dr. Yibing Li on June 10, 2013. In an Initial Consultation Form Petitioner candidly acknowledged a history of upper back pain pre-dating her fall at work. However, she associated her lower back pain with her fall at work. In his office note, Dr. Li noted Petitioner presented with "lower back pain for years, worse since last year s/p fall injury." Petitioner complained of stabbing pain across her low back and rated her pain as intermittent (5/10). Petitioner further described tingling sensations in her low back pain and felt that sitting increased her pain. (PX 2)

Dr. Li noted Petitioner had tried therapy, which had helped, and was taking Ibuprofen. Dr. Li's diagnosis was chronic back pain, myofascial or from facetogenic lumbar pain and degenerative disc disease with no radicular symptoms. Dr. Li recommended massage, trigger point or acupuncture. (PX 2)

Petitioner testified she decided against the treatment because she was not confident that the modalities would work and she had had problems with insurance.

Dr. O'Leary last examined Petitioner on June 11, 2013. On that date Petitioner complained of continued aches and pains in her low back aggravated by driving. The doctor noted Petitioner was working full duty. Dr. O'Leary's diagnosis remained lumbosacral strain status post fall and lumbosacral degenerative disc disease. From an orthopedic perspective he felt Petitioner had reached a healing plateau and he did not anticipate any further orthopedic interventions. Dr. O'Leary recommended anti-inflammatories as needed, continuation of her home exercise program and a home walking program and consultation with a pain specialist, if desired, and if her pain level continued. (PX 1; PX 4; RX 6)

Petitioner was re-examined by Dr. Hoffman on June 13, 2013 who noted her ongoing complaints of pain. Petitioner was receiving deep massage therapy and taking medications. He advised her to continue doing so. Her diagnosis remained unchanged. (PX 1)

Petitioner returned to see Dr. Hoffman on August 6, 2013 at which time she reported ongoing lumbosacral pain aggravated by daily activity. Petitioner was continuing to work. Dr. Hoffman's diagnosis was a lumbosacral strain and he prescribed a trial of Ultram. (PX 1)

At arbitration Petitioner testified that she has been employed by Respondent for 7 years as a trainer. Petitioner's job involves office work and classroom duties as she trains individuals working at DCFS.

Petitioner testified that on August 13, 2012 she was working at her cubicle in Springfield gathering papers that needed to be turned in. Petitioner described her work area. Petitioner worked in a cubicle with a swivel chair, plastic mat on the floor, and desk. Petitioner testified that the plastic mat was setting on top of the carpet. Petitioner testified that the chair had hard wheeled casters and there was no lock on the wheels. Petitioner testified that the floor was level. Petitioner could not exactly recall what she was reaching to get when she stood up but she thought it was probably a file folder or a roster. According to Petitioner as she went to sit down her chair slipped away and she hit the ground and the chair slid back and flipped. Petitioner testified that she was not standing straight up to get the papers/file as her knees were bent. When asked if any part of her back end hit the chair as she sat down, Petitioner responded in the affirmative. Petitioner testified that the chair slid away "real fast." It just slid away and she hit the ground and the chair flipped. Petitioner and she hit the front edge of the chair and it slipped away.

Petitioner reported the incident to her supervisor and complained of back pain.

Petitioner testified that after the accident she kept playing it over and over in her mind as to how it might have happened. At some point she began investigating her chair and in particular she was interested in whether there was any danger with roller chairs so she did some reading on the subject. Petitioner determined she had hard casters on her chair.

Petitioner testified that the plastic mat was removed from her cubicle within a couple of weeks. On cross-examination she acknowledged that she was the one who removed the mat and placed it in a closet.

Petitioner moved to her work space approximately 6 months prior to the date of accident. Prior to working in the cubicle she had a private office. In the private office, Petitioner had a similar

swivel chair but there was no plastic mat protecting the carpet. Petitioner has no reported history or difficulty with frequent falls or with sitting.

Petitioner further testified that she showed the photograph of her chair to Dr. O'Leary because she had a photo of it on her phone and thought it would help her explain what happened.

On cross-examination Petitioner reiterated that her buttocks touched the front of the chair as she sat down. She acknowledged that it was possible her buttocks pushed the chair and that as she sat down she was not looking behind her. Petitioner did not know if the chair simply rolled on its own away from her as it all happened behind her. She did not know of any defect in the chair that day. She did not recall anything being wrong with the mat.

Petitioner also explained that Dr. Hoffman issued the note in March of 2013 regarding her travel in an effort to help her lessen her travel to and from work as the traveling was aggravating her back. Petitioner had a FMLA request being processed at the time.

Petitioner testified that she researched chair casters so that she could make her workplace safer. Petitioner found that hard plastic casters should be used on carpeting. As to hard surfaces such as plastic mats, soft casters are recommended. Petitioner testified that her chair did not have soft casters.

Prior to this fall Petitioner had no history of any previous treatment to her lumbar spine. There is no evidence of any previous MRIs, orthopedic or neurological evaluations for her low back. Petitioner testified that she had not had any new falls or injuries since the accident of August 13, 2012. The records contain no history of any new accidents or injuries as well.

Petitioner currently complains of intermittent back pain. Petitioner testified that 2 to 3 times a week her back pain ranges from a 5 to 7 out of 10. Petitioner takes Ibuprofen daily and Tramadol as needed. On August 9, 2013, Petitioner was prescribed 20 Tramadol pills. As of the hearing date, Petitioner only had one (1) pill left. Petitioner had taken 19 pills between August 9, 2013 and October 10, 2013.

Petitioner testified that her pain is aggravated by driving and activities such as lifting, prolonged bending, or sitting. Petitioner continues to see Dr. Hoffman for flare-ups of pain and to get needed medication. She testified that he told her she would always have trouble with her back and that it would get progressively worse as she ages. Petitioner described her low back pain as "jabbing" and an "aching soreness." Petitioner notices the pain in a "V" pattern in her low back on both sides. The pain comes and goes depending upon activity or even when she is sitting. Some days she is pain free. Extensive traveling seems to aggravate it. Petitioner described herself as an "avid" walker who no longer walks as far as she previously did. Petitioner also acknowledged that she picks up her grandchildren and that it can hurt but she loves them and wants to do it. Petitioner does stretching exercises to help alleviate her pain complaints. Petitioner never had these problems prior to this incident. Petitioner continues to work regular duty.

Michelle Grove, Petitioner's supervisor, testified she quickly reviewed Petitioner's statement of injury and signed it. She did not know why there were plastic mats. Ms. Grove testified that the plastic mat can protect the carpet from the wear and tear of the rollers. Ms. Grove testified that not every work station had a plastic mat. All of the employees use rolling chairs.

Benjamin McDaniel also testified. He is a co-worker of Petitioner's and was working next to Petitioner in the adjacent cubicle. He heard the incident but did not observe it occuring. He walked over to the area to observe Petitioner picking herself up. He saw the chair a distance away still spinning slightly. He only spoke with Petitioner for a few seconds. He did not remember the chair being flipped over.

The Arbitrator concludes:

1. Accident. Petitioner was in the course of her employment when she fell on August 13, 2012. The primary issue is whether Petitioner's accident arose out of her employment.

For an injury to have risen out of the employment, the risk of injury must be particular to the work or a risk to which the employee is exposed to a greater degree than the general public by reason of his employment. *Orsini v. Indust. Comm'n.*, 509 N.E.2d 1008-1010 (1987). Based on all the evidence presented, the Arbitrator concludes Petitioner did not sustain an accidental injury that arose out of her employment with Respondent on August 13, 2012. The Arbitrator concludes that Petitioner's act of reaching for a folder on a shelf and sitting back down on a rolling chair did not subject Petitioner to a greater risk beyond that faced by the general public. By Petitioner's own admission rolling chairs are common, in and out of the workplace. The Arbitrator also notes that Petitioner was uncertain as to what caused the chair to not be underneath her when she sat down and she acknowledged that she, herself, might have pushed the chair out from behind her with her body.

In short, nothing about Petitioner's employment setting, or the condition of the equipment used, contributed to Petitioner's injury. The mere fact Petitioner was working when she fell does not, in and of itself, create an increased risk. Therefore, the Arbitrator concludes Petitioner did not sustain accidental injuries that arose out of her employment with Respondent on August 13, 2012. Petitioner's claim for compensation is denied. No benefits are awarded. All other issues are moot.

****

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

LINDA PETERS,

Petitioner,

vs. NO: 12 WC 21878

VILLAGE OF CASEYVILLE,

14IWCC0796

Respondent,

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of accident, causal connection, temporary total disability, medical expenses, and nature and extent, and being advised of the facts and law, reverses the Decision of the Arbitrator but attaches the Decision, which is made a part hereof, for the purposes of the Statement of Facts with the additions and modifications stated below.

The Commission finds that the manifestation date of Petitioner's right carpal tunnel syndrome was March 1, 2012. Although the parties had stipulated to an accident date of September 1, 2010, we find that it is within our discretion to change the accident date to conform to the evidence. See Beal v. Town of Normal, 10 IWCC 380 (2010). The medical records are clear that the first mention of any correlation between Petitioner's right carpal tunnel syndrome and her work duties is the March 1, 2012, office note of Dr. Mirly. Although Petitioner's report of injury on March 2, 2012, indicates a date of accident of "Sept 2011," we find that this is not an appropriate manifestation date in this case because Petitioner did not have a confirmed diagnosis at that time. Based on our determination of the date of accident, we find that Petitioner provided timely notice of her accidental injuries.

On the issue of causal connection, we find that Petitioner's treating doctor, Dr. Mirly, is more credible than Respondent's examining physician, Dr. Stewart. Both doctors agreed that Petitioner's job involved repetitive hand activities but Dr. Stewart did not believe that there was sufficient force involved to increase the risk for developing compression neuropathies.

Petitioner testified about and entered into evidence a typewritten list her job duties (Px6), which does indicate a lot of hand-intensive tasks. Dr. Mirly based his causation opinion upon a sufficient understanding of Petitioner's job as a water clerk, which she performed for 15 years. He opined that the repetitive activities of doing paperwork, tearing cards, filing, typing, and writing were a contributing factor in the development of Petitioner's condition of ill-being. We find that Petitioner has proven that her work activities were, at least, a contributing factor in her right carpal tunnel syndrome.

Therefore, we award Petitioner 2-1/7 weeks of temporary total disability benefits from the date of surgery on June 18, 2012, through the date of Dr. Mirly's release to full duty on July 2, 2012. We also find that Petitioner's medical expenses were reasonable, necessary, and causally related to her work injury and award the following:

Memorial Medical Group	$4,221.00
Belleville Surgical Center	$4,195.00
	$8,416.00

The above expenses shall be paid pursuant to the fee schedule in Section 8.2 of the Act. Respondent shall reimburse Petitioner for $1,722.18 in out-of-pocket payments made towards these bills. Respondent is solely responsible for the charges due to its examining physician, Dr. Stewart. Respondent shall receive Section 8(j) credit for all bills paid through group health insurance with Respondent holding Petitioner harmless for such payments.

Since Petitioner's injury occurred after September 1, 2011, we consider the five factors in Section 8.1b in determining permanent partial disability. There was no reported level of impairment according to the AMA Guides. Petitioner returned to work at her previous job as a clerk. She was 61 years old at the time of her injury, which we find leads to greater disability than that found in a younger person. There does not appear to be any reduction in her future earning capacity. Petitioner testified she notices diminished strength in the right hand and problems opening jars and door knobs. Based on the above, we find that Petitioner has sustained the 10% loss of use of her right hand. According to Section 8(e)9, since Petitioner's repetitive trauma injury occurred after June 28, 2011, her loss of use is based on 190 weeks, which results in a permanent partial disability award of 19 weeks.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $537.26 per week for a period of 2-1/7 weeks, that being the period of temporary total incapacity for work under §8(b) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $485.53 per week for a period of 19 weeks, as provided in §8(e)9 of the Act, for the reason that the injuries sustained caused the 10% loss of use of Petitioner's right hand.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $8,416.00 for medical expenses under §8(a) of the Act subject to the fee schedule in §8.2 of the Act, and shall reimburse Petitioner for $1,722.18 in out-of-pocket payments made towards these bills.

14IWCC0796

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent is entitled to a credit under §8(j) of the Act for amounts paid by its group health insurance carrier; provided that Respondent shall hold Petitioner harmless from any claims and demands by any providers of the benefits for which Respondent is receiving credit under this order.

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

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

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

DATED: SEP 19 2014

Charles J. DeVriendt

Daniel R. Donohoo

Ruth W. White

SE/
O: 8/26/14
49

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

PETERS, LINDA
Employee/Petitioner

Case# **12WC021878**

VILLAGE OF CASEYVILLE
Employer/Respondent

14IWCC0796

On 7/18/2013, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

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

1775 JOHN H HUSTAVA PC
ANDREW NALEFSKI
101 ST LOUIS RD POB 707
COLLINSVILLE, IL 62234

0180 EVANS & DIXON LLC
MARILYN C PHILLIPS ESQ
211 N BROADWAY SUITE 2500
ST LOUIS, MO 63102

14IWCC0796

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

Linda Peters
Employee/Petitioner

v.

Village of Caseyville
Employer/Respondent

Case # **12** WC **21878**

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 **Joshua Luskin**, Arbitrator of the Commission, in the city of **Collinsville**, on **5/22/13**. 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. ☒ What temporary benefits are in dispute?
☐ TPD ☐ Maintenance ☒ TTD
L. ☒ What is the nature and extent of the injury?
M. ☐ Should penalties or fees be imposed upon Respondent?
N. ☐ Is Respondent due any credit?
O. ☐ Other

FINDINGS

On **9/1/11**, Respondent **was** operating under and subject to the provisions of the Act.

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

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

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

Petitioner's current condition of ill-being **is not** causally related to the asserted 9-1-11 accident.

In the year preceding the injury, Petitioner earned **$41,906.16**; the average weekly wage was **$805.89**.

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

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

Respondent is not liable for 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 would be entitled to credit under Section 8(j) of the Act; however, this issue is moot.

ORDER

For reasons set forth in the attached decision, benefits under the Act are denied.

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

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

Signature of Arbitrator

July 16, 2013
Date

JUL 18 2013

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

LINDA PETERS,	)	**14IWCC0796**
	)	
Petitioner,	)	
	)	
vs.	)	**No. 12 WC 21878**
	)	
VILLAGE OF CASEYVILLE,	)	
	)	
Respondent.	)	

ADDENDUM TO ARBITRATION DECISION

STATEMENT OF FACTS

The petitioner, a right hand dominant woman, has been employed as a water department clerk for 15 years. She described her job duties as generally clerical in nature, including waiting on customers, answering phones, processing water bills and mail, running receipts both by hand and on the calculator, occasional typing of letters, and general organization of files. She works a seven and a half hour work day, including two breaks of 15 minutes each. The petitioner asserts carpal tunnel syndrome in the right hand and wrist incurred via repetitive trauma, with an effective date of loss of September 1, 2011. At that time, she was 61 years of age, 5'4," and 237 pounds.

The petitioner had previously received treatment for right hand problems, including the excision of a lipoma from between her index and middle finger metacarpals in 2008 and right thumb problems in 2009, for which she was treated conservatively and provided a thumb spica splint. See RX2.

Relative to this claim, the petitioner first treated on February 7, 2012. At that time she presented to Dr. Mirly, with whom she had previously treated. PX1, RX2-3. She described bilateral hand numbness, particularly in the right hand. Her handwritten history (see RX2) noted that five to six weeks prior, about the middle of December, a knot had appeared on the inside of her right wrist. RX2. Dr. Mirly assessed likely carpal tunnel syndrome and prescribed EMG testing. The petitioner declined a left wrist splint but accepted a right wrist brace. PX1, RX2.

EMG testing was performed on February 22, 2012. The results indicated mild carpal tunnel syndrome in the right wrist. PX2, RX3.

On March 1, 2012, Dr. Mirly reviewed the EMG and diagnosed right carpal tunnel syndrome. Notably, at this time the petitioner related a history of night paresthesia

for one year which had become constant in December 2011. Dr. Mirly recommended operative treatment. PX1, RX2-3.

The petitioner submitted a First Report of Injury form dated March 2, 2012, signed by Denise Logan, the petitioner's office manager. It indicates repetitive hand and wrist movement causing carpal tunnel syndrome in the right wrist. The date of loss indicated was "Sept. 2011." PX4.

The petitioner next saw Dr. Mirly on June 12, 2012. He scheduled her for a right carpal tunnel release via group insurance. On June 18, 2012, he performed a right open carpal tunnel release. PX1, PX3, RX2-3.

The petitioner saw Dr. Mirly postoperatively on June 26, 2012, and reported significant improvement in her symptoms. She declined physical therapy and Dr. Mirly released her to regular work as of July 2, 2012. He instructed her to return as needed. She did not return for a further appointment. PX1, RX2-3.

On October 18, 2012, Dr. Mirly provided a written causal opinion, asserting that he believed that her job duties would be a contributing factor to the development of her carpal tunnel syndrome, and her need for surgery. PX1, RX2.

The respondent had the claimant and her medical records evaluated by Dr. Stewart pursuant to Section 12 on December 18, 2012. See RX1. At that time she reported complete resolution of her pre-operative symptoms. She described her job duties. Dr. Stewart noted some repetition in the duties, but no force associated with them that would correlate with an increased risk of injury via repetitive trauma. He noted her history of obesity and also noted she had been diagnosed with hypothyroidism. He believed her non-occupational risk factors had caused her carpal tunnel syndrome diagnosis and that her work duties did not accelerate it.

The petitioner returned to work on July 2, 2012 and has continued to perform her regular job duties for the respondent.

OPINION AND ORDER

A claimant has the burden of proving by the preponderance of credible evidence all elements of the claim. See, e.g., *Parro v. Industrial Commission*, 260 Ill.App.3d 551 (1st Dist. 1993). The petitioner is relying on a repetitive trauma theory. See, e.g., *Peoria County Bellwood*, 115 Ill.2d 524 (1987); *Quaker Oats Co. v. Industrial Commission*, 414 Ill. 326 (1953). The respondent disputed accident, notice, and causal relationship, as well as medical expenses, temporary disability and the nature and extent of the injury.

The petitioner asserts a manifestation date of September 1, 2011. The determination of an accident date for purposes of repetitive trauma is somewhat flexible but is not completely fluid. In this case, there is nothing to indicate what makes any date

within or even proximate to September 2011 particularly significant. The petitioner did not present for treatment until February 7, 2012, and at that time, she noted symptoms which had arisen in December 2011. When she next saw Dr. Mirly on March 1, 2012, following the EMG of February 22, 2012, she indicated a history of a year's duration, which would have been since February or March 2011, and that these symptoms had spiked in December 2011. No treatment was received on or about September 1, 2011, and there was no indication of a revelation on the claimant's part of her relating her symptoms to work at that time. An accident date in a repetitive trauma claim is not a moving target. No evidence substantiates September 1, 2011 as a rational selection of a meaningful manifestation date within the parameters of *Durand v. Industrial Commission*, 224 Ill.2d 53 (2007).

Moreover, if accident were found, the September 1, 2011 accident date is clearly outside the 45-day statutory period for appropriate notice set forth in Section 6 of the Act. PX4 indicates that the first notice to the respondent was March 2, 2012. Accepting the accident date propounded by the claimant would concurrently establish a jurisdictional bar based on notice, as "Section 6(c) ... prohibits any claims under the Act unless the employee gives notice of his injury within 45 days of the accident." *Lambert v. Industrial Commission*, 79 Ill.2d 243, 247 (1980), internally referencing *Ristow v. Industrial Commission,* 39 Ill. 2d 410 (1968).

For the reasons set forth above, this matter is denied. The issues of causal connection, medical services, temporary total disability and the nature and extent of the injury are moot given the above findings.

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

GAYLE WACHTER,

Petitioner,

vs.

NO: 08 WC 44331
10 WC 12818

DEPT. OF HUMAN SERVICES,

14IWCC0797

Respondent,

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

This case comes before the Commission on Petitioner's §19(h) and §8(a) Petition, alleging a material increase in her disability resulting in additional permanent total disability and claiming additional medical expenses following the previous arbitration hearing, which was held on November 14, 2011. A hearing on the current petition was held before Commissioner Basurto on September 26, 2013, in Springfield, Illinois and a record was made.

The Commission, having considered the entire record, finds that Petitioner is entitled to additional medical expenses but is not entitled to additional permanency benefits.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

1) The original hearing for Petitioner's two cases was held before Arbitrator Granada on November 14, 2011. His decision was issued on December 21, 2011 and awarded 35% loss of the left arm, 15% loss of the left hand, 15% loss of the right arm, and 15% loss of the right hand. Respondent was entitled to a credit of 17.5% of the left arm. On July 9, 2012, the Commission issued a decision, which increased the award to 20% loss of each hand but affirmed the arm awards.
2) Petitioner testified that following her arbitration hearing on November 14, 2011, she returned to her surgeon, Dr. Greatting, because she had a lot more pain in her right arm, the top of the pinky and ring fingers and throughout her wrist. (T.10). Petitioner testified that she always had pain in the top her forearm but it was now on the bottom and side. (T.14).

3) Petitioner also saw Dr. Greatting for deQuervain's tenosynovitis, which is related to a separate workers' compensation claim and not at issue here.
4) Petitioner testified that her left upper extremity has gotten better even thought it was weak and she has "kind of like palsy" and spasms on the pinky side, "but it's about the same." (T.14).
5) Petitioner testified that she is doing the same job as she was prior to her injuries. She works at a work station that includes a keyboard, mouse, and a pad for writing. She was recently moved to a cubicle that has a lower desk but, previously, she felt pain and numbness because her hands were in a bent position. Petitioner testified that she does not do "normal," "simple" because there are a lot of special characters required. Other than an hour lunch and two, 15-minute breaks, Petitioner uses the keyboard and writes all the time during her 8 ½ hour work day. (T.15-17).
6) Petitioner testified that she has a problem reaching things on her desk and has to lean over to write because the keyboard is pulled out in front of her. (T.18).
7) Petitioner introduced photographs (Px9) of her hand "locking up" while she was driving home from work and testified that if she holds her hands in a certain position while typing it will lock up. (T.19).
8) Petitioner testified that she experiences the spasming in both hands:

Q: How frequently do you experience spasming of your hand? And you're describing your right hand. Are we talking about both your right and left hand?
A: Yes, both of them.
Q: Okay. How frequently do you experience the spasming?
A: Spasming on the right side of my pinky?
Q: Yes.
A: When I use this left hand, all the time. If I don't use it, it doesn't spasm. I use the mouse on my right a lot because I have my hand on the table and if I'm not using the mouse at the moment you just kind of rest your hand like this.
Q: Describe how you're resting your hand, please.
A: When you're not using your mouse you rest your hand on the side – on your pinky side of the hand when you're not using it so if I rest it there a lot and not use it then this starts spasming because I'm putting pressure on it.
Q: You're pointing to the outside of your hand?
A: Outside of my hand on the pinky side, yes.
Q: Are you right or left hand dominant?
A: I am right.

(T.20-21).

9) Petitioner testified that she is 53 years old, has approximately 12 years before retirement, and that the six sessions of massage therapy she received were very helpful and she would like to get additional therapy because "they just get sore, tense, tight, lock, and he was a very good massage therapist, he dug deep, they were relaxed, it felt good." (T.21).
10) On cross-examination, Petitioner admitted that she is currently earning more than she was at the time of her injuries and has the same job title. Other than the surgery for the

deQuervain's tenosynovitis, she has not had any additional surgeries since November 2011. (T.23-24).

11) Petitioner admitted that at the previous hearing she testified that that she was having pain, tingling, and spasming in both hands at that time. She also admitted that she was having the "same issues for a long period of time" of weakness, pain, pins and needles in the arms and hands that she complained to Dr. Greatting about on September 15, 2009. (T.24-25).

12) On redirect examination, Petitioner testified that she had tingling and spasms in both hands and that her fingers locked in November 2011 but that it has gotten worse with the right hand. (T.29-30). Petitioner testified:

Q: So when you presented to Dr. Greatting on [3/8/12] I'm going to read what he wrote down and I'm going to ask you if you agree or disagree with what he memorialized.

"She had revision cubital tunnel surgery by me and has improved following that surgery but has not had complete recovery. She is complaining today more of the right arm. She has diffuse complaints, she complains of numbness which involves her whole forearm and hand, she...complains that as she works during the day she will get cramping and spasm type sensations which will occur on the ulnar side of her hand and which will also cause her wrist and fingers to flex. She complains of some pain on the radial side of her wrist."

A: The wrist is really the one that probably brought me there. That's where I was – it had a lot more pain in this – in the top of my hand and my pinky area and across my wrist.

Q: And that's what got worse?

A: And that was different.

Q: Okay.

A: I've always had the tingles, numbness, stabbing.

(T.31-32).

13) On re-cross examination, Petitioner admitted that the right wrist is where she had the unrelated deQuervain's surgery and that Dr. Greatting has not placed any additional restrictions on her. (T.32-33).

14) At the previous hearing on November 14, 2011, Petitioner testified that she had pain, numbness, tingling, and spasming in both hands. (Px3 at 16). Petitioner testified:

Q: Do you notice anything about your fingers?

A: They shake, they tingle, they are like palsy, a couple of them are like palsy; they spasm a lot, they lock up.

Q: What locks up?

A: My hands lock up. Like if I do movement like this they will just lock in place.

(Id.)

Petitioner testified that she noticed all of those symptoms while doing her job duties. Petitioner claimed that she couldn't do a lot of things that she used to be able to

do such as cut steak, curl her hair, or anything that requires both hands. (Id. at 18). She testified that she couldn't hold anything heavy and that her hands lock up and spasm when doing yard work, driving, or holding a book. (Id. at 18-20). Petitioner testified that her right hand was more painful than the left. (Id. at 22). On cross-examination, Petitioner testified that her elbows didn't really bother her but her forearms and hands did and that she had a lot of atrophy in her hand. (Id. at 24-25).

15) At the previous hearing, Petitioner introduced a written list of her symptoms, dated August 4, 2011, which indicated:

> Pain – left and right
> **Hand shakes and sometimes my arm shakes** – left and right
> **Locks up** – left and right – more with left arm/hand
> **Tingles – left and right – more with right arm/hand**
> Stabbing sharp pains, very painful – left and right
> Weak – left and right – more with left arm/hand
> Ache – left and right
> Cold feeling – more with right arm/hand
> **Top and bottom of forearm aches and has stabbing pain** – left and right
> Hand is turning and curling in. Hurts to straighten fully. More in the left but the right is starting.
> Hand and arm tightens up…like Braxton hicks. My skin gets really tight and looks like a skeleton. (It feels like someone is squeezing –with pain, pain, pain then a release feeling).
> **Hand and forearm spasms**, you can visibly see them – left and right
>
> (Px3(Px4), Emphasis added).

16) Dr. Mark Greatting testified, via deposition on September 10, 2013, that prior to the last hearing, he had seen Petitioner on October 5, 2011. Petitioner was working without restrictions but would get shaking or tremors in her arm and some tabbing pains in her right forearm with increased activity. After the last hearing, he saw Petitioner on March 8, 2012, for continuing bilateral arm complaints. He testified that Petitioner complained of some cramping sensation in her left hand and numbness and weakness, which he felt was permanent and still related to her ulnar nerve problem. Petitioner also had complaints in her right arm of some numbness involving the forearm and hand. She described some cramping and spasm type problems in her right hand while working, and complained of pain on the radial side of her right wrist. Dr. Greatting testified that Petitioner had a new finding of deQuervain's tenosynovitis on the right. Comparing Petitioner's pre and post-arbitration hearing conditions, Dr. Greatting testified that her left arm was exactly the same but that the right arm numbness and tingling complaints "I think would have been new." (Px5 at 10).

17) Petitioner underwent treatment for her upper extremity complaints including follow up visits with Dr. Greatting. A repeat EMG/NCV on December 17, 2012, showed mild to moderate ulnar neuropathy at the right elbow and mild left C7 radiculopathy. On January 10, 2013, Dr. Greatting reviewed the EMG and opined that no further surgery would benefit Petitioner and that some of her symptoms are related to recurrent cubital tunnel

syndrome. Dr. Greatting noted that Petitioner's complaints were "mainly a lot of aching pain" more than numbness and tingling. Petitioner reported that her hands will lock onto things such as a steering wheel if she grasps them for a period of time and that writing with pressure on the ulnar side of her right hand caused some discomfort. Dr. Greatting specifically noted that "use of the keyboard and mouse does not bother her much." He allowed Petitioner to continue working and to see him as needed.

18) On August 4, 2011, prior to the previous hearing, Dr. Greatting opined that Petitioner might benefit from a trial of deep tissue massage. Respondent performed a utilization review on December 3, 2012, which certified as medically necessary the EMG/NCV as well as six massage therapy visits. Petitioner underwent six massage therapy sessions with William Davin, LMT from December 21, 2012 through January 18, 2013.

19) Petitioner was examined by Respondent's Section 12 examiner, Dr. Sudekum, on October 1, 2012, who also performed a record review. Although Dr. Sudekum opined that Petitioner's upper extremity complaints were related to a cervical condition, the Commission notes that, at the hearing, Respondent stipulated that it was no longer disputing causal connection but, rather, the reasonableness and necessity of the treatment and whether Petitioner had a material increase in her condition. We also note Petitioner was seen, on August 14, 2013, by Dr. Brian Russell who opined that Petitioner's upper extremity symptoms were not causally related to her cervical condition.

Based on the above and a review of the record as a whole, we grant Petitioner's Section 8(a) Petition in part. Of the medical expenses claimed in Px6, we find that only the following are reasonable, necessary, and causally related to Petitioner's work injuries:

3/8/12	Dr. Greatting office visit	$ 124.00
5//9/12	Dr. Greatting office visit	90.00
6/20/12	Dr. Greatting office visit	90.00
12/6/12	Dr. Greatting office visit	95.00
1/10/13	Dr. Greatting office visit	130.00
8/14/13	Dr. Russell office visit	100.00
12/17/12	Dr. Trudeau (EMG/NCV)	3,846.00
12/17/12	Memorial Medical Center	1,760.00
12/21/12	Massage therapy	84.00
12/25/12	Massage therapy	84.00
1/11/13	Massage therapy	84.00
	Total:	$6,487.00

We find that all of the remaining charges are related to Petitioner's other medical conditions such as deQuervain's tenosynovitis (injections, surgery), right thumb arthritis (x-ray), cervical condition (consultations, massage), and other unrelated conditions.

Although the new EMG did not show anything significantly different than the one performed previously, we find that it was reasonable for Petitioner to follow up with Dr. Greatting for additional treatment and get another EMG in light of her continuing complaints.

As noted above, we find that only three of the massage therapy visits (12/21/12, 12/26/12, and 1/11/13) were reasonable, necessary, and causally related to Petitioner's work injuries. The other three treating notes indicate that those visits were not related to Petitioner's arms or hands. For example, the December 28, 2012, note reflects: "states her arms are much better, would like me to work on her neck today"; January 4, 2013: "states arms are much better would like me to work on her neck and upper back"; January 18, 2013: "states her arms are much better, left neck is still hurting." It does not appear that Petitioner obtained any massage therapy to her right or left arms or hands on those three dates.

The Commission hereby awards $6,487.00 in additional medical expenses subject to the fee schedule in §8.2 of the Act with Respondent receiving credit for any amounts already paid. The Commission notes that some of these medical expenses may also be at issue in Petitioner's separate claim regarding her deQuervain's tenosynovitis. Any bills paid by Respondent pursuant to this decision shall be credited against the other claim and vice versa. In no event shall Petitioner receive double payment for these medical bills.

On the issue of Petitioner's §19(h) Petition, Petitioner's brief asks for additional permanency related to the right arm only. We find that she has failed to prove a material increase in her disability. Dr. Greatting testified that Petitioner's right arm numbness and tingling complaints were new when he saw her on March 8, 2012, after the first hearing. However, we do not find this credible because Petitioner's medical records and testimony from the prior hearing indicate that she was having those symptoms previously. Petitioner has no new restrictions, she is performing the same job, she is earning more now than she did before, she has had no additional surgeries, and her most recent EMG shows essentially the same thing as it did before the previous hearing.

Petitioner's testimony is not supported by the medical records. She claims that her hands lock up and spasm but that was also happening before. The "symptom list" that Petitioner created on August 4, 2011, includes all of the symptoms that Petitioner is claiming she experiences now. Her previous testimony (Px3) indicates that she was experiencing pain, tingling, and spasming in both hands and that they locked up when she did things like hold a steering wheel. At that hearing, Petitioner also claimed that her forearms bothered her as much as her hands did. (Id. at 24). We also note that despite Petitioner's claims of difficulties at work, she has continued working and has no restrictions. Significantly, the January 10, 2013 record of Dr. Greatting indicates that "use of the keyboard and mouse does not bother her."

Based on all of the evidence, while Petitioner may be experiencing a "marginal" increase in her right arm symptoms, we find that she has failed to prove a "material increase" that would warrant additional permanency benefits.

IT IS THEREFORE ORDERED BY THE COMMISSION that Petitioner's Petition under §19(h) is hereby denied.

IT IS FURTHER ORDERED BY THE COMMISSION that Petitioner's Petition under §8(a) is hereby granted, in part, as explained above.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pain to Petitioner $6,487.00 for medical expenses under §8(a) of the Act subject to the fee schedule in §8.2 of the Act.

14IWCC0797

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 19 2014

Charles J. DeVriendt

Daniel R. Donohoo

Ruth W. White

SE/
O: 7/23/14
49

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

Koby Bennett,

Petitioner,

vs.

NO. 08 WC 56663

14IWCC0798

United Airlines, Inc.,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19b having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of temporary total disability, medical expenses, prospective medical care, penalties and fees, 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 May 2, 2013 is hereby affirmed and adopted.

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

14IWCC0798

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

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

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $46,500.00. 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: SEP 19 2014
SJM/sj
o-9/4/2014
44

Stephen J. Mathis

Mario Basurto

David L. Gore

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

BENNETT, KOBY
Employee/Petitioner

Case# **08WC056663**

14IWCC0798

UNITED AIRLINES INC
Employer/Respondent

On 5/2/2013, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.08% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0365 BRIAN J McMANUS & ASSOC LTD
ROBIN FITT
30 N LASALLE ST SUITE 2126
CHICAGO, IL 60602

0560 WIEDNER & MCAULIFFE LTD
EMILY BORG
ONE N FRANKLIN ST SUITE 1900
CHICAGO, IL 60606

14IWCC0798

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)

Koby Bennett
Employee/Petitioner

v.

United Airlines, Inc.
Employer/Respondent

Case # 08 WC 56663

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 **Doherty**, Arbitrator of the Commission, in the city of **Chicago**, on March 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

14IWCC0798

FINDINGS

On the date of accident, **5/10/08**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**26,391.56**; the average weekly wage was $507.53.

On the date of accident, Petitioner was 39 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 $**73,469.32** for TTD, $0 for TPD, $0 for maintenance, and $0 for other benefits, for a total credit of $73,469.32.

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

ORDER

Respondent shall pay temporary total disability of $338.35 per week for 137-1/7 weeks commencing 11/3/09 through 6/22/12 . Respondent shall receive credit for amounts paid.

Respondent shall pay to Petitioner reasonable and necessary medical expenses incurred through 6/22/12 except as delineated in the Decision pursuant to Section 8(a) of the Act. Respondent shall receive credit for amounts paid.

Petitioner's request for prospective surgery is denied. See Decision

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

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

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

5/2/13
Date

ICArbDec19(b)

MAY - 2 2013

FINDINGS OF FACT

Petitioner, a 39 year old flight attendant, began working for Respondent in that capacity in 1998. He last worked for Respondent in 2011. Accident is not at issue. On May 10, 2008, Petitioner was at recurrent training when he bumped his head on the overhead bin. Petitioner developed neck pain radiating into his arms and hands bilaterally. This matter was last tried as a 19b on 11/2/09 and a Decision was issued on 2/2/10 finding that Petitioner causal connection for Petitioner's condition of C5-6 posterior anular bulge and osteophyte ridging complex causing mild central stenosis and also mild bilateral foraminal narrowing and a small broad based posterior disc bulge of 2 to 2.5mm. The Arbitrator awarded prospective medical treatment recommended by Petitioner's treating physician, Dr. Palmer, which included a trial of epidural injections and further physical therapy. The Arbitrator also noted Dr. Palmer's 2009 recommendation of possible further work up thereafter, including EMG/NCV, discography and possible surgery should Petitioner's condition not improve after the more conservative treatment. The Arbitrator also awarded TTD from 5/11/08 through 11/2/09- the date of the 19 B hearing. PX 10.

At issue at the current 19 B hearing before this Arbitrator, is causal connection for Petitioner's current condition of ill-being, medical bills, TTD after 11/2/09 to date, penalties and attorney's fees and prospective medical treatment. ARB EX 1.

At trial, Petitioner testified that he underwent the epidural injections awarded in the first hearing. The injections were performed in November 2010 by Dr. Paicius, Petitioner's treating pain management doctor in California where Petitioner resides. PX 4. Petitioner reported no improvement from the injections and was returned to Dr. Palmer, his treating neurosurgeon for follow up.

On 2/24/11, Dr. Palmer noted the failure of Petitioner's epidural injections. PX 3. He further noted Petitioner's complaints of pain in the base of his neck and pain in the left arm and hand greater than on the right side. Numbness and weakness was greater in the left hand. Dr. Palmer further noted that Petitioner's Oswestry cervical spine disability index score was 62/100. The neurologic exam was positive for numbness in the arms, tingling in the hands and headaches. The psychiatric exam was positive for anxiety, panic attacks and restlessness but negative for depression. He noted the cervical MRI results from 6/1/10 showed C5-6 degenerative joint disease, no central stenosis, no foraminal stenosis. PX 3. The impression was cervical degenerative joint disease and mild degenerative joint disease C5-6. Dr. Palmer recommended an EMG/NCV, pain management consult, discogram, and Ct myelography.

A 2/25/11 progress note from treating physician Dr. Sklar notes that Petitioner was scheduled for an EMG/NCV and discogram to be performed by Dr. Paicius and that Dr. Palmer scheduled Petitioner for possible surgery "after all the testing is evaluated." PX 2. On 4/1/11, Dr. Sklar noted that Petitioner was still waiting for treatment authorization and that he presented with bilateral radicular numbness in his legs on the outer portion of his calves from the knee to the ankle with positive neurological straight leg raising tests. PX 2. Petitioner was placed on Neurontin to decrease the calf pain.

Petitioner attended a Section 12 exam with Dr. Erickson in Illinois on 4/21/11. Dr. Erickson agreed Petitioner needed surgery at the C5-6 level and initially recommended a disc replacement rather than a fusion. In a revised letter dated the same day, Dr. Erickson recommended a discectomy and fusion at C5-6 as directed by the electrophysiologic studies and the MRI scan. Dr. Erickson determined that

Petitioner's subjective complaints of pain correlate with the MRI findings. He agreed with the need for an EMG/NCV. PX 8.

Petitioner underwent the EMG/NCV on 6/17/11. The test was performed by Dr. Spokoyny and the impression was that the testing revealed "no evidence of carpal tunnel syndrome, other compression neuropathies, cervical radiculopathy, and peripheral neuropathy." PX 5. The only abnormal finding was ulnar motor nerve abnormal L-R latency difference (0.7 ms). PX 5.

Petitioner returned to Dr. Palmer on 6/27/11. PX 3. He repeats that the EMG/NCV studies were normal. He further states that options for care were discussed including disc replacement or fusion and mentions Dr. Erickson's initial recommendation for disc replacement and Petitioner's desire to undergo a disc replacement rather than an anterior cervical discectomy and fusion. Dr. Palmer ordered flexion and extension x-rays, DEXA scan and a new MRI to determine which surgery would be appropriate. The cervical MRI of 8/10/11 revealed a C4-5 less than 2 mm broad based disk osteophyte complete without significant spinal stenosis or neural foraminal narrowing, a C5-6 2 mm broad based disk osteophyte complex without significant spinal stenosis and mild bilateral neural foraminal narrowing and at C6-7 minimal less than 2 mm broad based disk osteophyte complex without significant spinal stenosis or neural foraminal narrowing. PX 3. The x-rays revealed mild bony foraminal stenosis at the C5-7 levels with mild uncovertebral joint spurring identified, mild degenerative changes at the C5-6 disc with mild retrolisthesis of C5 at 1mm and with flexion and extension, fixed retrolisthesis of C5. The impression was fixed retrolisthesis of C5, mild degenerative changes at this level with posterior osteophyte and foraminal stenosis. PX 3.

Petitioner followed up with Dr. Palmer on 8/29/11. Dr. Palmer viewed the above testing and noted that the MRI scan showed "...C5-6 degenerative joint disease with a 2mm bulge and moderate foraminal stenosis, left greater than right, with minimal degenerative disc disease at C4-5 and C6-7. X-rays with flexion and extension viewed showed C5-6 degenerative joint disease with partial collapse of the disc, no motion on flexion/extension, only minimal; thus normal motion is seen. There is mild foraminal stenosis at C5-6 and C6-7." PX 3. He noted the DEXA scan was not approved unless a disc replacement was elected. Dr. Palmer noted neck guarding with moderate limitation of motion on exam. He recommended a discogram at C4-5, C5-6 and C6-7 to evaluate for possible anterior cervical discectomy and fusion versus total disc replacement. A discogram was performed on 1/16/12 as noted by Dr. Palmer at the next visit of 1/18/12. Dr. Palmer noted the discogram "... was positive at C6-7 and negative at C4-5, which showed a normal morphology on Ct scanning. However, C6-7 was negative as well but did show an abnormal morphology consistent with degenerative disc disease." The post discogram CT scan showed symmetric bulging disc and grade 5 annular tears at the C5-6 and C6-7 levels. PX 3. The discogram itself showed "positive C5-6 discogram negative above and below." PX 3. Dr. Palmer discussed options with Petitioner and noted that "I think that a total disc replacement at C5-6 would be his first choice, leaving C6-7 alone and without having to fuse C5-6 and C6-7 which may continue to function for some time in the future." He further concluded that if a discectomy and fusion were performed C5-6 and C6-7 would be fused at the same time. Dr. Palmer ordered the DEXA scan based on the elected C5-6 disc replacement.

Petitioner attended a Section 12 examination with a second examining physician, Dr. Deutsch on 6/22/12. Dr. Deutsch is a neurosurgeon at Rush University Medical Center. I his reported dated 6/22/12, Dr. Deutsch notes Petitioner's prior treatment and objective test results. Petitioner reported 8/10 pain and that

he could not generally drive due to severe neck pain which was worsening over time. Dr. Deutsch also notes that he reviewed surveillance video from January 2012 and noted the video depicted Petitioner "functioning without any disability." RX 3. Petitioner was wearing a soft cervical collar at this visit and reported neck pain and stiffness with rotation. Dr. Deutsch assessed Petitioner degenerative disc disease at C5-6 per his MRI of 8/10/11. He further noted that Petitioner's "complaints of pain and pain with neck motion at the examination seem inconsistent with the activities noted on the surveillance material. At the examination he is wearing a soft cervical collar not worn during his surveillance. His examination is consistent with symptom exaggeration." He further noted that the described mechanism of injury is not sufficient to cause cervical spine damage and based on the MRI showing degenerative condition and not an acute disc herniation or other trauma Dr. Deutsch opined that the initial diagnosis of cervical strain is reasonable. Accordingly, Dr. Deutsch opined that the treatment has been excessive and that disc surgery is not reasonable give the "inconsistency of the physical examination and surveillance data provided." He further determined that surgery is unlikely to help axial neck pain and that Petitioner was at MMI and could return to full duty work. RX 3.

Petitioner's TTD was terminated as of 7/3/12. RX 1.

Petitioner did not follow up with Dr. Palmer after seeing Dr. Deutsch. Dr. Palmer continued with his surgical recommendation for a disc replacement at C5-6 and Petitioner wants to undergo the surgery. He continues to treat with pain management doctor, Dr. Paicius. Petitioner is on multiple medications for complaints of pain at 10/10. Medications include Neurontin, MS Contin, Effexor, Zofran and Xanax. PX 4. Petitioner testified that his pain medication includes both instant morphine and extended relief morphine.

Dr. Palmer's deposition was taken on November 12, 2012. PX 9. Dr. Palmer testified that he reviewed the 6/1/10 MRI and found degenerative disc disease at C5-6 with no significant central or foraminal stenosis. PX 9, p. 11. He stated that there was "a little bit of bulging of that disc ... consistent with the degenerative process at that disc level." PX 9, p. 12. When compared to the MRI of 2009 he stated the study results were equivalent and that the bulge was a result of the collapsed disc space. PX 9, p. 13. Based on his review of the MRI films he saw some narrowing of the foramen which would correlate with Petitioner's complaints of bilateral arm pain, numbness and weakness in February 2011. PX 9, p. 14-15. He diagnosed mild degenerative joint disease at C5-6 giving Petitioner neck pain and arm pain. PX 9, p. 15. Dr. Palmer ordered an EMG, flexion and extension x-rays and a discogram. Dr. Palmer agreed that the EMG was negative. PX 9, p. 16. The MRI of 8/10/11 showed degenerated disc at C5-6 with partial collapse, a 3 mm bulge with moderate foraminal stenosis more prominent on the left than right and minimal degeneration at the adjacent discs. PX 9, p. 23. In his opinion, the subsequent discogram showed positive reproduction of pain at C5-6. PX 9, p. 25. The following CT scan showed a level 5 annular ligament tear at C5-6. PX 9, p. 25-26. In his opinion, Petitioner requires a total disc replacement at C5-6. PX 9, p. 29.

Dr. Palmer opined that the mechanism of Petitioner striking his head on an overhead bin is sufficient to aggravate a degenerative disc and cause Petitioner's current cervical condition of grade 5 annular tears at C5-6. PX 9, p. 31. Hi opinion was further supported by the fact that Petitioner was not symptomatic before this injury. PX 9, p. 33. On cross, Dr. Palmer clarified that Petitioner's flexion and extension x-rays were "by no means normal" in that he read them to show a lack of normal motion at C5-6. PX 9, p. 40. He also clarified his 1/18/12 report to read that the discogram was positive at C5-6 not C6-7. PX 9,

p. 43. He agreed the pain scale is totally subjective and that Petitioner reported on more than one occasion that his pain level was severe. PX 9, p. 45-47. Petitioner reported a worsening of symptoms since the original accident. PX 9. P. 50. Dr. Palmer stated that he would expect Petitioner to have restriction in his neck motion in 2011 and 2012. PX 9, p. 56. He testified that Petitioner might be able to work a desk job but that his work capacities would be limited due more to his pain medication usage than to his structural limitations in his neck. PX 9, p. 57. Finally, Dr. Palmer agreed that someone with Petitioner's pathology could be asymptomatic and never need surgery. The surgical recommendation for Petitioner is in part based on his reported symptoms. PX 9, p. 58. Dr. Palmer testified if Petitioner "... was proven to be malingering and have no pain, then he may not need surgery...". PX 9, p. 59. On redirect, Dr. Palmer testified that based on his visits with Petitioner and on his review of Petitioner's medical records from other providers including Dr. Paicius, he found no indication of symptom exaggeration other than a reference to "some surveillance data." PX 9, p. 61. He further opined that it is "normal" for Petitioner to display symptoms from this injury based on the correlation between the totality of his symptoms and the objective test results including the MRIs, x-rays and discogram. PX 9, p. 63

Dr. Deutsch was deposed on 2/1/13. He examined Petitioner on 6/22/12 and reviewed the MRI films, records of Dr. Palmer, reports of epidural injections, the discogram results, and as surveillance video from January 2012. Petitioner was wearing a soft cervical collar to the exam and often grimaced and changed positions during the exam. RX 5, p. 9. He found Petitioner neurologically intact on exam and that his complaints of neck pain on any rotation of the neck were suggestive of symptom magnification. RX 5, p. 9. He reviewed the surveillance video and testified that it was at odds with Petitioner's complaints of neck pain and motion as on the video he saw Petitioner "moving his neck fine...". He testified "I thought that his MRI was consistent with degenerative disc disease and I thought that his overall exam and symptom complaints were consistent with symptom exaggeration. I don't believe he has an acute disc herniation. I believe he was initially diagnosed with a cervical strain, which is reasonable, possibly, but those symptoms should have resolved within several weeks after the injury." RX 5, p. 11. Again, he testified that the MRI showed disc bulging and degenerative changes and that Petitioner does not have a true cervical radiculopathy based on a lack of significant arm complaints. RX 5, p. 13. The EMG was normal reinforcing his opinion that there is no evidence of cervical radiculoapthy. RX 5, p. 31. He saw no nerve compression on any MRI. Regarding the discogram, he opined that it is not a medically appropriate test that should ever be done as it is controversial and unreliable in a cervical situation. RX 5, p. 15. Dr. Deutsch further opined that the 2011 MRI showed normal degenerative findings which tend to worsen over time thus explaining the difference between the 2008 and 2011 MRI results. RX 5, p. 17. He does not read the MRI or the discogram to show tears but only degenerative changes. RX 5, p. 18.

With regard to the video surveillance, Dr. Deutsch considered Petitioner to be active in the video and found significant the fact that Petitioner was not seen wearing the cervical collar. RX 5, p. 20. In the office during the exam Dr. Deutsch noted that Petitioner was wearing the collar and that he "was walking sort of like a robot where he wasn't turning his head at all. He was wincing a lot; you know any time he had to change position he grimaced. I didn't see any of that on the surveillance video." RX 5, p. 20. Petitioner was seen walking quickly and driving on the video backing his car out of a parking space. Petitioner reported that he could minimally drive at best. RX 5, p. 21. Dr. Deutsch further noted of significance was the fact that Petitioner had two visits with his pain doctor, Dr. Paicius, where he reported 8/10 pain levels during the same period of time the video surveillance was taken. Dr. Deutsch opined that Petitioner is over representing his pain relative to his functional capacity. RX 5, p. 25. Finally, he

testified that he does believe Petitioner has some neck pain but that he believes it is not very severe and not severe enough to warrant surgery. RX 5, p. 28-29.

The Arbitrator notes that at trial, Petitioner wore a soft neck brace and exhibited extensive pain behavior. He testified that he is not able to work and can barely perform activities of daily living. He testified he is unable to walk long distances and cannot drive as he is on morphine. He testified that his pain limits him such that he cannot donate any time to charity work. His activities of daily living are affected in that he cannot cook or perform household chores and that his quality of life with his life partner is decreased. Petitioner testified that he has no feeling in his hands and pain in the arms and neck. Lifting a gallon of milk is difficult. Petitioner's partner testified that he is in constant pain.

The Arbitrator reviewed surveillance video of Petitioner taken on 12/28/11, 12/29/11, 1/6/12 and 1/14/12. RX 6. On 12/28/11, Petitioner is seen getting in and out of a black Ram 1500 truck and driving the truck on various errands to retail stores. He walks freely to and from the stores across parking lots quickly and erectly with arms swinging at his sides. He backs the truck out of parking spaces. Petitioner is seen leaning in and out of the passenger side of the truck. On 12/29/11, Petitioner is seen running errands as a passenger in a smaller vehicle driven by Mr. Stace. Again, he is seen walking freely, quickly and erect with no evidence of grimace or restricted movement. He is not wearing a cervical collar in any video. On this date, Petitioner is seen pushing various shopping carts in the parking lots with what appears to be minimal items in the carts. On one occasion he is seen lifting champagne bottles two at a time from a cart height down to the ground level into a bag and vice versa from the bag on the ground back into the cart. While doing this activity he is bending freely at the waist and does not appear in pain. The last two days of video on 1/6/12 and 1/14/12 Petitioner is not readily visible as most of the footage was shot either at night or inside the Pistons bar owned by Mr. Stace. Petitioner is briefly seen sitting at a computer in the bar office.

According to Respondent's witness David Goodrich, the investigator hired to do the surveillance, he saw Petitioner checking stock of liquor bottles behind the bar on 1/14/12. He testified that he observed Petitioner in this activity for about 3 minutes but did not turn the surveillance camera on because he would appear to conspicuous. As a result, this activity is not on video. The activity is documented in his report. RX 7.

As part of the surveillance report, Respondent submitted photos at trial of Petitioner and his connection to Pistons bar. Petitioner testified that the bar is solely owned by his partner, Robert Stace. Petitioner testified that the bar is a neighborhood establishment and that he frequents the bar simply because his partner owns the bar and he is there to support Mr. Stace. Petitioner testified he is not an owner or employee of the bar. The photos submitted were taken from the bar's website. Petitioner is depicted with several others in a shot entitled "Here to serve you." RX 7.1 Petitioner and the others are wearing Pistons t-shirts. Petitioner testified that any customer who wants a t-shirt can have one. He is also in a photo with the winner of a bar contest entitled "Mr. Pistons Leather 2011" and is seen with both arms extended over the winner in a jovial manner. RX 7. Finally, Respondent submitted print outs from a blog entitled "Leatherati" which references the passing of Pistons ownership from the prior owner to "new owners" Robert Stace and Koby Bennett. On another entry, Petitioner is listed as the general manager. RX 7. No W2 forms were submitted that showed income from any employer other than Respondent from 2008 – 2011. Petitioner testified that he makes casual stops at the bar to bring supplies to Mr. Stace.

Mr. Stace testified that Petitioner is not an owner but that he alone is the sole owner of the bar. Took ownership of the bar in February 2010. All corporate documents including the lease agreement and liquor license are solely listed to Mr. Stace as the owner. Mr. Stace testified that any reference on the website to Petitioner's ownership is incorrect. Mr. Stace testified that Petitioner's photo is the bar website because it is a small family run business. T-shirts go to all customers as a promotion and are not intended solely for employees. Further Mr. Stace testified that it is not uncommon for customers to go behind the bar and that Petitioner has free access to all areas of the bar as his spouse.

Petitioner testified that he has been unable to work from May 2008 through the present time. Petitioner has filed an ADE lawsuit to be reinstated as a flight attendant and for back pay for a period that covers the period he has received TTD. Petitioner testified on cross that he was able to function as seen on the videos as his pain levels ranged from 5 to 7/10 and is severe on occasion. When asked about the amount of pain medication he was on as compared to his testified occasional severe pain, Petitioner testified that his pain can spike at any time.

CONCLUSIONS OF LAW

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

In support of the Arbitrator's decision relating to whether the condition of ill being was caused by the injury and whether prospective medical treatment is appropriate and related, the Arbitrator finds as follows:

The Arbitrator finds that the Petitioner failed to prove that his current complaints, now nearing 5 years after the accident, remain causally related to the work injury on May 10, 2008. The Arbitrator further finds that the cervical surgery proposed by Dr. Palmer is not reasonable, necessary or causally related to that workplace incident.

The evidence introduced at both hearings in the matter establishes that Petitioner did have a compensable accident on May 10, 2008, when he arose from a seat in a mock plane and struck his head on the overhead bin. The medical evidence establishes that Petitioner has received extended conservative care for what the medical experts agree stems from degenerative disc disease at C5-6. Dr. Palmer reads the medical evidence to suggest annular tear at C5-6 with radiculopathy meriting cervical surgery. Dr. Deutsch determined that Petitioner does not suffer from radiculopathy and that his condition does not merit any additional treatment. Dr. Palmer opined that Petitioner's condition stems from the accident which aggravated Petitioner's degenerative condition. Dr. Deutsch opined that the mechanics of the accident do not support that opinion. Dr. Deutsch opined that Petitioner's MRI films revealed degenerative findings, with no evidence of nerve compression or of disc herniation. The EMG was in fact normal. Dr. Palmer agrees the EMG was normal but bases his surgical opinion on a positive discogram.

The Arbitrator finds Dr. Deutsch's testimony that the positive discogram is of no clinical significance persuasive in light of the medical evidence as a whole and specifically, the negative EMG. Dr. Palmer's opinion is based on his interpretation of the MRI's, the positive discogram, and on Petitioner's continued subjective pain complaints. Dr. Palmer has admitted on deposition that absent pain, petitioner would not necessarily be a surgical candidate. He admitted that patients with the petitioner's disc pathology can be asymptomatic and not require surgical intervention. Dr. Palmer further agreed that if Petitioner "... was

proven to be malingering and have no pain, then he may not need surgery...". PX 9, p. 59. On redirect, Dr. Palmer testified that based on his visits with Petitioner and on his review of Petitioner's medical records from other providers including Dr. Paicius, he found no indication of symptom exaggeration other than a reference to "some surveillance data." PX 9, p. 61. The Arbitrator notes that Dr. Palmer did not see the surveillance video.

In light of the fact that the surgical recommendation is based in large part on continued subjective pain complaints, the Arbitrator finds that Petitioner's credibility is at issue in determining causal connection for Petitioner's current condition of ill-being and whether the recommended surgery is to be awarded. Based upon a review of the totality of the evidence, the Arbitrator finds Petitioner not credible in his testimony regarding his current condition or his pain complaints over the last 3 years. In so finding, the Arbitrator notes Petitioner's presentation at trial was fraught with constant grimacing and rocking in pain. Petitioner was wearing a cervical collar, which he testified was prescribed 5 years ago by Dr. Sklar, and was severely limiting his movements. He testified extensively to constant pain and to the extinction of his daily activities despite taking significant pain medication. The Arbitrator contrasts this behavior and testimony with what is seen on the video surveillance as did Dr. Deutsch. The Arbitrator finds the surveillance footage described above demonstrates inconsistencies in Petitioner's alleged pain complaints and claimed disability. The inconsistencies noted are of such significance so as to negate Petitioner's claim of causal connection and the need for surgery.

Petitioner's medical records in late 2011 indicate that his pain complaints are severe. However, during the purported severe pain period, Petitioner is seen on the video walking, moving his neck, driving, and running errands freely, without limitation and without a cervical collar. The video further shows Petitioner backing a Ram truck out of parking space, carrying bags and boxes, reaching in an out of the front seat and trunk of the vehicles, making several stops, and moving bottles from cart height to ground level and vice versa- all without apparent effect. The video activity vastly differs from Petitioner's presentation at trial.

Based on the foregoing, the Arbitrator finds the opinion of Dr. Deutsch regarding Petitioners' condition of ill-being more credible than that of Dr. Palmer. Accordingly, the Arbitrator finds causal connection for Petitioner's condition of ill-being through 6/22/12, the date of his exam by Dr. Deutsch. The Arbitrator further finds that Petitioner is not entitled to the requested surgery.

In support of the Arbitrator's decision relating to whether TTD benefits are due and owing, the Arbitrator finds as follows:

The Arbitrator notes that Petitioner's last work restrictions were given to him by Dr. Sklar and included light duty restrictions of no lifting more than 15 pounds. The Arbitrator does not assign great weight to the repeated off work notations of Dr. Paicius as they appear formulaic and without substantive basis. The Arbitrator further finds the evidence intending to show that Petitioner was an employee or owner of Pistons bar insufficient to negate his receipt of the TTD paid to him by Respondent through 7/2/12. Specifically, the Arbitrator finds the evidence insufficient to show Petitioner's ability to work during the period he received TTD so as to negate his receipt of same. Rather, the Arbitrator finds that Petitioner casually frequented the bar as it was owned by his spouse.

The Arbitrator notes Respondent has paid TTD benefits through 7/7/12 and terminated benefits at that time based on the opinion of Dr. Deutsch. Based on the Arbitrator's findings solely on the issue of causal connection for Petitioner's condition of ill-being through 6/22/12, the Arbitrator further finds that Petitioner is entitled to TTD benefits commencing 11/3/09 through 6/22/12 at the TTD at the rate of $338.35. Respondent shall receive credit for amounts paid.

In support of the Arbitrator's decision relating to whether the medical services that were provided to Petitioner were reasonable and necessary and whether Respondent has paid all appropriate charges for all reasonable and necessary medical services, the Arbitrator finds as follows:

The Arbitrator notes that Petitioner did sustain a neck injury while working for the Respondent on May 10, 2008. The Arbitrator notes that all medical expenses from May 10, 2008 through the present were placed at issue at the current 19(b) hearing. Based on the Arbitrator's finding of causal connection, the Arbitrator further finds that the medical care received by Petitioner through 6/22/12 is reasonable, necessary and causally related to the accident, with the exception of the discogram. In so finding with regard to the discogram, the Arbitrator finds credible the opinion of Dr. Deutsch questioning the reliability of the discogram in light of the prior diagnostic testing and Petitioner's pain complaints as well as on the UR report submitted at RX 11. The Arbitrator notes the opinion of Dr. Deutsch and the UR physician regarding the lack of diagnostic value of a discogram given Petitioner's cervical complaints. The Arbitrator's findings are further based on the causal connection findings discussed above.

Accordingly, Respondent shall pay to Petitioner the reasonable and necessary medical expenses incurred from May 10, 2008 through 6/22/12 with the exception of the discogram, pursuant to Section 8(a) of the Act. ARB EX 1, PX 7. Respondent shall receive credit for amounts paid.

In support of the Arbitrator's decision relating to whether penalties and fees should be assessed against Respondent in this case, the Arbitrator finds as follows:

The Arbitrator notes that Respondent paid TTD benefits up through July 7, 2012. The Respondent did not terminate benefits until after Petitioner's exam by Dr. Deutsch. Based on the Arbitrator's findings on the issue of causal connection, the Arbitrator further finds that Respondent's conduct in terminating benefits based upon the opinions of Dr. Deutsch was neither so unreasonable nor vexatious so as to warrant the imposition of fees and penalties under the Act. Therefore the Arbitrator finds that no penalties and fees should be awarded against the Respondent 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

Lech Marszalek,

Petitioner,

vs.

NO. 05 WC 17491

14IWCC0799

JKC Trucking,

Respondent.

DECISION AND OPINION ON REVIEW

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

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

14IWCC0799

The party commencing the 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 19 2014
SJM/sj
o-8/7/2014
44

Stephen J. Mathis

David L. Gore

Mario Basurto

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

MARSZALEK, LECH
Employee/Petitioner

Case# **05WC017491**

JKC TRUCKING INC
Employer/Respondent

14IWCC0799

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:

2902 PETER G LEKAS
ATTORNEY AT LAW
221 N LASALLE ST SUITE 1700
CHICAGO, IL 60601

1706 SONENTHAL, LLOYD
70 W MADISON ST
SUITE 2275
CHICAGO, IL 60602

14IWCC0799

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

Lech Marszalek
Employee/Petitioner

v.

JKC Trucking Inc.
Employer/Respondent

Case # **05** WC **17491**

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 **Milton Black**, Arbitrator of the Commission, in the city of **Chicago**, on **March 28, 2013** and subsequently reassigned and heard by the Honorable **Barbara N. Flores**, Arbitrator of the Commission, in the city of **Chicago**, on **July 22, 2013** and **September 25, 2013**. After reviewing all of the evidence presented, the undersigned Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☒ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☒ What was the date of the accident?
E. ☒ Was timely notice of the accident given to Respondent?
F. ☒ Is Petitioner's current condition of ill-being causally related to the injury?
G. ☐ What were Petitioner's earnings?
H. ☐ What 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 10, 2003**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

As agreed by the parties preceding the injury, Petitioner earned **$45,344.00**; the average weekly wage was **$872.00**. *See* AX1.

On the date of accident, Petitioner was **50** years of age, ***married*** with **no** dependent children.

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

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

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

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

ORDER

As explained in the Arbitration Decision Addendum, Petitioner failed to establish that a compensable accident arose out of and in the course of his employment. By extension, all other issues are moot and all requested compensation and benefits are denied.

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

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

Signature of Arbitrator

December 31, 2013
Date

DEC 31 2013

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION *ADDENDUM*

Lech Marszalek
Employee/Petitioner

v.

JKC Trucking Inc.
Employer/Respondent

Case # **05** WC **17491**

Consolidated cases: **N/A**

FINDINGS OF FACT

The issues in dispute are accident, notice, causal connection, Petitioner's entitlement to a period of temporary total disability benefits, and the nature and extent of Petitioner's injury. Arbitrator's Exhibit[1] ("AX") 1. The parties have stipulated to all other issues. AX1.

Background

Petitioner testified about some prior injuries and treatment to his left leg and left shoulder. He was involved in a car accident in 1989 and injured his left leg and left shoulder. Thereafter he received medical treatment for three months and underwent physical therapy, but did not undergo any surgery. Petitioner was off work for two months. He testified that he did not have any problems with his left leg or left shoulder thereafter. Petitioner also testified that he was involved in a second car accident in 1992 when he was rear-ended by a drunk driver. Petitioner testified that he received medical treatment for three months and had physical therapy with Dr. Senno at Diversey Medical Center for the injuries to his left leg and left shoulder. He testified that he did not undergo any MRIs or x-rays and that he was then "ok" and back to normal.

Before working for Respondent, Petitioner had his own demolition, wrecking and excavating business for 15 years. Due to the economy, however, Petitioner testified that he closed this business in approximately 2000 and then began working for a general contractor. Petitioner testified that he had no back problems between 2000 and 2003, and that he did not work during this period because there were no jobs.

On cross examination, Petitioner testified that he was self-employed in the wrecking/excavating business at the time of the 1989 accident. He had a back hoe and loader machines, but did not drive the trucks that got these machines to the job sites. Petitioner testified that these machines did not vibrate or shake during the 15 years that he was in the demolition business. Petitioner testified that there is no lifting involved in the demolition business and he denied telling any doctors that he could drive dump trucks.

Petitioner testified that he got his Class A driver's license approximately two months before his pre-employment screening. He then took a pre-employment exam for Respondent on April 8, 2003, which he passed. The test required him to lift 75 pounds, which he understood was a requirement to unload trucks. *See also* PX5.

Petitioner testified that he had no low back pain or pain in either leg prior to July 10, 2003.

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[1] The Arbitrator similarly references the parties' exhibits herein. Petitioner's exhibits are denominated "PX" and Respondent's exhibits are denominated "RX" with a corresponding number as identified by each party. Exhibits attached to depositions will be further denominated with "(Dep. Exh. _)." The Arbitration Hearing Transcript is denominated by the date of hearing and "Tr." with corresponding page numbers.

July 10, 2003

On the claimed date of accident, Petitioner was employed by Respondent as a long distance driver for approximately three months driving 18-wheelers. Petitioner described his truck as a simple 10-speed truck and testified that he has an A-class driver's license for 18-wheelers. Petitioner testified that his route was from Summit, Illinois to Sacramento, California, usually to a Walgreens warehouse, and that it took three days. Petitioner testified that he would change to an empty trailer at the warehouse and then go somewhere in California to pick up fruits and such after which he would call dispatch in Chicago and would be given a second load somewhere in California to bring back.

Petitioner testified that on July 10, 2003 he was on his way back from California when he noticed "big" and sharp pain in both legs. He testified that he could not walk or move completely. He noticed this while in the Walgreens warehouse in Sacramento, California when he was delivering product. He testified that he did not unload this product, but rather dropped the trailer and the Walgreens workers unloaded the product. Petitioner testified that he did not experience pain on the way to Sacramento, California, but that he felt pain on the way back to Chicago, Illinois located in his low back all the way to his toes with worse pain in the left leg.

Petitioner added that, while the truck has a suspension system, it vibrated and shook and he noticed pain in his low back when this occurred as well as when he hit potholes. On his return to Chicago, Petitioner testified that he called his boss, Mr. Kucharski, the owner, at 5:00 a.m. and told him that he had a problem with his back from his trip to Sacramento and that he could not work or go back to Sacramento with a new load.

On cross examination Petitioner testified that he did not quit and he was not fired, but he told Respondent that he could not drive anymore. He applied for disability. Petitioner testified that he laid on the floor for two months.

Petitioner also testified on cross examination that the seat in the truck was broken and that it did not go up and he acknowledged that he did not complain about a broken seat. He later testified that he mostly took the same truck on the trips for Respondent. Petitioner testified that he did not lift anything before noticing the pain and that he did not fall. Rather, while in Sacramento, California he was in the truck when he noticed the pain. He explained that he was sitting in the truck approximately 2-3 hours sleeping and laying down in the sleeper section of the truck waiting for his turn to unload. When Petitioner woke up, he testified that that is when he noticed the pain immediately. Petitioner did not recall whether the pain woke him up and believed that the pain came from driving the truck. Petitioner testified that he got out of the truck and went to the pharmacy to get over-the-counter pain pills. He also testified that he called Mr. Panek, he thinks, or someone at Respondent and reported that he had pain in his back and they told him to return to Chicago. Petitioner testified that the pain increased while driving.

Petitioner further testified that on cross examination that when he returned to Summit, Illinois he talked to Mr. Panek and told him that he had pain and that his back hurt from driving the truck. Petitioner did not recall what Mr. Panek said to him, except to bring papers for the new load, and he denied telling Mr. Panek that his back hurt over several years.

Petitioner further testified that someone else told him to notify the owner and he called Mr. Kucharski because he had a big pain after coming from the emergency room at Swedish Covenant Hospital when he got a shot the day after returning to Summit, Illinois.

Medical Treatment

Petitioner testified that he always reported that the pain he experienced was from the truck and a bouncy ride from Sacramento, California to Summit, Illinois. Petitioner acknowledged that he did not tell any doctor that any specific event (other than the bouncy truck ride) caused his pain.

Petitioner was initially examined by Dr. Senno at Diversey Medical Center on July 19, 2013. PX1 at 3. Dr. Senno diagnosed Petitioner with sciatica, prescribed Vicodin and Flexeril, and ordered a lumbar spine MRI and physical therapy. *Id.* Petitioner began physical therapy at Diversey Medical Center on July 22, 2003 reporting severe low back pain radiating to both lower extremities. PX1 at 4. By July 28, 2003, Petitioner reported no improvement with physical therapy and continuing severe low back pain and that he could hardly walk that day. *Id.* Petitioner reported some improvement thereafter with physical therapy through August 1, 2003. PX1 at 5. Petitioner testified that he had pain in the low back and legs during physical therapy.

Petitioner went to Swedish Covenant Hospital's emergency room on August 1, 2003 and underwent the recommended MRI. PX1 at 6-7; PX2. He reported that he was a long haul trucker and that he began experiencing right lower back pain after a particularly long trip from California, and that he experienced this pain over the prior three weeks. PX2 at 2. The interpreting radiologist noted: (1) diffuse lumbosacral spondylosis, a subtle bulging disc, resultant borderline spinal stenosis at L1-L2, L2-L3, and moderate stenosis at L3-L4; (2) degenerative disc disease at L4-L5, extensive disc extrusion and superior migration into the central epidural space of L4, resultant near spinal block secondary to severe central spinal stenosis, and bilateral moderate foraminal stenosis; (3) a left ventral disc extrusion at L5-S1 encroaching the left S1 nerve root, mild central and bilateral moderate-to-severe foraminal stenosis as well as left lateral recess stenosis; and (4) a lobulate cystic mass lesion adjacent to the right facet joint of T11-T12 with intrinsic calcification, synovial cyst formation or other cystic bony neoplasm to be ruled out and a recommended CT scan or MRI at T11-T12. PX2 at 4-5. The emergency room physician diagnosed Petitioner with a lumbar strain with radiculopathy and administered a shot of Toradol. PX2 at 2-3. He also prescribed Motrin and instructed Petitioner to follow up with Dr. Senno. *Id.*

Petitioner was then examined in the emergency room at Cook County Hospital on August 26, 2003 reporting numbness in the right lower extremity, severe back pain, and right lower extremity pain. PX6 at 1-3. Petitioner was diagnosed with lumbar stenosis and instructed to take his MRI films and go to the neurosurgery clinic for further evaluation. *Id.*

Petitioner went to the neurology clinic at Cook County Hospital on August 29, 2003 reporting that he was a long distance truck driver "x 3yrs" with low back pain radiating to the bilateral lower extremities, right greater than left, and with weakness in the right leg greater than the left leg. PX6 at 4. The physicians recommended a laminectomy and discectomy. *Id.* Petitioner testified that he did not want to undergo surgery at Cook County Hospital.

Petitioner returned to Swedish Covenant Hospital on October 30, 2003, at the request of Dr. Senno and saw Dr. Ketki Modi. PX2 at 6-8. Petitioner reported that he was a long-distance truck driver and that he started to experience pain in his low back approximately three months earlier, which was aggravated by the bumping in the road and that his pain got worse and worse. *Id.* Dr. Modi diagnosed Petitioner with a herniated disc involving the L4-5 and L5-S1 regions with moderate to severe central spinal stenosis. *Id.* Dr. Modi referred Petitioner to Dr. Gutierrez for further evaluation of a large extruded disc, etc., referred Petitioner to Dr. Chang

for further evaluation of epidural injections after evaluation by Dr. Gutierrez, prescribed Ultram, recommended a thoracolumbar MRI to rule out any neoplastic or mass compression, and restricted Petitioner from heavy lifting, pulling, pushing, or prolonged sitting. *Id.*

On November 11, 2003, Petitioner returned to see Dr. Senno who also recommended a follow up MRI. PX1 at 9. Petitioner underwent the recommended MRI on November 19, 2003, which the interpreting radiologist noted showed: (1) diffuse lumbosacral spondylosis with degenerative disc disease worse at the lower lumbar spine; (2) persistent extensive disc extrusion and migration at L4-L5 resulting in severe spinal stenosis as on 8/1/03; (3) multi-lobulated or lulti-loculated cystic bone tumor of the right T12 involving the right sided pedicle and adjacent posterior arch, and synovial or bony cystic neoplasm should be investigated (a CT scan could be helpful). PX2 at 10-11.

Petitioner was next seen at Swedish Covenant Hospital on January 12, 2004 at which time he underwent the recommended CT scan of his lumbar spine, which the interpreting radiologist noted showed: (1) diffuse lumbosacral spondylosis, degenerative disc disease, and a bulging disc; (2) resultant mild spinal stenosis at T12-L1, L1-L2, and L2-L3; (3) extensive bulging at L3-L4 and L4-L5 resulting in moderate to severe spinal stenosis; (4) left paracentral disc protrusion with bony spurring at L5-S1 and mild central and bilateral severe lateral stenosis; and (5) focal expansile osteolytic lesions of the right pedicle and posterior arch of T12 vertebral body, possibly benign, and a non-ossifying fibroma or other cystic bony neoplasm, metastasis or primary malignancy is less likely. PX2 at 13-14.

Petitioner returned to Cook County Hospital on October 8, 2004 reporting low back pain and right leg pain refractory to conservative treatment. PX6 at 5. Petitioner acknowledged on cross examination that he reported being a long-distance hauling driver for three years at the time of this visit. PX6 at 4. The physician recommended another MRI. PX6 at 5. Petitioner returned again on March 31, 2005 for a lumber MRI, which the interpreting radiologist noted showed a lobulated enhancing lesion in the right posterior elements of the T12 vertebra and moderate to marked central canal stenosis at L4-L5 with thecal sac compression at this level. PX6 at 6-7.

The medical records reflect Petitioner occasionally returned to Dr. Senno throughout 2005 and 2006, but he testified that Dr. Senno could not help him. PX1 at 9-11. Petitioner also began receiving social security disability benefits beginning in 2005. Petitioner testified that he did see various other doctors including someone at NorthShore Hospital in Evanston for a second opinion, Dr. Jivic at Evanston Hospital, and Dr. Cicero in Winchester. Nonetheless, Dr. Senno referred Petitioner to Dr. Baktiar Yamini on October 31, 2005 with whom Petitioner resumed primary treatment for his low back condition. *Id.*

Petitioner first saw Dr. Yamini on November 14, 2005. PX3 at 1-3. Petitioner reported back pain, bilateral leg pain worse on the left, and weakness which had been going on for a couple of years. *Id.* Dr. Yamini diagnosed Petitioner with lumbar radiculopathy and noted that he had severe symptoms with significant atrophy in the left leg. PX3 at 1-3. He recommended decompression surgery involving a laminectomy. *Id.* Petitioner indicated that his mother was terminally ill in Poland and that he would contact the doctor in the following month after deciding whether he wanted to proceed with the surgery. *Id.*

In an undated note addressed "To Whom It May Concern" Dr. Yamini stated that when Petitioner first came to him, he told Petitioner that "it was possible that his back problems were related to his job of driving a truck because of the constant bouncing causing pressure on the spinal cord." PX4.

Petitioner underwent the recommended surgery on December 8, 2005 at University of Chicago Medical Center. PX3 at 8-9. Dr. Yamini diagnosed Petitioner with a herniated L4-L5 disk with severe canal stenosis and he performed a decompression of the left thecal sac at L4-5, removal of the herniated disc, a foraminotomy bilaterally at L4-5, and decompression of the thecal sac. *Id.*

The medical records reflect a pre-operative admission form indicating that the onset of Petitioner's illness was "1/1/03" and that the illness was not work related. PX3 at 34; RX1. On cross examination, Petitioner denied that he wrote this information on the form and testified that it was probably a doctor or nurse that did so. He denied that he stated that his injury was not work-related and testified that he told them "yes" that it was work related, but he acknowledged that he reported that his pain began on January 1, 2003.

Petitioner saw Dr. Yamini postoperatively on December 19, 2005 at which time he recommended a course of physical therapy and instructed Petitioner to avoid any heavy lifting to avoid a re-herniation. PX3 at 4.

On January 26, 2006, Petitioner underwent a postoperative MRI which the interpreting radiologist noted showed: (1) post-operative change of diskectomy noted at L4-L5, a left paracentral disc herniation again noted at L4-L5 causing tight spinal canal stenosis and enhancing scar tissue noted in the left posterior and left lateral epidural space; and (2) posterior disc bulge at L5-S1 that was stable, contacting the ventral thecal sac and exerting mild mass effect on the intrathecal portion of the left S1 nerve root. PX3 at 10-11, 23-24.

On February 13, 2006, Dr. Yamini noted Petitioner's new symptoms in the right lower extremity and, after reviewing Petitioner's January 26, 2006 lumbar spine MRI, he diagnosed him with a relatively large disc herniation at L4-L5, more on the left side and slightly in the midline. PX3 at 5. Dr. Yamini recommended surgery or further conservative treatment before surgery; Petitioner elected a conservative approach first. *Id.*

Dr. Yamini authored a letter addressed "To Whom It May Concern" on April 19, 2006 in which he reiterated that Petitioner's most recent MRI showed a disc herniation at L4-L5. PX3 at 6. Dr. Yamini recommended a fusion, noted that Petitioner was "unable to work thru this whole process" and that he should "take it easy" and regain his strength to avoid further damage to his spine. *Id.*

Petitioner sought a second opinion from Dr. Ivan S. Ciric on July 30, 2008. PX8. Dr. Ciric recommended a lumbar mylelogram-CT scan followed by decompression surgery and did not recommend a fusion noting that Petitioner had radicular pain into the right leg and no back pain. *Id.* Petitioner received no further treatment for three years.

Dr. Kornblatt – Section 12 Examination & Deposition Testimony

Petitioner submitted to an independent medical examination at Respondent's request on May 10, 2010. RX3 (Dep. Exh. 2). Petitioner reported working various trips for Respondent: (1) May 23-29, 2003; (2) June 15-16, 2003; (3) June 17-22, 2003; (4) June 25-30, 2003; and (5) July 3-10, 2003. *Id.*; RX2. Regarding his physical condition at the time, Petitioner reported that he experienced constant low back pain, pain into the bilateral legs, numbness and tingling into the bilateral legs, difficulty standing and walking, and inability to walk over 10-15 minutes without needing to sit down. RX3 (Dep. Exh. 2). Petitioner denied any prior low back or leg symptoms prior to the driving incident in California. *Id.*

Dr. Kornblatt issued a report in which he rendered opinions about Petitioner's condition after taking a history from Petitioner, examining him, and reviewing various medical records. *Id.* He diagnosed Petitioner with

lumbar spinal stenosis-neurogenic claudication. *Id.* Ultimately, Dr. Kornblatt opined that Petitioner's low back condition (i.e., spinal stenosis or degenerative disc disease) was not caused by his five driving trips for Respondent. *Id.*

Dr. Kornblatt testified via evidence deposition on November 8, 2010 and testified consistent with the opinions contained in his report. RX3. Additionally, he testified that Petitioner reported to him "that after a trip to California while working for [Respondent], he noted pain in his low back and into his left leg." RX3 at 24, 25. Dr. Kornblatt could not recall if Petitioner reported that he noted pain in his back during the trip from Illinois to California or during the trip from California back to Illinois. RX3 at 25-26, 34-35. He also could not recall whether Petitioner indicated how soon he began experiencing back pain after completing the California trip and ht testified that Petitioner did not provide any detail as to what happened that gave rise to the low back and radiating left leg pain. RX3 at 26.

Dr. Kornblatt also opined that Petitioner's L4-L5 herniated disc was degenerative in nature and explained that normally discs do not herniated unless someone has a major fracture and, other than those cases, in 100% of the cases the herniated discs are caused by degeneration. RX3 at 30-31. He further opined that there was no specific event that resulted in Petitioner's condition, that if Petitioner was driving a truck with an air ride suspension that he was in no greater risk for a herniation than someone driving in a regular passenger car, and that the cause of the herniation in Petitioner's case was degeneration. RX3 at 31-34. On cross examination, he testified that whether the truck was old, had an air ride suspension at all, or if Petitioner hit a very big pothole on his trip it would not change his opinion; Dr. Kornblatt did not believe that Petitioner's trip could cause a permanent anatomic change. RX3 at 44-45. He conceded that something like hitting a pothole and bouncing up ten feet and hitting his head on the truck cab ceiling might cause a herniation, but that he would have expected Petitioner to have reported such an incident. RX3 at 45-46.

On cross examination, Dr. Kornblatt testified that "an aggravation is a permanent anatomic change of a pre-existing condition" and that he did not believe that Petitioner's 6,000 mile trip to and from California aggravated Petitioner's low back condition, but rather acknowledged that something happened to Petitioner in July of 2003 (i.e., onset of symptoms) which he believed was "just a component of degenerative disc disease." RX3 at 43-44. He explained that while the disc herniated, it was not as a result of a specific episode, fall or major accident where he fractured any vertebra resulting in a herniated disc. *Id.* Dr. Kornblatt also disagreed with the theory that a lot of vibration in a truck with no suspension could cause an aggravation. RX3 at 46.

On re-direct examination Dr. Kornblatt testified that Petitioner did not report any specific incident to him such as hitting a pothole or engaging in heavy lifting. RX3 at 50-51.

Continued Medical Treatment

Petitioner testified that he then went to Johns Hopkins Medical Center for a second opinion because he still had "big" pain and he sought treatment to avoid another surgery. The medical records reflect that Petitioner went to John Hopkins Bayview Medical Center on August 23, 2011 reporting low back pain and right-sided radiculopathy for which further diagnostic tests were ordered. PX7 at 1-4.

Petitioner underwent a CT scan of the lumbar spine on September 1, 2011 which the interpreting radiologist noted showed: (1) a well defined bone lesion with a sclerotic border involving the posterior elements of T12 to the right of the midline suggesting a benign tumor such as an aneurismal bone; (2) diffuse degenerative spondylosis most significant at L4-5 where a combination of dorsal spurring and facet arthropathy contributes to

bilateral recess and neural foraminal narrowing and a borderline central stenosis; and (3) postoperative laminectomy at L5-S1 with facet arthropathy. PX7 at 7. He also had an MRI which the interpreting radiologist noted showed: (1) prominent degenerative changes particularly at L3-L4 and L4-L5 where there was prominent hypertrophy, resulting mild-to-moderate narrowing of the spinal canal at these levels particularly involving the lateral recesses greater on the right; (2) very minimal development of right sided facet joint cyst and prominent degenerative changes arising from the vertebral end plates; and (3) a small left paracentral disk protrusion at L5-S1 contributing to mild narrowing of the left lateral recess of the spinal cord. PX7 at 8-9.

Petitioner followed up with Dr. Mohammad Mehdi at Johns Hopkins who reviewed the results and recommended trial epidural steroid injections at L4-L5 and L5-S1 which, if successful, could be followed by further injections and, if not, would be followed by a surgical recommendation. PX7 at 5-6. Petitioner received no further treatment here.

Petitioner was last examined by Dr. Yamini on October 12, 2011. PX3 at 7. He reported right leg pain, but no severe weakness in the leg. *Id.* Dr. Yamini reviewed a lumbar spine MRI and noted that it was actually improved with a smaller compression noted at L4-L5 and stable disk disease at L5-S1. *Id.* He recommended a course of physical therapy and no additional surgery with Petitioner to return to see him as needed. *Id.*

Additional Information

Regarding his current condition, Petitioner testified that he is in constant pain and that he has pain in his back and in his right leg from the top of the leg to the toes. He takes Vicodin every two days as prescribed by his regular doctor Dr. Bonnczak in Lake in the Hills at the Sherman Clinic. Petitioner testified that he is not working and that he receives SSDI benefits since 2004. Petitioner also testified that he is scheduled to see his regular doctor, but that he has no visits scheduled with any surgeons.

Ireneusz Panek

Respondent called Mr. Panek as a witness. He testified that he was last employed by Respondent three years ago as a safety director. His duties included training and hiring truck drivers, explaining safety issues, maintaining log books and maintaining accuracy and compliance with federal laws.

Mr. Panek testified that he hired Petitioner in approximately May of 2003. Petitioner completed an application. Mr. Panek did not recall whether Petitioner reported pre-existing back pain radiating down his legs.

Regarding training, Mr. Panek testified that he told employees, including Petitioner, that if they were in an accident they were to call and immediately report all accidents and incidents at an 800 number or an on-duty safety officer. He also provided written instructions. He testified that if calls were received by the on-duty officer, he or she must contact Mr. Panek directly within 20 minutes to his cell or home phone number.

Mr. Panek testified that he reviewed Petitioner's records and he did not recall when Petitioner drove for Respondent. Mr. Panek testified that there is a dispatch record that he created, however, which was submitted as Respondent's Exhibit 2 and reflects the months within which Petitioner worked and the trips that he took for Respondent.

Mr. Panek testified that Petitioner made five trips for Respondent. He did not know whether Petitioner used the same tractor for all of the trips, but testified that all tractors had air-ride suspension systems with a pneumatic

driver's seat so that the driver could have lumbar and leg support as well as elevation of the seat as needed. Mr. Panek testified that the air-ride suspension system was operative and that Petitioner did not report any inoperable seats. Mr. Panek also testified that no complaints were made by Petitioner to any on-duty officer about pain in his back.

He did have a phone conversation on or about Wednesday, July 16, 2003 with Petitioner. Mr. Panek testified that he was born in Poland and speaks Polish and that he generally spoke with Petitioner in Polish. During this conversation, Mr. Panek testified that Petitioner called him and identified himself. Petitioner complained that he had issues with his lower back and that he needed a few days off. Mr. Panek testified that Petitioner reported that this was not the first time that this happened to him and told him that he had an appointment scheduled with his doctor. He asked Petitioner if he had reported it, and Petitioner said no that he was reporting it now.

Mr. Panek testified that that Petitioner then stated that he "wants to find out if we can provide him with the insurance because this is why he started working for [Respondent] because he heard that we go Workers' Comp insurance." 7/22/13 Tr. at 110. He further testified that during that conversation Petitioner told him that he had prior back problems prior to working for Respondent. *Id.* Specifically, Mr. Panek testified that Petitioner "said that he was working for himself and for several other companies when he was a 1099 or contract employee and he never was given the option to have the Workers Comp coverage. This is why he joined the [Respondent]. If he will feel bad, he will be looking for treatment as Workers' Comp. injuries." *Id.* Mr. Panek testified that he then told Petitioner to fill out the insurance form and he gave him the 800 number to the insurance. *Id.* Mr. Panek also testified that he specifically asked Petitioner what caused his pain and Petitioner could not explain it. 7/22/13 Tr. at 111. He also testified that he specifically asked Petitioner if he had been involved in an accident and Petitioner said no. *Id.*

On cross examination, Mr. Panek testified that he examines trucks when they come back from trips and physically examines the cabs if there is a reported problem, and that he did not recall examining Petitioner's truck after the trip in question because no one reported it to him. He testified that Petitioner is required to inspect his vehicle at the end of the trip and go to the maintenance shop which is open 24 hours or supervisors to review any issues or significant safety issues with the vehicle.

Mr. Panek further testified that on cross examination that Petitioner "didn't say specifically [that he hurt his back] driving the truck. He said he got a lower back problem and the leg, and he requesting [sic] the insurance information." 7/22/13 Tr. at 126. Mr. Panek reiterated that he Petitioner did tell him that he had an ongoing back problem; he asked Petitioner "what kind of nature of the accident was he involved in? Nothing was reported to me. He said there was no incident. He got a prior problem constant with the lower back and, right now, it's kind of he needs health insurance because he never was provided insurance, never had the chance to have insurance with any other employers or co-employers that he worked for." 7/22/13 Tr. at 126-127. He added that "[Petitioner] definitely referred to years before. He said, this is a long-time problem." *Id.*

ISSUES AND CONCLUSIONS

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

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

An employee's injury is compensable under the Act only if it arises out of and in the course of the employment. 820 ILCS 305/2 (LEXIS 2007). The "in the course of employment" element refers to "[i]njuries sustained on an employer's premises, or at a place where the claimant might reasonably have been while performing his duties, and while a claimant is at work...." *Metropolitan Water Reclamation District of Greater Chicago v. Illinois Workers' Compensation Comm'n*, 407 Ill. App. 3d 1010, 1013-14 (1st Dist. 2011). The "'arising out of' component refers to the origin or cause of the claimant's injury and requires that the risk be connected with, or incidental to, the employment so as to create a causal connection between the employment and the accidental injury." *Metropolitan Water Reclamation District*, 407 Ill. App. 3d at 1013-14 (*citing Caterpillar Tractor Co. v. Industrial Comm'n*, 129 Ill. 2d 52, 58 (1989)). A claimant must prove both elements were present (i.e., that an injury arose out of and occurred in the course of his employment) to establish that his injury is compensable. *University of Illinois v. Industrial Comm'n*, 365 Ill. App. 3d 906, 910 (1st Dist. 2006).

An employee who suffers a repetitive trauma injury may also apply for benefits under the Act. *Durand v. Industrial Comm'n*, 224 Ill. 2d 53, 65 (2006). Compensation is allowable where an injury is not sudden, but gradual so long as it is linked to the claimant's work. *Durand*, 224 Ill. 2d at 66 (*citing Peoria County Belwood Nursing Home v. Industrial Comm'n*, 115 Ill. 2d 524, 529 (1987)). The Illinois Supreme Court went on to highlight its *Peoria County* decision stating that "[t]o deny an employee benefits for a work-related injury that is not the result of a sudden mishap *** penalizes an employee who faithfully performs job duties despite bodily discomfort and damage." *Durand*, 224 Ill. 2d at 66 (*citing Peoria County*, 115 Ill. 2d at 529-30).

An employee claiming that he suffered a repetitive-trauma injury must point to a date within the statutory limitations period on which both the injury and its causal link to his work became plainly apparent to a reasonable employee. *Durand*, 224 Ill. 2d at 65 (*citing Williams v. Industrial Comm'n*, 244 Ill. App. 3d 204, 209 (1st Dist. 1993)); *see also Peoria County*, 115 Ill. 2d at 531. "[B]ecause 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." *Id.*, (*citing Oscar Mayer v. Industrial Comm'n*, 176 Ill. App. 3d 607, 610 (4th Dist. 1988)). Employees who claim to have suffered repetitive trauma injuries are not exempt from meeting the statutory notice requirement. *White v. Workers' Compensation Comm'n*, 374 Ill.App.3d 907, 910-911 (4th Dist. 2007) (*citing Three "D" Discount Store v. Industrial Comm'n*, 198 Ill.App.3d 43 (4th Dist. 1989)).

In this case, Petitioner testified that he had no prior low back pain or bilateral leg pain or symptoms prior to the claimed date of accident and that he experienced immediate pain and symptoms on the return trip from California while driving for Respondent. Petitioner's testimony, however, is not credible.

Petitioner's testimony is contradicted by his own testimony on cross examination about when he experienced the back and leg pain (i.e., after waking up while waiting at a warehouse in California or after bouncing around

in the cab of the truck on the way back from California). Petitioner's testimony that he did not work from 2000-2003 prior to working for Respondent is also contradicted by the medical records which reflect his report that he was a long-distance truck driver for three years before he sought treatment at Cook County Hospital in 2004. His testimony that he did not work for those years is also undermined by Mr. Panek's testimony that he would not have hired an employee, and that it was against insurance policy to hire a new driver, that only had two months of driving experience. Finally, Petitioner's testimony that his back and leg pain onset at some point during this trip to or from California is contradicted by Dr. Yamini's medical records which reflect Petitioner's report that he had an onset of low back pain in January of 2003, not July of 2003 as claimed.

Moreover, Mr. Panek testified that Petitioner specifically asked about regular health insurance coverage and workers' compensation insurance coverage as it related to a long-standing low back problem. Mr. Panek also testified that Petitioner told him that he specifically went to work for Respondent because he heard that it had workers' compensation insurance so that he could get coverage for a workers' compensation injury. Given the record as a whole, after observing Mr. Panek and Petitioner's testimony, and noting that Mr. Panek also no longer works for Respondent, the Arbitrator finds the testimony of Mr. Panek to be more credible than that of Petitioner.

The Arbitrator also finds the opinions of Dr. Kornblatt to be persuasive in this case. He reasonably explained that Petitioner's low back and radicular leg condition was wholly pre-existing and degenerative in nature, and that his condition could not have been caused or aggravated by the specific trip alleged by Petitioner or even the five cross country trips taken by Petitioner while employed by Respondent.

Thus, in consideration of the record as a whole the Arbitrator finds that Petitioner failed to prove by a preponderance of credible evidence that he sustained a compensable injury on July 10, 2003 as claimed. By extension, all other issues are rendered moot and all requested compensation and benefits are denied.

STATE OF ILLINOIS)
) SS.
COUNTY OF LAKE)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Araceli Dure,

Petitioner,

vs. NO. 99WC53741

14IWCC0800

ITW Paslode,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of medical expenses, permanent disability, causal connection, 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 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 $6,300.00.

14IWCC0800

The party commencing the 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 19 2014
SJM/sj
o-9/4/2014
44

Stephen J. Mathis

David L. Gore

Mario Basurto

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION
CORRECTED

DURE, ARACELI
Employee/Petitioner

Case# **99WC053741**

ITW PASLODE
Employer/Respondent

14IWCC0800

On 1/8/2013, 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:

0147 CULLEN HASKINS NICHOLSON & ET AL
DAVID B MENCHETTI
10 S LASALLE ST SUITE 1250
CHICAGO, IL 60603

2461 NYHAN BAMBRICK KINZIE & LOWRY PC
JAMES A MORAN
20 N CLARK ST SUITE 1000
CHICAGO, IL 60602

STATE OF ILLINOIS)
)SS.
COUNTY OF LAKE)

14IWCC0800

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
CORRECTED ARBITRATION DECISION

Araceli Dure
Employee/Petitioner

Case # 99 WC 53741

v.

ITW Paslode
Employer/Respondent

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Anthony C. Erbacci**, Arbitrator of the Commission, in the city of **Waukegan**, on **October 23, 2012**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. [ ] Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. [ ] Was there an employee-employer relationship?
C. [ ] Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. [ ] What was the date of the accident?
E. [ ] Was timely notice of the accident given to Respondent?
F. [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

14IWCC0800

FINDINGS

On **August 24, 1999**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$21,320.00**; the average weekly wage was **$410.00**.

On the date of accident, Petitioner was **36** 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 is entitled to a credit of **$53,300.86 for medical expenses + $41,551.57 for non-occupational disability benefits** under Section 8(j) of the Act.

ORDER

The Respondent shall pay the Petitioner permanent partial disability benefits of $246.00 per week for 25 weeks because the injuries sustained caused 5% loss of use of the person as a whole, as provided in Section 8(d)(2) of the Act.

No other benefits are awarded herein.

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

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

Arbitrator Anthony C. Erbacci

January 3, 2012
Date

JAN 8 – 2013

FACTS:

On August 24, 1999, while performing her regular duties as an assembler, the Petitioner sustained undisputed accidental injuries that arose out of and in the course of her employment with the Respondent when she experienced pain involving her low back and left side while she was lifting a heavy garbage can into a dumpster. The Petitioner continued working as an assembler and first sought medical treatment at Lake Forest Hospital Occupational Health Services (LFHOHS) on September 8, 1999. The Petitioner was seen by Dr. Chin and his impression at that time was work-related left low back pain and possible radiculopathy. The Petitioner was prescribed light duty work and physical therapy.

The Petitioner then came under the care of Dr. Tack of Lake Forest Orthopaedic Associates on September 30, 1999. Dr. Tack noted that the Petitioner reported that the therapy had been "quite helpful" but she continued to have some degree of back pain. Dr. Tack diagnosed the Petitioner as having a resolving lumbar strain and prescribed continued physiotherapy. On October 28, 1999, the Petitioner reported numbness and coldness in both of her feet but no radicular pain. At that time, Dr. Tack noted that neurologic screening demonstrated volitional weakness on the left which disappeared with diversion. Dr. Tack continued the Petitioner's work restrictions, ordered an MRI, and suggested that a referral for evaluation at the Pain Management Program would be appropriate if the MRI proved to be normal.

A lumbar MRI was performed on November 3, 1999, and was reported to be normal. On November 16, 1999, Dr. Tack noted the normal MRI and indicated that there was no abnormality present in the MRI which would explain the Petitioner's symptoms and he noted that her symptoms were becoming progressively more diffuse in nature. Dr. Tack also noted his impression that there was a "significant disconnect between the level of this patient's symptoms and her evidence of structural injury." Dr. Tack released the Petitioner to return to work "essentially unrestricted" and referred her to the Pain Treatment Center "for evaluation and management". Dr. Tack reported that he saw no indications for ongoing surgical management of the Petitioner.

The Petitioner returned to work for the Respondent and continued to work until November 30. 1999 when she returned to Lake Forest Hospital emergency room with complaints of severe low back pain and a history of low back pain and an L1-L2 bulging disc. The Petitioner reported that she initially developed low back pain two months ago and had been undergoing physical therapy. She reported that was doing better until she returned to her regular job that day and that she now had severe low back pain, which radiated to both buttocks and up the right side of the thorax into the neck. The diagnosis at that time was "Recurrent low back pain" and she was discharged to return to work, with restrictions, on December 2, 1999.

On December 2, 1999, the Petitioner went to the emergency room at Condell Medical Center with complaints of low back pain into the left thigh and up the right side. She reported that she had a low back strain three months prior and was okay while she was on light duty

but was put on regular duty and felt more back pain. The clinical impression at that time was an acute exacerbation of chronic back pain. A bone scan was performed at Condell Medical Center on December 10, 1999, apparently on the order of Dr. Jay Levin, and the results were noted to demonstrate no significant abnormalities of the lumbar spine.

In January of 2000, the Petitioner underwent a pain treatment evaluation at Lake Forest Hospital Center for Rehabilitation for pain management on referral from Dr. Tack. She was seen initially by Dr. Ingberman on January 10, 2000 and then underwent a psychological evaluation on January 20, 2000. It was noted that MRI and plain x-rays of the lumbar sacral spine were normal; the psychological diagnosis was noted to be "Pain disorder associated with psychological factors"; and the MMPI results were noted to suggest a somatization profile. In his letter report of January 27, 2000, Dr. Ingberman indicated that his diagnosis was myofascial pain syndrome and he recommended that the Petitioner participate in a six to eight week outpatient pain management program that would include physical/occupational therapy, psychological counseling and biofeedback.

The Petitioner then chose to treat with Dr. Bruce Irwin at the Center for Pain Control beginning on March 22, 2000. The Petitioner's complaints at that time included low back pain, right neck pain and headaches, and Dr. Irwin's diagnoses included sacroilitis, piriformis syndrome, myofascial pain syndrome, facet syndrome, and cervicogenic headache. Dr. Irwin prescribed injection therapy and the Petitioner was advised to refrain from repetitious activities at work.

The Petitioner continued to treat with Dr. Irwin through at least April 28, 2009. Dr. Irwin's treatment consisted of multiple injections; including trigger point injections, trigger joint injections, costovertebral joint injections, nerve root injections and SI joint injections, medicine and physical therapy. Dr. Irwin also ordered a lumbar MRI and an MRI of the brain which were performed on May 29, 2001. The MRI of the brain was reported to be normal and the lumbar MRI was reported to be normal except for minimal degenerative changes at L1-2 and mild facet arthrosis at L4-5 and L5-S1.

On December 4, 2003, the Petitioner underwent a functional capacity evaluation, prescribed by Dr. Irwin, at the Condell Medical Center. The Petitioner was noted to have demonstrated inconsistent effort throughout the evaluation, passing only 7 of 19 sub-tests for maximal effort. That test was considered to be invalid and it was felt that the Petitioner's physical abilities were higher than those reflected in the evaluation. Another functional capacity evaluation prescribed by Dr. Irwin was performed at Lake Forest Hospital on January 19 and 20, 2004. It was noted that the Petitioner gave inconsistent effort during the evaluation, giving maximum effort in only 6 of 27 tests. It was also noted that the Petitioner exhibited significant pain behaviors and did not finish tasks secondary to pain complaints and self-limiting body mechanics. It was recommended, for the Petitioner's safety, that she function at a sedentary level with a 10 pound weight lifting restriction.

The Petitioner testified that she received five hundred or more injections from Dr. Irwin over the course of the nine years she treated with him.

In his deposition testimony, Dr. Irwin indicated that the Petitioner's diagnoses included sacroiliitis, cervicogenic headaches and chronic pain. Dr. Irwin opined that the Petitioner injured her sacroiliac joint in the work accident and that the injury resulted in her current chronic pain syndrome. Dr. Iriwin further opined that the Petitioner was not at maximum medical improvement as of the last time he saw her on April 28, 2009 and that the Petitioner is not able to be gainfully employed. Dr. Irwin also opined that all of the treatment that he rendered to the Petitioner was reasonable and necessary and related to the initial injury of August 24, 1999.

The Petitioner testified that she was off work from April 3, 2000 through August 30, 2000 and that she received short term disability benefits from the Respondent for that period of time. The Respondent's records show the Petitioner as being absent-sick during that period of time. The Petitioner then worked until February 3, 2001, when the Respondent's records show her on a leave of absence. The Respondent paid disability benefits to Petitioner after that date. The Petitioner testified that she has not worked since February 3, 2001 and that she has not looked for work since that time through the present.

The Petitioner testified that some of the medical bills for her treatment were paid by workers' compensation, some by her health insurance through the Respondent, some by her husband's health insurance, and some bills remain unpaid. The medical bills were introduced into the record as PX 7 and the summary of the bills shows the following unpaid balances due: Garand Oaks Anesthesia, $3,264.00; Grand Oaks Surgical, $118,426.00; Center for Pain Control, 118,702.27. The total unpaid balance indicated is $240,392.27. The parties stipulated that the Respondent is entitled to an 8(j) credit of $50,300.86. The Petitioner's husband's health insurance paid medical bills in the amount of $8,680.00 for which there is no 8(j) credit claimed by the Respondent. The parties also stipulated that the Respondent is entitled to an 8(j) credit for payment of non-occupational disability benefits in the amount of $41,551.57, which is the equivalent of 152 weeks of temporary total disability benefits at the rate of $273.33 per week, based on the Average Weekly Wage of $410.00 as stipulated by the parties.

The Respondent introduced into the record a series of utilization reviews which non-certify all of the Petitioner's treatment from 2000 and thereafter. The Respondent also introduced into the record, the medical reports of Dr. Mark Levin, who examined the Petitioner at its request on February 16, 2000, March 28, 2001, September 4, 2008, January 25, 2010, and April 2, 2010. Dr. Levin reported that the Petitioner's diagnosis was consistent with fibromyalgia and he opined that the fibromyalgia was not related to any work injury. Dr. Levin noted that he could find no objective pathology that was related to an alleged work injury and that there was no objective orthopedic pathology that would prevent the Petitioner from returning back to work full duty. Dr. Levin opined that the treatment the Petitioner received from Dr. Irwin was not related to any alleged work injury and he specifically noted that none of the injections performed by Dr. Irwin were necessary.

The Petitioner testified that she currently feels pain in her back when lifting more than

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five pounds, when vacuuming, and when using her hands more than 20-40 minutes. She complained of pain in the neck, hand and arm on the left, with driving. She testified to pain while standing more than one hour and while walking more than two blocks. She testified she felt pain in her back with tingling and numbness to her left leg when she sits for more than an hour. The Petitioner testified that she had never experienced these complaints prior to August 24, 1999, and that she was not receiving any medical treatment and was working full duty prior to that date.

CONCLUSIONS:

In Support of the Arbitrator's Decision relating to (F.), Is Petitioner's current condition of ill-being causally related to the injury, the Arbitrator finds and concludes as follows:

It is axiomatic that the Petitioner bears the burden of proving all of the elements of her claim by a preponderance of the credible evidence. The Arbitrator finds the Petitioner failed to meet her burden in proving that her current condition of ill-being causally related to her work accident. In finding that the Petitioner failed to meet her burden, the Arbitrator notes the findings and opinions of Dr. Levin that the Petitioner was not suffering from any orthopedic condition which was related to an August 24, 1999 accident. The Arbitrator also notes that the Petitioner continued to work for the Respondent for six months subsequent to her accident and that all of the objective diagnostic testing performed on the Petitioner, including the November 3, 1999 lumbar MRI, the December 10, 1999 full body bone scan, the May 29, 2001 lumbar MRI, and the May 29, 2001 MRI of the brain, was reported to be normal. The Arbitrator notes that Dr. Levin's opinions are consistent with those normal objective diagnostic tests. Further, the Arbitrator notes the results of functional capacity testing which took place on December 4, 2003, and January 19 and 20, 2004, which all reported that the Petitioner failed to provide maximal effort and failed validity testing throughout. Dr. Levin's opinion that the Petitioner was not suffering from any orthopedic pathology was supported by those functional capacity evaluations as well. Additionally, the Arbitrator notes the findings and opinions of the Petitioner's first treating physician, Dr. Tack, who released the Petitioner to full duty work on November 16, 1999, and discharged her from his care.

While the Arbitrator notes the opinions of Dr. Irwin, the Arbitrator finds them to be unpersuasive and unreliable. In so finding, the Arbitrator notes that Dr. Irwin did not review any of the records from Lake Forest Hospital, Lake Forest Hospital Occupational Health Service or Dr. Tack. Dr. Irwin admitted that he did not review those records and that he did not know that the Petitioner's treating physician released her to return to fully duty as of November 16, 1999. He also admitted that he was unaware the Petitioner's initial treating physician found a significant disconnect between her symptoms and his clinical findings. Dr. Irwin also acknowledged that there were no findings on the Petitioner's diagnostic testing that would explain the subjective complaints she communicated to him at the time of his initial, March 22, 2000 examination. Finally, while Dr. Irwin testified that the Petitioner was feeling

relief from the treatment that he was pursuing, he admitted that despite providing ten years of treatment and hundreds of injections, the Petitioner's pain diagram showed greater areas of pain in October, 2008 as compared to the first visit on March 22, 2000 and that the symptoms the Petitioner identified had become more pronounced.

Although the Arbitrator notes that the Petitioner's complaints of pain began contemporaneously with her work injury and continued thereafter until the present, the mere fact that the Petitioner has complaints is, without more, insufficient to support a conclusion that those complaints are related to the work injury. Additionally, the results of the functional capacity evaluations the Petitioner submitted to call into question the veracity of her pain complaints.

Based upon the foregoing, and having considered the totality of the credible evidence adduced at hearing, the Arbitrator finds that the Petitioner failed to meet her burden of proving a causal connection between the multitude of symptoms she testified to at trial and her August 24, 1999 work injury. The Arbitrator concludes that, as a result of the work injury of August 24, 1999, the Petitioner sustained, at most a back strain/sprain type injury, from which she reached maximum medical improvement prior to beginning her treatment with Dr. Irwin on March 22, 2000.

In Support of the Arbitrator's Decision relating to (J.), Were the medical services that were provided to Petitioner reasonable and necessary/Has Respondent paid all appropriate charges for all reasonable and necessary medical services, the Arbitrator finds and concludes as follows:

The findings and conclusions of the Arbitrator relating to the issue of causal relation are adopted and incorporated herein.

The Arbitrator has found that, as a result of the work injury of August 24, 1999, the Petitioner sustained, at most a back strain/sprain type injury, from which she reached maximum medical improvement prior to beginning her treatment with Dr. Irwin on March 22, 2000. The Arbitrator also notes that much of the medical care provided to the Petitioner by Dr Irwin was evaluated pursuant to a series of authorized medical utilization reviews and was non-certified. Additionally, Dr. Levin specifically opined that the series of hundreds of injections administered to the Petitioner by Dr. Irwin were unnecessary, and the Petitioner's own testimony indicates that they were of little, if any, lasting benefit. The Arbitrator further notes that the Petitioner's initial treating physician, Dr. Tack, released the Petitioner to return to work full duty as of November 16, 1999, that subsequent functional capacity evaluations showed the Petitioner failed to put forth maximal effort and that diagnostic tests, including MRIs of the lumbar spine, cervical spine, a bone scan, and X-rays, were all reported to be negative.

Based upon the foregoing, and having considered the totality of the credible evidence adduced at hearing, the Arbitrator finds that the Petitioner failed to prove that the medical care and treatment she received after November 16, 1999 was reasonable, necessary or causally related to the work accident of August 24, 1999.

In Support of the Arbitrator's Decision relating to (K.), What temporary benefits are due, the Arbitrator finds and concludes as follows:

The findings and conclusions of the Arbitrator relating to the issue of causal relation are adopted and incorporated herein.

The Petitioner continued to work for the Respondent for six months following the work accident of August 24, 1999 and her treating physician, Dr. Tack, released her to full duty as of November 16, 1999. The Petitioner saw Dr. Irwin on March 22, 2000 and he restricted her from work as of April 3, 2000. The Petitioner testified that she was off work from April 3, 2000 through August 30, 2000 and that she received short term disability benefits from the Respondent for that period of time. The Respondent's records show the Petitioner as being absent-sick during that period of time. The Petitioner then worked until February 3, 2001, when the Respondent's records show her on a leave of absence. The Respondent paid disability benefits to Petitioner after that date. The Petitioner testified that she has not worked since February 3, 2001 and that she has not looked for work since that time through the present.

The Arbitrator notes that Dr. Levin, the Respondent's examining physician, repeatedly found the Petitioner capable of working full duty and a series of diagnostic tests were all negative. The Petitioner participated in functional capacity evaluations wherein she was noted to have provided less than maximal effort and to be capable of performing at a higher level than shown on the testing. The Arbitrator also notes that the job description for the assembler position the Petitioner performed showed the position involved no lifting more than ten pounds. Additionally, the Arbitrator notes that the Petitioner testified she has not looked for work throughout the pendency of this claim. As such, the Arbitrator finds the Petitioner failed to meet her burden in proving by a preponderance of the evidence her entitlement to temporary total disability benefits.

Additionally, as the Arbitrator has found that the Petitioner reached maximum medical improvement from her work injury prior to beginning her treatment with Dr. Irwin on March 22, 2000, the Arbitrator finds that any inability of the Petitioner to work after that date is not related to the to work accident of August 24, 1999. The Petitioner did not allege or claim entitlement to any Temporary Total Disability benefits prior to March 22. 2000.

Based upon the foregoing, and having considered the totality of the credible evidence adduced at hearing, the Arbitrator finds that the Petitioner failed to prove she was entitled to any Temporary Total Disability benefits as a result of the work accident of August 24, 1999.

In Support of the Arbitrator's Decision relating to (L.), What is the nature and extent of the injury, the Arbitrator finds and concludes as follows:

The findings and conclusions of the Arbitrator relating to the issue of causal relation are adopted and incorporated herein.

The Arbitrator finds the Petitioner suffered a strain/sprain injury to her lumbar spine on August 24, 1999. She was released to full duty by her treating physician as of November 16, 1999. As such, the Arbitrator finds that the Petitioner suffered permanent partial disability to the extent of 5% loss of use of the whole person.

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Jose Gutierrez,

Petitioner,

vs.

NO. 10 WC 38757

Prestress Engineering Corp.,

14IWCC0801

Respondent.

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed April 1, 2013 is hereby affirmed and adopted.

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

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 $63,200.00. 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: SEP 19 2014
SJM/sj
o-7/31/2014
44

Stephen J. Mathis

David L. Gore

Mario Basurto

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

GUTIERREZ, JOSE
Employee/Petitioner

Case# **10WC038757**

14IWCC0801

PRESTRESS ENGINEERING CORP
Employer/Respondent

On 4/1/2013, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

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

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

1296 CHILTON YAMBERT & PORTER LLP
BILL PORTER
2000 S BATAVIA AVE SUITE 200
GENEVA, IL 60134

STATE OF ILLINOIS)
)SS.
COUNTY OF LaSalle)

14IWCC0801

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

Jose Gutierrez,
Employee/Petitioner

v.

Prestress Engineering Corp.,
Employer/Respondent

Case # **10** WC **38757**

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 **New Lenox, Illinois**, on **December 13, 2012**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

14IWCC0801

On the date of accident, **June 30, 2010**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**33,638.46**; the average weekly wage was $**646.89**.

On the date of accident, Petitioner was **42** years of age, ***married*** with **3** dependent children.

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

Respondent shall be given a credit of $**41,949.60** for TTD, $**0** for TPD, $**0** for maintenance, and $**1,000.00** for other benefits, for a total credit of $**42,949.60**.

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 $431.26/week for 124-2/7 weeks, commencing June 30, 2010 through December 31, 2012 (less four (4) weeks), as provided in Section 8(b) of the Act.

Respondent shall pay reasonable and necessary medical services, pursuant to the medical fee schedule, to the extent applicable, of $1,590.43 to Midwest Orthopedics at Rush, $3,856.02 to Dr. Speca, $132.55 to KMB Services, $34.00 to St. James Radiologists, $265.00 to Oak Lawn Radiology Imaging, $678.00 to Dr. Samuel Baz, $2,955.51 to ATI Physical Therapy, as provided in Sections 8(a) and 8.2 of the Act.

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

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

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

Signature of Arbitrator

3/26/13
Date

ICArbDec19(b)

APR 1 - 2013

FINDINGS OF FACT:

Since 1997, Petitioner, Jose Gutierrez, has worked for Respondent, Prestress Engineering Corporation ("Prestress"). On June 30, 2010, he was employed as a group leader on a project that required the fabrication of beams for the construction of a bridge.

Petitioner testified that on June 30, 2010, he was standing on a beam about six inches above the ground, after just completed the rolling up of a metal cable. As he turned to hand the cable to another individual, he fell off the beam with his right arm extended outward. Mr. Gutierrez explained his entire right arm from his shoulder to his hand was in immediate pain. The most severe pain was in his right thumb and index finger. He also noted numbness from the area below his right elbow through his first three fingers, bruising and a scrape on his right shoulder. Shortly thereafter, Petitioner was taken to the St. Mary's Hospital healthcare facility in Ottawa, Illinois.

At the hospital, Petitioner was seen by Dr. DeAngelo. Petitioner provided a history that he lost his balance at work and fell on his outstretched right upper extremity. He had complaints of pain principally in his right hand and elbow. There was forearm edema and the right wrist was painful and tender. A CT scan demonstrated a comminuted fracture of the distal radius and an ulnar styloid fracture with radial displacement. Chiplike fracture fragments arising from the lunate bone of the right wrist were also noted. (PX 5) Mr. Gutierrez stated he experienced pain in the right shoulder through his hand but explained the pain was most severe in the wrist and hand.

On the referral of Dr. DeAngelo, Petitioner came under the care of Dr. John Speca, an orthopedic surgeon, July 1, 2010. Dr. Speca obtained a history indicating Petitioner had fallen at work and experienced a fracture of the right distal radius. After performing an examination and reviewing diagnostic studies, Dr. Speca diagnosed anugulated and displaced right Frykman type VIII Cole's fracture. The doctor recommended surgery. (PX 4)

On July 3, 2010, Dr. Speca underwent an open reduction and internal fixation of the fragmented right Colles fracture. The fracture required the placement of a plate and twelve screws. (PX 4)

Post surgery, Petitioner commenced a course of physical therapy. Petitioner testified that during that period he continued with right hand pain, numbness and tingling that traveled throughout his entire arm. At his July 13, 2010 appointment with Dr. Speca, he provided complaints of numbness in the right hand accompanied by tingling. Dr. Speca ordered Petitioner continue physical therapy, remain splinted and told him remain off work. (PX 4)

In a follow up appointment of July 27, 2010, Dr. Speca noted Petitioner continued to have numbness and tingling in his right hand and reported distal radialulnar joint instability following his surgery on the right distal radius. A MRI was ordered of the hand and Petitioner was told to remain off work. The MRI of August 9, 2010 demonstrated internal fixation of the fracture of the distal radius with screws, a fracture of the distal ulnar styloid process with bone edema. The findings were also suspicious for injury to the triangular fibrocartilage. Widening of the scapholunate carpal bone, suggesting ligamenous injury was also reported. (PX 4)

On August 19, 2010, Dr. Speca noted Petitioner continued to have difficulty with his right wrist and with flexing the index finger. After reviewing the MRI taken, the doctor felt there was also a scapholunate ligament injury to the right wrist as well. He felt Petitioner would require more extensive rehabilitation and probable

additional surgery. Dr. Speca referred Petitioner to Dr. Fernandez, at Midwest Orthopedics at Rush. The doctor also released Petitioner to restricted work. (PX 4) Petitioner did not return to work as Respondent had no work available for him at that time.

Mr. Gutierrez presented to Dr. Fernandez on September 7, 2010. Dr. Fernandez noted Petitioner slipped off a steel beam and fell onto his right outstretched hand. He noted Petitioner was seen by the St. Mary's emergency room and then by Dr. John Speca who performed a right wrist distal radius open reduction and internal fixation. The doctor reported Petitioner underwent a MRI in August of 2010 which revealed a widening scapholunate ligament tear and a possible tear of the TFCC. At that visit, Petitioner reported pain in the wrist that was worse with rotation and an inability to supinate his forearm. Dr. Fernandez discussed various treatment options, including conservative treatment or surgery. He felt Petitioner should undergo bilateral wrist CT scans for comparison purposes. Norco was provided for pain relief and Petitioner was returned to work with no use of the right upper extremity.(PX 3) Respondent had no work within these restrictions.

CT scans taken later that day demonstrated postsurgical changes consistent with prior internal fixation of the distal right radial fracture with a volar surgical plate. The test revealed a persistent fracture along the dorsal ulnar aspect of the distal radius with a fracture line extending into the articular surface of the distal radialulnar joint. Moderate right wrist effusion along with severe disuse demineralization of the right wrist was also reported. (PX 3)

Prior to returning to Dr. Fernandez, Petitioner remained in physical therapy at Vital Care. (PX 8) Mr. Gutierrez continued to follow regularly with Dr. Speca, his local orthopedic, seeing him six more times. (PX 3 & 4) During those visits, Dr. Speca noted postoperative changes with osteoarthritis of the distal radial ulnar joints secondary to a trauma of the wrist. (PX 4) Physical therapy continued and Petitioner made some progress. On November 12, 2010, Dr. Speca noted Petitioner may end up requiring surgery recommended by Dr. Fernandez. At this visit with Dr. Speca on December 30, 2010 Petitioner complained of pain that tends to be over the distal radioulnar joint, but also occurred along the radial side and radiates up to the elbow and occasionally to the shoulder. (PX 4)

On January 13, 2011, Petitioner saw Dr. Fernandez. At that appointment, Petitioner continued to complain of right upper extremity pain, numbness and tingling. Tingling was noted throughout Petitioner's right index finger, thumb area and through his arm to the lower shoulder upper bicep area as indicated in a drawing submitted to Dr. Fernandez. During the visit, Mr. Gutierrez reported minor improvement as he now had the ability to perform personal hygiene tasks. Pain was a five out of ten. Dr. Fernandez noted Petitioner remained off work due to his restrictions. In his notes, the doctor reported limited improvements in Petitioner's range of motion. Dr. Fernandez explained Petitioner was responding somewhat to therapy but his pain continued. Dr. Fernandez suggested a surgical option that included arthroscopy with an ulnar shortening osteotomy to level out the joint to address his ulnar-sided symptoms and for possible improvement in his motion. He would also require continued therapy to improve other motion issues. He might further require excision and burial of the palmar cutaneous neuroma of the medial nerve which was causing numbness at the base of the thumb with local sensitivity at the scar. (PX 3 & RX 5) Petitioner opted for surgery.

On March 14, 2011, Dr. Fernandez performed a right wrist arthroscopy with debridement of chondral lesions, debridement of the central triangular fibrocartilage tear, a right wrist and forearm ulnar shortening osteotomy and a right wrist excision and burial of the palmar cutaneous neuroma. He was provided with continued work restrictions of no use of the right upper extremity. (PX 3) No work was provided for him within his restrictions. He continued to undergo physical therapy. (PX 6)

Petitioner followed with Dr. Fernandez in March and April of 2011 where he was provided physical therapy and splinting of the right arm. By June 7, 2011, Dr. Fernandez reported Petitioner had pain which was

unchanged. Physical therapy along with work restrictions were again provided. Petitioner continued to follow with Dr. Fernandez on August 23, 2011. Because of continued symptoms in the right hand and wrist, surgery was considered and work restrictions were ordered along with a bone scan. (PX 3)

After the bone scan at St. Mary's Hospital Petitioner returned to Dr. Fernandez on September 20, 2011. Petitioner continued with right extremity complaints through his arm to the lower shoulder upper bicep area as indicated in a drawing submitted to Dr. Fernandez. The doctor discussed additional surgery with Petitioner. On October 24, 2011, Petitioner underwent his third surgical procedure that included a right wrist proximal row carpectomy, radial styloidectomy, along with a posterior interosseus nerve resection and distal radial removal of the plate and screws previously placed. A right thumb flexer policis longus tenolysis was also performed. (PX3 & 7)

Dr. Fernandez continued to follow Petitioner after his surgery in November and noted improvement in his symptoms. Therapy was ordered and Petitioner was placed on work restrictions of no use of the right arm. (PX 3) Petitioner testified that during this period he was experiencing more pain in his right shoulder than he was in his wrist.

On December 7, 2011, Petitioner saw Dr. Fernandez who noted continual improvement. The doctor noted that Petitioner stated that the majority of his discomfort was now currently coming from his right shoulder. Dr. Fernandez wrote, "He has not received shoulder evaluation as of yet and states that his symptoms continue to increase in severity mainly with difficulty of raising the arm and moving the shoulder." The doctor referred Petitioner to a shoulder specialist, Dr. Gregory Nicholson. Petitioner's work restrictions were continued. (PX 3)

On January 13, 2012, Mr. Gutierrez presented to Dr. Nicholson. In his history, Dr. Nicholson reported Petitioner comes to him for a worker's compensation evaluation and treatment of his right shoulder. He wrote Petitioner fell onto his outstretched right hand and fractured his distal radius. An ORIF procedure was performed on the distal radius at that time. Dr. Nicholson reported Mr. Gutierrez had some shoulder pain since that time but nothing was done with it due to the fact he was treating for his wrist. During the intervening period, his shoulder did not have significant pain. However, over the last several months, he started to have symptoms from his hardware in the wrist and ultimately underwent its removal. Subsequently, during the performance of physical therapy after the surgery, the shoulder pain became more significant and constant. It was to the point where it interrupted his sleep. The doctor noted there has been no formal physical therapy for his shoulder to date and he is only taking anti-inflammatories and pain medications for the wrist which seemed to help the shoulder as well. The pain was primarily located in the anterior aspect of the shoulder. However, he does relate shoulder pain throughout the joint. An examination revealed tenderness over the right AC joint along the head of his biceps. Range of motion was largely limited by pain. He had increased symptoms in the shoulder and biceps during Speed's and Yergason's testing. Dr. Nicholson felt Petitioner had impingement syndrome and accompanying right shoulder pain. Dr. Nicholson wrote that "...this is somewhat of a common thing that we have seen in the past for patients who have hand and wrist surgery and injuries, have subsequent shoulder pain. I feel it is largely an inflammatory component..." The doctor felt Petitioner's inflammatory symptoms could be reduced and his pain eased. A Medrol Dose pack of tapering steroids was prescribed. Dr. Nicholson indicated that following the Medrol Dose pack, if significant pain continued, a MRI could be performed to evaluate, "with his past history of a fall onto outstretched hand," the rotator cuff and soft tissues around the shoulder. He was prescribed off work. (PX 3)

On February 8, 2012, Petitioner followed with Dr. Fernandez for the last time. At this visit, he reported Mr. Gutierrez continued to have pain limitations involving his right wrist. Hand symptoms at rest were two out of ten but worse with activity. Range of motion in the right wrist extension / flexion is 40/20, right grip strength was 40 while on the left it was 120. Dr. Fernendez wrote that Petitioner's responses were valid.

Dr. Fernandez indicated Petitioner had plateaued in terms of his recovery and functional status regarding the right hand and wrist. His capabilities with the right hand were limited at ten to twenty pounds with restrictions on repetition and use of tools and machines. He is also unable to climb. These restrictions are permanent. Lastly, Dr. Fernandez wrote Petitioner may require further surgery, including a fusion and continued medication, specifically Ultram. (PX 3)

Petitioner returned to Dr. Nicholson on February 24, 2012. In the interim, he had obtained the recommended MRI of the right shoulder at St. Mary's Hospital in Streator, Illinois. The MRI demonstrated a high riding right shoulder with a partial tear of the supraspinatus and a proximal longitudinal split tear of the biceps tendon. (PX 5) In his correspondence of February 24, 2012 to Sara Black, the nurse case manager of Respondent, Dr. Nicholson explained the MRI of the right shoulder demonstrated a full thickness tear of the rotator cuff in the anterior aspect of the supraspinatus. He reported that Petitioner's examination demonstrated significant pain to resisted supraspinatus abduction which is consistent with his symptomology. Dr. Nicholson explained to Respondent's nurse that Petitioner's shoulder dysfunction is due to his rotator cuff which he believes to be directly related to his fall at work. Recovery and the activities, including immobilization, have exacerbated that issue. He recommended a right shoulder arthroscopy, subacromial decompression and a right arthroscopic rotator cuff repair. Dr. Nicholson reported he could not schedule the surgery until written approval was received. (PX 3) Petitioner remained off work.

At Petitioner's next appointment of November 13, 2012, Dr. Nicholson reported Petitioner had a marked positive impingement sign, weakness and pain with resisted supraspinatus abduction and pain with palpation over the long head of the biceps combined with a positive Speed's test. Pain remained on the lateral aspect of the deltoid with resisted external rotation. He again explained Petitioner's injury "was more likely than not, caused by the fall that created the wrist injury." He remained unable to work and continued with his recommendation of right shoulder arthroscopy, subacromial decompression and arthroscopic rotator cuff repair. He felt this would dramatically relieve his pain and allow him to rehabilitate successfully and get back to a higher level of function. (PX 3)

Respondent obtained a Section 12 medical examination by Dr. Daniel Troy on April 3, 2012. Dr. Troy notes Petitioner underwent three right wrist surgeries after his June 30, 2010 fall on his outstretched right arm. He indicates Petitioner's first complaints of shoulder pain were documented seventeen months after the initial injury. Dr. Troy agreed Petitioner suffers from right shoulder impingement syndrome associated with a partial tear of the supraspinatus tendon and proximal longitudinal split tear of the long head of the bicep tendon. He explained Petitioner's MRI findings appear to be degenerative. He explains the treatment for the right wrist and hand has been reasonable and necessary. He felt Petitioner was at maximum medical improvement for his injury and should be placed on a ten to twenty pound lifting restriction. (RX 2)

Petitioner testified he currently remains off work on the orders of Dr. Gregory Nicholson. Petitioner provided that he has continuing pain and discomfort in his right hand and wrist but explains it is much decreased. Mr. Gutierrez reports the pain in his right arm has transitioned. Initially after his accident, his right wrist and hand were the center of his problems but after multiple surgeries, the pain is more focused in his upper arm and shoulder. He wants to undergo the recommended surgery to try and relieve the discomfort.

Mr. Gutierrez reported, with the exception of the four weeks following his accident that he was provided light duty, he has not been provided work by Respondent or kept off work completely by his physicians.

With respect to issue (F), Is Petitioner's current condition of ill-being causally related to the injury, the Arbitrator finds as follows:

On June 30, 2010, Petitioner fell onto his outstretched right upper extremity. He expressed the pain he felt was mostly in the right hand at the wrist but also extended into the elbow and shoulder which were much less of a problem. Mr. Gutierrez was treated by Dr. Speca who treated an angulated and displaced right frykman type VIII Colles fracture through the placement of a plate and twelve screws. Following the procedure, Petitioner continued to complain of pain and discomfort in his hand and upper extremity. Because of continuing pain and difficulty with the extremity, he was referred to Dr. Fernandez at Midwest Orthopedics at Rush.

Dr. Fernandez noted Petitioner had ongoing right wrist and hand pain, accompanied by stiffness. A MRI of Petitioner's right hand and wrist on September 7, 2010 demonstrated a persistent fracture line along the dorsal ulnar aspect of the distal radius with the fracture line extending into the articular surface of the distal radialulnar joint with continuing right wrist effusion and disuse mineralization of the right wrist. Due to his ongoing complaints of pain in the right hand and wrist, Petitioner underwent additional surgery on March 14, 2011 where he had a right wrist and forearm ulna shortening osteotomy along with an excision of the palmar cutaneous neuroma and reburial of the same. Following this procedure , as was the same following initial treatment of the fracture, his arm was immobilized and casted. After some initial relief, Petitioner's pain in his right wrist worsened. Therapy was terminated and Petitioner underwent his third surgery on October 24, 2011.

Dr. Fernandez performed a right wrist proximal row carpectomy, a styloidectomy, right wrist posterior inteosseous nerve resection, removal of the previously placed plate and screws and a right thumb flexer pollicis longus tenolysis. His limb was again immobilized through casting. Petitioner reported that this last procedure provided him with limited improvement in his ability to move his right wrist and further provided a reduction in the overall pain in his right wrist and forearm. Petitioner also provided that while receiving this improvement, pain in his right upper arm and shoulder area worsened. As such, he was referred to Dr. Nicholson.

Petitioner was seen by Dr. Nicholson on January 13, 2012 and reported Petitioner fell onto his outstretched right hand and after multiple surgeries and immobilizations, he now suffered right shoulder pain and impingement. A MRI demonstrated Petitioner had a high riding right shoulder with a partial tear of the supraspinatus and a proximal longitudinal split tear of the long biceps tendon. Dr. Nicholson believed that these conditions were directly related to his fall that created the wrist injury and that the activity and immobilization that followed the wrist injury caused or exacerbated the injuries from his fall. Dr. Nicholson recommended surgical repair of his work related condition through a subacromial decompression and a rotator cuff repair.

Respondent's Section 12 examiner, Dr. Troy, opined that Petitioner's symptoms related to the wrist and forearm are related; however, he does not connect the shoulder as being causally related to his injury. He indicates Petitioner's first complaints of shoulder pain were documented seventeen months after the initial injury. Records submitted show the first documented shoulder/upper arm discomfort was actually noted as early as December 30, 2010 when Petitioner complained to Dr. Speca that his pain tended to be over the distal radioulnar joint, but also occurring along the radial side and radiating up to the elbow and occasionally to the shoulder. On January 2011, Petitioner submitted a pain drawing documenting shoulder/arm discomfort. A subsequent pain drawing also documented shoulder/upper arm discomfort in September 2011. Petitioner orally related shoulder discomfort was documented and appearing in the records approximately five months after the accident. Petitioner credibly testified to continued pain throughout his arm but especially the right wrist and hand as this was most painful.

Relying on the mechanism of injury, Petitioner credible testimony and the opinions of Dr. Fernandez and Dr. Nicolson, the Arbitrator finds Petitioner's current condition of ill-being is causally related to the injury. These injuries include the right shoulder, biceps, forearm, wrist and hand.

With respect to issue (J), Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services, the Arbitrator finds as follows:

Petitioner's Exhibit #1 is a compilation of the medical bills incurred by Petitioner in the amount of $179,793.30. Respondent has paid $105,290.32 and insurance discounts of $64,898.57 have been received. (PX 1) Petitioner has paid $92.94 out of pocket and an additional $9,511.47 remains unpaid (Midwest Orthopedics at Rush: $1,590.43, Dr. John Speca: $3,856.02, KMB Services: $132.55, St. James Radiologists: $34.00, Oak Lawn Radiology Imaging: $265.00, Dr. Samuel Baz: $678.00, and ATI Physical Therapy: $2,955.51). The Arbitrator notes that of these bills, $4,531.87, relates to undisputed care and treatment received by Petitioner.

Respondent has disputed the causal connection for the bills relating only to treatment for Petitioner's right shoulder. Having reconciled that Petitioner's right shoulder condition of ill-being is causally related to the accident herein, the Arbitrator finds that the medical services received by Petitioner were reasonable and necessary. As such, Respondent shall pay the reasonable and necessary medical expenses of Petitioner in the amount of $9,604.41 ($92.94 for out of pocket expenses of Petitioner and $9,511.47 remaining unpaid) according to the medical fee schedule, to the extent applicable.

With respect to issue (K), Is Petitioner entitled to any prospective medical care, the Arbitrator finds as follows:

The Arbitrator incorporates the findings in Section (F) and as such finds that Respondent shall authorize the surgery and treatment as prescribed by Dr. Nicholson.

With respect to issue (L), What temporary benefits are in dispute, TTD, the Arbitrator finds the following:

Respondent's challenge regarding the period of TTD stems from their dispute with respect to Petitioner's right shoulder condition of ill-being. With the exception of four weeks, Petitioner has either been off work completely or on light duty. Mr. Gutierrez testified that he worked, shortly after his accident, for a period of 4 weeks. Accordingly, the Arbitrator finds that Petitioner was temporarily totally disabled for the period of June 20, 2010 to December 13, 2012, less four (4) weeks, or a period of 124-2/7 weeks.

With respect to issue (M), Should penalties or fees be imposed upon Respondent, the Arbitrator finds as follows:

The Arbitrator finds that a legitimate dispute existed with respect to a causal relationship to Petitioner's right shoulder condition of ill-being and the accident sustained. Respondent paid TTD from the date of accident, June 30, 2010, through June 16, 2012 (97-2/7 weeks) for a total of $41,949.60. It also provided an advance of $1,000.00 after Respondent terminated Petitioner's TTD benefits. Petitioner agreed that limited duty work had been made available for him relative to his wrist condition during September of 2010, for a period of four (4) weeks. Petitioner also admitted that he was aware that light duty would be made available for him for his wrist injury. As such Petitioner's request for penalties is 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

Linda Cieslewski,

Petitioner,

vs.

NO. 10 WC 32964

14IWCC0802

Simplex Grinnell,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19b having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of accident, temporary total disability, medical expenses, prospective medical care, 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 November 13, 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.

14IWCC0802

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.

SEP 19 2014

DATED:
SJM/sj
o-8/28/2014
44

Stephen J. Mathis

David L. Gore

Mario Basurto

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

CIESLEWSKI, LINDA
Employee/Petitioner

Case# **10WC032964**

SIMPLEX GRINNELL
Employer/Respondent

14IWCC0802

On 11/13/2013, 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:

1189 WOLTER BEEMAN & LYNCH
BRENT A BEEMAN
1001 S 6TH ST PO BOX 5276
SPRINGFIELD, IL 62705

0075 POWER & CRONIN LTD
MARTIN DEELY ESQ
900 COMMERCE DR SUITE 300
OAKBROOK, IL 60523

STATE OF ILLINOIS)
)SS.
COUNTY OF SANGAMON)

14IWCC0802

☐ 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)

LINDA CIESLEWSKI
Employee/Petitioner

v.

SIMPLEX GRINNELL
Employer/Respondent

Case # 10 WC 32964

An *Application for Adjustment 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 **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. ☒ 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

14IWCC0802

FINDINGS

On **April 19, 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 **$47,935.16**; the average weekly wage was **$921.83**.

On the date of accident, Petitioner was **43** years of age, ***single*** with **1** dependent child.

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

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

Respondent shall be given a credit of **$8,608.04** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$8,608.04**.

Respondent is entitled to a credit under Section 8(j) of the Act for all medical bills paid by it or through its group carrier. (See Respondent's Exhibit 10).

ORDER

Respondent is not liable to Petitioner for future medical care as Petitioner's current condition of ill-being is not causally related to the April 19, 2010 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.

Signature of Arbitrator

10/30/2013
Date

ICArbDec19(b)

NOV 13 2013

14IWCC0802

STATE OF ILLINOIS)
) SS
COUNTY OF SANGAMON)

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

LINDA CIESLEWSKI
Employee/Petitioner

v. Case # 10 WC 32964

SIMPLEX GRINNELL
Employer/Respondent

MEMORANDUM OF DECISION OF ARBITRATOR

FINDINGS OF FACT

Petitioner, Linda Cieslewski, has been employed by Respondent, Simplex Grinnell, since May 1996, as an associate inspector, which involves traveling to work job sites to inspect and test fire alarm systems and to make minor repairs to those systems if needed. Ninety to ninety-five percent of the inspections were performed with the help of a second person. The work involves carrying equipment, such as ladders and a sensitivity machine, which weighs about 25 pounds. Petitioner was provided a work truck to travel back and forth from work sites.

It is undisputed that on April 19, 2010, Petitioner was stopped at a red light when she was rear-ended by another vehicle. Petitioner testified that the force of the impact moved around the contents of the truck and damaged the bumper of the work truck. Petitioner testified that the vehicle was "totaled." Petitioner testified that she was in good health prior to the automobile accident, with no symptoms in her head, neck, or arms. She testified that she did not suffer any accident after April 19, 2010.

Petitioner sought medical treatment soon after the accident with her primary care physician, Dr. Gerald Suchomski, who has managed Petitioner's care since the date of accident. Petitioner has presented to Dr. Suchomski on several occasions over the years since the April 2010 work accident. (Petitioner's Exhibit (PX) 2).

Petitioner underwent a CT scan on April 25, 2010, which was unremarkable and noted no traumatic abnormalities. (RX 4). Petitioner underwent MRI testing on June 25, 2010, almost two months following the vehicle accident, which showed a small central and right-sided extradural defect at C5-6 with mild narrowing of the neural foramen, but was otherwise unremarkable. (RX 3). Petitioner underwent EMG/NCV testing on July 28, 2010 with Dr. John Watson, which was found normal. (RX 5). Further EMG testing conducted on December 3, 2010 by Dr. David Gelber was found to be normal. (RX 6).

Petitioner underwent a second cervical spine MRI on August 1, 2011, which revealed disc protrusions at C2-C3 and C3-C4; disc herniation at C4-C5; and disc bulging with moderate bilateral neural foramina narrowing at C5-C6. (RX 7). Further EMG/NCV testing was performed on November 17, 2011, which was noted as abnormal and revealed mild to moderately severe chronic left C6 radiculopathy. (RX 8).

Dr. Stephen Pineda, Petitioner's treating orthopedic surgeon, has recommended continued medical treatment of either continued pain management or surgery in the form of disc replacement or fusion. (PX 7).

Dr. Suchomski's evidence deposition testimony was offered as Petitioner's Exhibit 8. Dr. Suchomski testified that he is a family physician. (PX 8, p. 5). Dr. Suchomski opined that Petitioner received a neck injury as a result of her work-related motor vehicle accident of April 19, 2010, and that said injury led to the ongoing sequence of symptoms that Petitioner has had since that time. (PX 8, pp. 46-48). Dr. Suchomski currently has Petitioner off of work. (PX 8, pp. 49-50).

Dr. Suchomski testified that he reviewed the CT scan from April 25, 2010, and he agreed that it showed no trauma and no changes in the cervical spine at the time of the emergency room visit. (PX 8, p. 66). The MRI of June 25, 2010 was reviewed, and Dr. Suchomski again agreed that said MRI did not show any herniated discs at the cervical level. (PX 8, p. 67). Further, Dr. Suchomski reviewed the July 28, 2010 EMG report, which he noted was negative for a herniated disc in the cervical spine. (PX 8, p. 68). The December 2010 EMG testing was also reviewed by Dr. Suchomski, and he agreed that was negative for any showing of herniated discs. (PX 8, p. 69). Dr. Suchomski also reviewed the August 1, 2011 MRI test ordered by Dr. Pineda. Dr. Suchomski agreed that there was a significant change in findings in the August 1, 2011 MRI that subsequently then showed a C5-C6 herniated disc that was not present in the June 25, 2010 MRI. Further, Dr. Suchomski reviewed the November 17, 2011 EMG study and again agreed that there was a significant change from the prior study of December 2010. Dr. Suchomski provided no explanation as to why these changes occurred. (PX 8, pp. 70-78). In March 2011 and May 2011, Dr. Suchomski testified that Petitioner reported new symptoms to him; she was reporting right side radiculopathy in 2011 that was not present in 2010. (PX 8, pp. 70-72).

On May 22, 2012, Petitioner was examined at Respondent's request by board-certified orthopedic surgeon, Dr. Thomas Gleason, pursuant to Section 12 of the Illinois Workers' Compensation Act, 820 ILCS 305/1 *et seq.* (hereafter the "Act"). (RX 1, Dep. Exh. 2; RX 1, p. 5). Dr. Gleason noted that Petitioner was 42 years old at the time of his examination. (RX 1, p. 25). It was Dr. Gleason's opinion that Petitioner had a degenerative process developing in her neck prior to the accident. (RX 1, pp. 17, 25-26). Dr. Gleason also noted that Petitioner's symptoms got significantly worse after May 2011, which was approximately a year after the accident date of April 19, 2010. (RX 1, p. 26; RX 1, Dep. Exh. 2). The doctor also noted that Petitioner's radiographic findings changed after May 2011. He noted that the cervical MRI of August 2011 showed herniated discs at the C4-C5 and C5-C6 levels, which were not present in the prior MRI conducted on June 25, 2010. The doctor noted that the June 25, 2010 MRI did not show any signs of herniated cervical discs. He further noted that the EMG/NCV testing of November 2011 had findings indicating a herniated disc at C5-C6. Dr. Gleason also noted that the November 2011 EMG showed radiculopathy at the C6 level, but that the EMG tests conducted on July 28, 2010 and December 3, 2010 revealed no radiculopathy or signs of a herniated disc at the C6 level, or at any other level in the cervical spine. (RX 1, pp. 26-30).

Dr. Gleason pointed out that Petitioner's evaluation records of March 21, 2011 showed that her neck was stable and that her pain was mostly in the mid-back. When Petitioner was seen by her family doctor on June 10, 2010, she complained of occasional neck pain. When she was seen by her family doctor on August 3, 2010, she was not complaining of her neck, but was complaining of sinus headaches along with coughing and sneezing. When she was seen by Dr. Watson on August 31, 2010, the symptoms in her neck were moderately better. (PX 2; PX 4; RX 1, pp. 18-26).

Based on this objective testing, Dr. Gleason testified to a reasonable degree of medical and surgical certainty that any proposed surgical intervention did not result from an automobile accident that occurred on or about April 19, 2010, and further that Petitioner's increased symptoms and findings during and after May 2011

would not be related to the April 2010 accident. Dr. Gleason opined that Petitioner sustained a soft tissue type strain injury and/or temporary aggravation of a pre-existing condition in her neck as a result of the work accident. (RX 1, pp. 28-30). Dr. Gleason also opined that Petitioner was capable of full-time employment. (RX 1, pp. 30-31).

CONCLUSIONS OF LAW

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

The Arbitrator finds most persuasive the objective radiographic testing performed during the course of Petitioner's treatment in this matter. The Arbitrator notes that immediately following the accident, on April 25, 2010, an EMG was conducted. This EMG was negative for any findings of a herniated disc in the cervical spine. On June 25, 2010, an MRI of the cervical spine was performed. At that time, the MRI of the cervical spine revealed no finding of herniated discs. On July 28, 2010, a further EMG was conducted. At that time, there was no finding of herniated discs at the cervical spine. A further EMG was conducted on December 28, 2010, and again there was no finding of herniated discs at the C5-C6 levels.

It was only until August 1, 2011, at the request of Dr. Pineda, that a further MRI was performed. At this time, there were findings of a herniated disc at the C4-C5 level. This represents a significant change from the prior MRI results. Finally, by November 17, 2011, a subsequent EMG performed revealed signs of a herniated disc at the C6 level. Again, this represents a significant change from the prior EMG testing conducted in April 2010, July 2010, and December 2010.

The Arbitrator notes that there was no causal connection opinion or testimony on behalf of Dr. Pineda, Petitioner's treating orthopedic surgeon, regarding claims of herniated discs at C4-C5 or C5-C6, or any relationship to the accident of April 19, 2010.

In light of this evidence, the Arbitrator finds the opinions of Dr. Gleason most persuasive after his review of medical records and the objective radiographic reports. The Arbitrator agrees with Dr. Gleason that Petitioner's current condition of ill-being in her cervical spine is not related to the April 19, 2010 accident.

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

The Arbitrator notes that Petitioner has submitted medical bills in this matter, and that Respondent has paid most, if not all, of these medical bills. (PX 1; RX 10). The Arbitrator finds that Respondent is not liable for any unpaid medical bills following August 1, 2011.

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

The Arbitrator finds that Respondent is not liable for any future medical treatment consistent with rulings in Issue (F) (discussed *supra*), as Petitioner's current condition of ill-being is not causally related to the April 19, 2010 automobile accident.

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

The Arbitrator finds that Respondent is not liable for temporary total disability (TTD) benefits beyond August 1, 2011, as Petitioner's condition of ill-being had significantly changed by that point to a level that was not causally related to the work injury. Therefore, consistent with prior conclusions, the Arbitrator finds Respondent is not liable for any claimed TTD benefits in 2013. (See AX 1).

Issue (N): Is Respondent due any credit?

The Arbitrator finds that Respondent is due credits consistent with submissions for medical bills and TTD paid. (See Arbitrator's Exhibit (AX) 1; RX 9; RX 10).

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

BRENDA JERRELL,

Petitioner,

vs.

NO: 13 WC 9576

ADDUS HEALTHCARE,

14IWCC0803

Respondent,

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of accident, causal connection, temporary total disability, and medical expenses, and being advised of the facts and law, reverses the Decision of the Arbitrator but attaches the Decision, which is made a part hereof, for the purposes of the Statement of Facts with the additions and modifications stated below.

The Commission finds that Petitioner failed to prove that she sustained accidental injuries arising out of and in the course of her employment on May 8, 2012. The Arbitrator found that "Petitioner credibly testified regarding the accident which occurred on May 8, 2012 which resulted in a sudden onset of low back pain. Respondent provided no contradictory evidence or testimony to suggest the accident did not occur." (Dec. at 3). However, we find that this is not accurate because the initial medical records, Petitioner's delay in seeking treatment, and the testimony of Respondent's witnesses are all evidence that Petitioner did not sustain an injury on May 8, 2012.

Petitioner claims that she injured her back while mopping a floor on Tuesday, May 8, 2012. She continued to work and on Friday, May 11th, she was at the same client's house, again doing mopping, and felt worse back pain that now went into her hip, left leg, and left foot. However, Petitioner did not seek treatment at that time. The first medical record is from two

weeks later on May 25, 2012, with Hally Barke, PA-C. This note indicates that Petitioner was complaining of left leg pain that "may have started in her back and left hip area" and had been "going on since the beginning of this week." This timeline would not be consistent with an onset of back or leg pain on May 8th. Even more interesting is that this record indicates "no known injury or trauma, but she has had history of surgery on that leg, and problems with pain." Despite this specific statement in the record, Petitioner testified that she thought she did report to Ms. Barke that she hurt her back and leg while mopping.

Petitioner next saw her primary care physician, Dr. O'Connor, on June 7, 2012. This note also indicates "denies any trauma." Again, however, Petitioner denied telling Dr. O'Connor that she didn't have any trauma to her back and testified that she did, in fact, tell him that she hurt her back while mopping.

Petitioner saw Dr. O'Connor again on June 11th and there is no mention of any specific work injury. It is not until June 18th that there is any mention of mopping when Dr. O'Connor wrote, "She says it started with some low back pain, she does mopping as part of her duties as working for one of the visiting nurses organizations.... She thinks that that maybe (sic) the cause of it now but **this is the first time that she really mentioned that specifically**." (Emphasis added.) This note indicates that Petitioner believed, in hindsight, that mopping in general may have been a cause of her symptoms since there is no specific date of injury mentioned; particularly there was no mention of an injury on May 8th.

Even though Petitioner testified that she was aware that she needed to report any injuries immediately (T.22), she didn't report any work injury until June 18th (T.19). While Petitioner was in Dr. O'Connor's office, she received a phone call on her cell phone from her supervisor. (T.38). Lori Aston, the lead coordinator at Respondent, called Petitioner who informed her that she was at the doctor's office at the time. (T.74). Ms. Aston testified that Petitioner told her that she wasn't sure how she hurt herself but she hurt her back. (T.74, 78). Ms. Aston directed Petitioner to contact her supervisor, Ethan Parks, who filled out an injury report. This Supervisor's Report, dated June 18, 2012, indicates a date of accident of May 8th and that Petitioner "was mopping clients (sic) floor and back started hurting."

Ms. Aston testified that when Petitioner came in to complete her incident report on June 19th, she reported that she was hurt mopping a floor but, the day earlier on the phone, Petitioner told her that she wasn't sure how she hurt herself. (T.78). Petitioner's Employee Injury Report indicates an accident date of May 8, 2012, "mopping kitchen floor," "back just started hurting." Interestingly, this report also states, "5/15/12 low back pain went down to L hip and L leg and into foot." This is not consistent with Petitioner's testimony that it was on Friday May 11th when she had increased back and new leg pain.

Kim Evans, Respondent's Agency Director, testified that she met with Petitioner on June 19th with Lori Aston present. Ms. Evans testified that "on several occasions while we were discussing this injury when asked how or what happened to her back, she would say I don't know. I don't know if I did it working. I don't know. I've had lower back problems before." (T.60).

It is also interesting that Petitioner was seen by Dr. Taveau's C.N.P., Robert Deaton, on August 27, 2012, who recorded a "sudden onset w/ injury" while mopping on June 8th. This is a month later than Petitioner's alleged accident date. Petitioner eventually saw Dr. Taveau on

September 17th and Dr. Taveau also recorded an injury date of June 8th. Dr. Taveau testified that "I have been informed that it was actually May 8th" (Px11 at 6) but he was certain that Petitioner told him it was June 8th. (Id. at 30). Dr. Taveau was not questioned about how he became aware that the accident date was actually May 8th. Petitioner also saw Dr. Criste for a pain management consult on November 2, 2012. A pain questionnaire completed by Petitioner indicates that her pain started "6-8,15-2012." This is not consistent with Petitioner's claimed accident date of May 8, 2012.

We note that another aspect regarding Petitioner's credibility is related to her questioning about whether she was told by Ms. Evans on December 14, 2012 to contact the insurance adjustor about continued light duty work with a third party company called Cascade. On cross-examination, Petitioner testified that Ms. Evans "never said anything to me about that" (T.43) but that Ms. Evans did tell one of the other girls about Cascade and when Petitioner asked Ms. Evans about it she was told that Ms. Evans "had to find out more about it." (T.44). Both Kim Evans and Lori Aston testified that Petitioner was given the phone number of the adjustor to call. (T.55, 77). In her rebuttal, Petitioner testified that she did try to call the person from Liberty Mutual for light duty but he had quit. (T.82). On rebuttal cross-examination, the following exchange took place:

Q: Ma'am, you just testified that you were given a slip about calling this Gentleman at Liberty Mutual; is that right?
A: I don't know if I got one or not. But this other girl got one, and I could have got it from her.
Q: So you're telling me you got a slip from some other employee?
A: No. There was two of us in the room, and this other girl got one. I – I suppose I got one.
Q: Okay. But you just said you contacted the adjustor and he wasn't working there anymore?
A: No.
Q: No, that's correct or no, that's not correct?
A: No, he did not work there any longer.
Q: All right. So now you're telling me that you did believe you got something and you had – you're telling us that you believe you had a discussion with Ms. Evans and she gave you a slip about additional light duty?
A: Yes.

Petitioner was evasive and not entirely truthful regarding whether she was given the phone number and offer of light duty through Cascade. We find that this reflects negatively on Petitioner's credibility regarding her alleged work injury as well.

Two separate medical providers (Hally Barke on May 25th and Dr. O'Connor on June 7th) specifically noted that Petitioner reported that there was no trauma that caused her pain. We find it hard to believe that neither of these providers would have mentioned mopping at work if Petitioner had, in fact, given them this history. The first mention of any "mopping" at work is Dr. O'Connor's note on June 18th, which is the same day that Petitioner reported her alleged

injury to Respondent. There are several other inconsistent dates in the medical records as noted above. Petitioner's condition of ill-being is degenerative disc disease with no apparent acute pathology. We note that it is possible that Petitioner began experiencing symptoms while mopping at work and she may have gotten the date wrong. However, it seems more likely than not that Petitioner began having problems with her back unrelated to her employment and saw Hally Barke on May 25th, but it was not related to any "mopping" incident. Rather, it seems likely that Petitioner is alleging an accident date prior to her first visit with Hally Barke so she can claim it was work-related instead of simply a degenerative condition.

The Arbitrator's decision is not accurate in its finding that there is "no contradictory evidence or testimony to suggest the accident did not occur." There is the lack of any mention of a work injury in the initial medical records. The testimony of Kim Evans and Lori Aston was that Petitioner was unsure how she hurt her back. The dates in the medical records are inconsistent with Petitioner's date of accident.

Based on the above and a review of the record as a whole, we find that Petitioner's testimony is not credible, is not consistent with the other evidence, and that she has failed to prove accidental injuries arising out of and in the course of her employment.

IT IS THEREFORE ORDERED BY THE COMMISSION that the decision of the Arbitrator, dated December 5, 2013, is hereby reversed and the awards vacated.

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

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

DATED: SEP 2 2 2014

Charles J. DeVriendt

Daniel R. Donohoo

Ruth W. White

SE/
O: 8/27/14
49

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

JERRELL, BRENDA
Employee/Petitioner

Case# **13WC009576**

ADDUS HEALTHCARE
Employer/Respondent

14IWCC0803

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:

LAW OFFICES OF FOLEY & DENNY
TIM DENNY
PO BOX 685
ANNA, IL 62906

2795 HENNESSY & ROACH PC
RICHARD A DAY
415 N 10TH ST SUITE 200
ST LOUIS, MO 63101

STATE OF ILLINOIS)
)SS.
COUNTY OF Jefferson)

14IWCC0803

☐ 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)

Brenda Jerrell
Employee/Petitioner

v.

Addus Healthcare
Employer/Respondent

Case # 13 WC 009576

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 4, 2013**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

14IWCC0803

On the date of accident, **05/08/2012**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**17,376.84**; the average weekly wage was $**334.17**.

On the date of accident, Petitioner was **59** 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 $**2000.00** for TTD, $**0.00** for TPD, $**0.00** for maintenance, and $**0.00** for other benefits, for a total credit of $**0.00**.

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

ORDER

Respondent shall pay petitioner temporary disability benefits of $222.78 per week for a period of 42 weeks, commencing on December 15, 2012 through October 4, 2013 as provided in Section 8(b) of the Act. Respondent shall receive credit of $2,000.00 for temporary total disability paid to date.

Respondent shall pay any reasonable, related, necessary, and outstanding medical bills contained in Petitioner's exhibit 9 pursuant to sections 8(a) and 8.2 of the Act. Respondent shall receive credit for any amounts paid by their workers compensation insurance carrier.

Respondent shall authorize and pay for the related, prospective, medical treatment recommended by Dr.Taveau including the L5-S1 Laminectomy.

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

12/3/13
Date

ICArbDec19(b)
Jerrell v. Addus Healthcare, 13 WC 9576

DEC 5 – 2013

Findings of Fact

The petitioner, Brenda Jerrell, is a home healthcare provider who has been employed by the respondent for approximately three years. Her job consists of going to clients homes to provide home health care. She will visit three or four homes on an average day. At each home she is required to provide for the healthcare needs of the clients that may include helping them in or out of bed, medications, or other medical needs. She also assists clients with preparation of meals and cleaning of their homes.

On May 8, 2012 the petitioner was working in the home of a client and mopping the floor. This client's task was particularly difficult because the mop did not work properly and the client had a dog which made cleaning more strenuous. While she was mopping the petitioner felt a sudden onset of pain in her back. The petitioner attempted to continue working the remainder of the week. Throughout the week her pain increased and she began experiencing shooting pain across her hip into her leg. She hoped the pain would resolve, but when it did not, she went to see her family physician.

Petitioner presented to Anna Rural Health because her regular physicians was not available in Dongola. Petitioner reported pain in her back and hip area to the physician's assistant on May 25, 2012. Petitioner continued to treat with her family physician at Dongola Rural health. Records from Dongola Rural Health indicate the petitioner denied trauma. Upon strenuous cross examination, the petitioner persistently and without waiver testified she reported the injury to her physician as occurring while she was mopping at work.

The petitioner testified that she when she was unable to work and her supervisor asked her what had happened. Her supervisor asked if it was work related and the petitioner did not know if she still had time to turn the claim into work comp. Petitioner testified that after completing paperwork reporting the claim to her supervisor, the Respondent arranged for her to be treated by Dr. Austin at Work Care.

The petitioner's personnel filed was admitted into evidence as Petitioner's Exhibit 10. The file contains documentation that she reported her injury as occurring while she was mopping a floor. The documents show the injury was reported to her employer on or about June 18, 2013. Medical records from Dr. Mark Austin from Work Care were admitted into evidence as Petitioner's Exhibit "1". The Petitioner presented to Work Care on June 19, 2012 and provided a history that she noticed back pain after mopping a floor. The patient reported low back pain into the hip that goes into the left leg and left foot. In his initial diagnosis Dr. Austin noted that the significant radiculopathic signs and symptoms and he could not exclude a lower lumbar disc herniation. Dr. Austin recommended physical therapy. The Petitioner followed up with Dr. Austin on July 3, 2012 who prescribed heat, with stretching and medications. He also recommended an MRI. Petitioner was last examined by Dr. Austin on July 27, 2012 who noted persistent left leg radiculopathic signs and symptoms that fit an L5 root distribution and the MRI shows compression of both right and left nerve roots at the neuralforminia. Dr. Austin kept the Petitioner on a 10 pound lifting restriction and referred the patient to a neurosurgeon, Dr. Jones or Dr. Taveau.

The Petitioner's MRI of the lumbar spine was admitted into evidence as were the records from Herrin's Hospital as Petitioner's Exhibit "2". The impression noted compression of each L5 nerve root in the foramin which could be the source of the pain/radiculopathy.

Medical records of Trinity Neuroscience and Dr. Jon Taveau were admitted into evidence as Petitioner's Exhibit "5". The initial request from a consultation with Dr. Taveau was made on July 30, 2012 by Kim Evans. The reason for the consultation was back pain travelling into the left hip as a work related injury. Petitioner was first examined at Trinity Neuroscience on August 27, 2012 and reported low back pain that radiates in to the left foot after an episode of mopping on June 8th of this year. An NCV/EMG was recommended as well as flexion extension xrays. Petitioner was re-examined on September 17, 2012 and it was noted the EMG/NCV showed L5 radiculopathy. An L5 laminectomy with medial facetectomy and foraminaotomy with possible discectomy was recommended by Dr. Taveau. An off work slip dated January13, 2013 noted the Petitioner was continued off work. Petitioner was examined again by Dr. Taveau on February 13, 2013 who again recommended an L5-S1 laminectomy, medial facetectomy, forinanotomy and possible discectomy.

The evidence deposition of Dr. Jon Taveau was admitted into evidence as Petitioner's Exhibit "11". Dr. Taveau is board certified in neurological surgery. The August 27, 2012 examination consisted of evaluation by his nurse practitioner. Dr. Taveau clarified that his notes specifies that the Petitioner was injured on June 8th, but he has been informed that it was actually May 8th. Dr. Taveau indicated that his PA felt there was a herniated disk and felt additional testing was needed. Flexion and extension views were ordered as well as a nerve conduction study. The patient was next evaluated on September 17, 2012 and it was noted the EMG revealed impingement at the L5 nerve root consistent with her MRI findings and the flexion extension views.

Dr. Taveau performed a physical examination who noted straight leg raising and range of motion pain without neurologic deficit. Dr. Taveau recommended an L5-S1 laminectomy and decompression with medial facetectomy and foraminotomy with possible discectomy. The surgery was denied by workers' compensation on September 4, 2012. Dr. Taveau then referred her to Dr. Criste for injections. The Petitioner was examined by Dr. Criste on November 2, 2012 and he recommended lumbar epidural steroid injections.

Dr. Taveau next examined Ms. Jerrell on February 13, 2013 and she still had left leg pain, numbness and tingling at the L5-S1 distribution with low back pain. That is the last time he examined the Petitioner but he continued his recommendation for an L5-S1 laminectomy. Dr. Taveau's recommendation for surgery is based upon a patient with a history of back pain with a distribution which correlated with her L5-S1 nerve roots. The flexion extension xrays showed a mild grade 1 spondylolesis. The nerve conduction study revealed an L5 nerve root impingement. The patient also had straight leg raising which is consistent with lumbar radiculitis so decompressing the nerve roots would benefit at that level. Dr. Taveau indicated that it was his opinion that her condition was aggravated by her work activity.

The records attached to Dr. Taveau's records contain a utilization review dated September 24, 2012 indicating non-certification for the surgery recommended by Dr. Taveau. Also contained within Dr. Taveau's records is a February 20, 2013 utilization review report indicating that the requested surgery had been certified as medically appropriate.

Respondent offered the deposition transcript of Dr. Brett Taylor into evidence as Respondent's Exhibit "1". Dr. Taylor performed a Section 12 examination on behalf of the Respondent. Dr. Taylor's diagnosis and recommendations for treatment virtually mirror that of Dr. Taveau. Dr. Taylor believes surgical intervention is appropriate for this patient as long as conservative measures have been exhausted. Dr. Taylor does not believe it was cause related by her work accident. Dr. Taylor's opinion is that the

Petitioner's condition pre-existed the work accident. Dr. Taylor conceded that he would not recommend surgery for a degenerative condition for a patient who was asymptomatic. However, he did state that if the patient with positive MRI and EMG findings became symptomatic he would recommend surgery. However, Dr. Taylor would not concede that if there was an incident that caused the condition to become symptomatic he does believe the incident is in any way related to the patient's need for surgery. It is Dr. Taylor's opinion that because he does not define mopping as trauma that it could not have been the causal factor in her condition. Ultimately Dr. Taylor did concede that events that cause pain that a patient can no longer tolerate that causes them to go see a doctor would be a factor in why they chose to seek treatment.

CONCLUSIONS OF LAW

1. Regarding the issue of accident, the Arbitrator finds that the Petitioner has met her burden of proof. Petitioner credibly testified regarding the accident which occurred on May 8, 2012 which resulted in a sudden onset of low back pain. Respondent provided no contradictory evidence or testimony to suggest the accident did not occur. Petitioner specifically described the strenuous nature of the mopping activity she was engaged in at the time of the onset of her back pain. Petitioner specifically noted that due to the multiple stops through the course of the day and the nature of performing on behalf of a client required much more strenuous exertion than would be required in her household daily activities. While providing benefits under the Act is not an admission, the Respondent provided medical care through Dr. Austin at Work Care and provided light duty accommodation for approximately six months verifying their belief that an accident did occur that arose out of the course of the employment with the Respondent.

2. Petitioner provided timely notice of her accident to the Respondent. While the Respondent has disputed notice in this case, the Petitioner's personnel file which included accident reports and the testimony of both the Petitioner and Respondent's representatives indicate that notice was given on or before June 18, 2012. This is within the 45 day period required by the Act. Furthermore, Respondent has not provided evidence that it was prejudiced in any way by notice approximately 4o days after the accident.

3. Petitioner has met her burden of proof regarding the issue of causation. The Petitioner credibly testified that she has never had back pain in her entire life. The Petitioner has been engaged in the home health care profession in various forms for nearly 30 years. She has been employed by the Respondent in the home health care profession for more than three years. The Respondent confirmed that the Petitioner has never had to miss work due to a pre-existing back injury. Although the Respondent indicates the Petitioner's current condition of ill being is completely related to a pre-existing injury, the evidence overwhelming supports the conclusion the petitioner's current condition began while working on May 8, 2012. The un-contradicted evidence shows that the Petitioner was able to work every day as a home health care provider until the work accident that occurred on May 8, 2012. Therefore, the Arbitrator concludes that the Petitioner has met her burden of proving her current condition of ill being is causally related to the work injury.

4. Petitioner is awarded medical expenses. Respondent's primary disputes in this case were based upon accident and causation above. Respondent's own expert did not have a significant dispute with the care and treatment that had been provided to the Petitioner to date. Therefore, the Arbitrator concludes that

14IWCC0803

the medical services provided to the Petitioner to date have been reasonable and necessary. Medical bills contained within Petitioner's Exhibit "9" indicate substantial portions of the medical have been paid for by the Respondent. Respondent shall receive credit for any amounts paid though their group health insurance carrier. Furthermore, Respondent is ordered to pay for all reasonable and necessary causally related medical treatment rendered to the Petitioner outlined in Petitioner's Exhibit "9".

5. Petitioner is awarded prospective medical care. As noted above Respondent's primary disputes with this case pertain to accident and causation. Furthermore, Respondent's own expert did not dispute the reasonableness and the necessity of the medical care rendered to the Petitioner to date. It is noted in the deposition of Dr. Taveau, the Respondent has obtained a utilization review report certifying the surgery recommended by Dr. Taveau as medically necessary. Therefore the Arbitrator concludes the Petitioner is entitled to prospective medical care including but not limited to the L5-S1 laminectomy recommended by Dr. Taveau.

6. Petitioner is awarded TTD. Consistent with the Arbitrators findings above on accident, causation, and notice the Petitioner is entitled to TTD benefits. The parties did not dispute that the Petitioner was provided light duty accommodation through December 14, 2012. Parties do not dispute that the Petitioner was unable to work in the full capacity of her employment as a home health provider after that date. Respondent's primary temporary total disability dispute arises out of their allegations light duty may have been available through a third party vendor. While the Arbitrator appreciates the Respondent's efforts to assign the Petitioner through a third party vendor the facts in this case do not show light duty was in fact available or offered to the Petitioner. Furthermore, the Arbitrator can find no authority in the Act that enables an employer to assign an injured worker to a third party for employment to relieve them of their obligations under section 8(b) of the Act. Therefore, the Arbitrator concludes the Petitioner is entitled to 42 weeks of TTD benefits starting with December 15, 2012 through the date of trial.

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

Terence Green,
Petitioner,

vs.

NO: 10WC 42582

14IWCC0804

Gunite,
Respondent,

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed September 24, 2013, is hereby affirmed and adopted.

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

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

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $1,100.00. 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:
o090914 SEP 2 2 2014
CJD/jrc
049

Charles J. DeVriendt

Daniel R. Donohoo

Ruth W. White

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

GREEN, TERENCE
Employee/Petitioner

Case# **10WC042582**

10WC004319

GUNITE
Employer/Respondent

14IWCC0804

On 9/24/2013, 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 0.05% 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:

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0507 RUSIN MACIOROWSKI & FRIEDMAN LTD
RANDALL STARK
10 S RIVERSIDE PLZ SUITE 1530
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

Terence Green
Employee/Petitioner

v.

Gunite
Employer/Respondent

Case # **10** WC **42582**

Consolidated cases: **10 WC 4319**

14IWCC0804

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Anthony C. Erbacci**, Arbitrator of the Commission, in the city of **Rockford**, on **August 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 **July 16, 2010**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$34,583.64**; the average weekly wage was **$665.07**.

On the date of accident, Petitioner was **39** years of age, ***single*** with **1** dependent children.

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

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

ORDER

Respondent shall pay reasonable and necessary medical services of **$1,004.95**, as provided in Sections 8(a) and 8.2 of the Act and consistent with the medical fee schedule. Respondent shall be given a credit for any of the awarded medical benefits that it has previously paid.

No other benefits are awarded herein.

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

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

Arbitrator Anthony C. Erbacci

September 19, 2013
Date

SEP 24 2013

14IWCC0804

FACTS:

On July 16, 2010 the Petitioner was employed by the Respondent as an Iron Pourer. The Petitioner testified that on July 16, 2010, he noticed pain and irritation in his left eye while in the course of his employment. He testified that he continued working and went home after his shift. The Petitioner testified that he wore safety glasses while performing his job. The following morning, the Petitioner reported to Freeport Memorial Hospital due to ongoing eye pain. The Freeport Memorial Hospital records note that Petitioner complained of left eye pain due to particles from the foundry. The Petitioner reported blurred vision along with his pain. The Petitioner's diagnosis was foreign body left eye and he was referred to an ophthalmologist. The Petitioner was seen by Dr. Wadhwa that afternoon. The note from Dr. Wadhwa indicates that the Petitioner reported that he thought a toy hit his eye. The Petitioner testified that he had no idea what the reference to a toy was as he had not been hit by a toy. Dr. Wadhwa's record also noted that a foreign body with rust was removed from the Petitioner's left eye.

CONCLUSIONS:

In Support of the Arbitrator's Decision relating to (C.), Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent, the Arbitrator finds and concludes as follows:

The Arbitrator finds that an accident occurred that arose out of and in the course of Petitioner's employment by Respondent on July 16, 2010. The Petitioner testified that he felt discomfort in his eye while in the course of his employment. His medical records the next day note a consistent history and note that a rusty foreign body was removed from his eye. The notation of being hit by a toy is contrary to the medical history provided by the Petitioner when he first sought treatment and contrary to the Petitioner's testimony.

While the Arbitrator notes the history contained in Dr. Wadhwa's record, the Arbitrator finds that Petitioner's testimony to be sufficiently credible and persuasive so as to be reliable. The Arbitrator also notes that the Petitioner is employed in a foundry where one would expect that rusty debris would be abundant.

Based upon the foregoing and having considered the totality of the credible evidence adduced at hearing, the Arbitrator finds that that Petitioner suffered an injury to his left eye that arose out of and in the course of his employment by Respondent on July 16, 2010.

In Support of the Arbitrator's Decision relating to (F.), Is Petitioner's current condition of ill-being causally related to the injury, the Arbitrator finds and concludes as follows:

The Arbitrator finds that Petitioner's current condition of ill-being is causally related to his work injury of July 16, 2010. The Arbitrator relies upon the emergency room records and

Petitioner's testimony. The Petitioner testified that the sun continues to bother his eye but he has not received any additional treatment relative to his eye injury following the treatment on July 17, 2010.

In Support of the Arbitrator's Decision relating to (J.), Were the medical services that were provided to Petitioner reasonable and necessary/Has Respondent paid all appropriate charges for all reasonable and necessary medical services, the Arbitrator finds and concludes as follows:

The Arbitrator finds that the medical services that were provided to Petitioner were reasonable and necessary. The Respondent has not paid the necessary charges for the emergency room treatment or the foreign body removal. As such, Respondent is responsible for the outstanding medical bills from Freeport Health Network, totaling $1,004.95, submitted as Petitioner's Exhibit 6.

In Support of the Arbitrator's Decision relating to (L.), What is the nature and extent of the injury, the Arbitrator finds and concludes as follows:

As Petitioner did not receive any additional treatment following the emergency room visit on July 17, 2010, the Arbitrator finds that Petitioner has not demonstrated any permanent disability as a result of the injury. The medical treatment provided at Freeport Hospital successfully removed the foreign body and Petitioner has suffered no loss of vision as a result of his injury. As such, the Arbitrator finds Petitioner has not sustained any permanent partial disability as a result of the work accident of July 17, 2010.

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 up	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

TERENCE GREEN,

Petitioner,

vs.

NO: 10 WC 4319

GUNITE,

14IWCC0805

Respondent,

DECISION AND OPINION ON REVIEW

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

The Commission, upon consideration of Petitioner's testimony, treatment history, medical records, and the physicians' medical opinions, finds that Petitioner sustained the 25% loss of use of the right foot and modifies the Arbitrator's award to increase the permanent partial disability from 22.5% to 25%.

All else is affirmed and adopted.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $399.04 per week for a period of 41.75 weeks, as provided in §8(e) of the Act, for the reason that the injuries sustained caused the loss of use of 25% of the right 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.

14IWCC0805

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $17,000.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED SEP 2 2 2014

Charles J. DeVriendt

Daniel R. Donohoo

Ruth W. White

SE/
O: 9/9/14
49

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

GREEN, TERENCE
Employee/Petitioner

Case# **10WC004319**

10WC042582

GUNITE
Employer/Respondent

14IWCC0805

On 9/24/2013, 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 0.05% 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:

2489 LAW OFFICE OF JIM BLACK & ASSOC
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14IWCC0805

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

Terence Green
Employee/Petitioner

Case # **10** WC **4319**

v.

Consolidated cases: **10 WC 42582**

Gunite
Employer/Respondent

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Anthony C. Erbacci**, Arbitrator of the Commission, in the city of **Rockford**, on **August 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

14IWCC0805

FINDINGS

On **November 2, 2009**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$34,583.64**; the average weekly wage was **$665.07**.

On the date of accident, Petitioner was **39** 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 **$7,299.13** for TTD, **$0.00** for TPD, **$0.00** for maintenance, and **$0.00** for other benefits, for a total credit of **$7,299.13**.

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

ORDER

Respondent shall pay Petitioner permanent partial disability benefits of **$399.04**/week for **37.575** weeks, because the injuries sustained caused the **22.5%** loss of the **right foot**, as provided in Section 8(e) of the Act.

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

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

Arbitrator Anthony C. Erbacci

September 19, 2013
Date

SEP 24 2013

14IWCC0805

FACTS:

The Petitioner is employed by the Respondent as an iron pourer in the foundry. On November 2, 2009, the Petitioner sustained an undisputed accident which arose out and in the course of his employment with the Respondent. The Petitioner testified that the ladle he was using to pour iron became "frozen" and when he tried to move the ladle, sparks fell upon him, causing him to run away from the area. The Petitioner testified that he felt something in the back of his right foot and experienced immediate sharp pain in his right lower extremity. The Petitioner reported the incident to his supervisor and was directed to the Respondent's on site medical facility. The Petitioner was then seen at Health Services where he described his pain as 10/10. Petitioner's boot was removed by cutting down both sides and he was sent to the emergency room of Swedish American Hospital for further treatment.

Petitioner was seen at the emergency room of Swedish American Hospital with complaints of severe right ankle pain. He provided a consistent history of injury and diagnosed as having an acute rupture of the Achilles tendon. A short leg splint was applied and the Petitioner was referred to Rockford Orthopedic Associates for treatment.

On November 3, 2009, Petitioner was examined by Dr. Kelly John of Rockford Orthopedic Associates. Dr. John confirmed the existence of a ruptured Achilles tendon and recommended surgery. On November 5, 2009, Dr. John performed a surgical repair of the Achilles tendon without complication. Thereafter, the leg was casted at the ankle and the Petitioner was given two crutches to ambulate. Stitches were removed on November 18, 2009 and there was no sign of infection. The cast was removed on November 23, 2009 and then a non weight bearing fiberglass cast was applied.

In December 2009, the Petitioner started physical therapy at FHN Physical Therapy Services. Petitioner was subsequently given a pneumatic boot and a crutch to walk. On March 15, 2010, Petitioner returned back to work modified duty work per orders of Dr. John.

On March 31, 2010, the Petitioner returned to Dr. John for reevaluation. The Petitioner was still working with restrictions (four hours a day sedentary and four hours a day standing/walking) and was noted to be able to full weight bear and to ambulate with a regular shoe. Dr. John's physical evaluation found no palpable deficit within the Achilles tendon.

On April 28, 2010, Dr. John released the Petitioner to return back to work to full duty without restrictions. At the time of this appointment, the Petitioner rated his pain as 0/10 currently and 6/10 at worst. The neurological examination was normal. There was palpable thickening of the distal Achilles tendon but there was no palpable deficit within the Achilles tendon. The Petitioner was found to be "doing well" status post-surgery and pleased with the results. He was told to follow up on an as needed basis.

The Petitioner testified that after he was released to return back to work full duty, he

was given a position in the Machining Department as an Operator at a lesser amount of pay. At the time of trial, the Petitioner was working full duty and there was no difference between his pre-accident and post-accident rate of pay.

On his own initiative, the Petitioner sought treatment at the University of Wisconsin Hospital in Madison on October 15, 2010. The Petitioner was recommended to have additional physical therapy and then a functional capacity evaluation. The Petitioner testified that he did not follow up with this recommendation due to insurance concerns.

On November 30, 2010, the Petitioner was examined at the Respondent's request by Dr. Samuel Vinci of M&M Orthopedics. The Petitioner advised Dr. Vinci that he subjectively could not stand on his tiptoes on his right extremity and needed to go up and down stairs one step at a time. He also reported some sensitivity at the incisional site. Physical examination was essentially normal except for some hypertrophy at the area of the incisionl. Comparison between the range of motion of the right foot and ankle and the left foot and ankle was symmetrical with no differences. Similarly, x-rays showed no biomechanical abnormalities. Dr. Vinci opined that the Petitioner was post surgical repair of Achilles tendon rupture. It was his opinion that there was "minimal partial disability" and that the only permanent changes were a little loss of sensation on the surgical site and some thickening or fibrous adhesions. Dr. Vinci opined that there was no need for permanent restrictions and that the Petitioner was capable of full unrestricted work. He further opined that the Petitioner was at maximum medical improvement and required no further treatment.

On February 23, 2011, the Petitioner was seen, at his attorney's request, by Dr. Jeffrey Coe. The Petitioner was noted to have subjective complaints of pain in the back of his right ankle extending up into his right calf which was primarily brought on by exertion. The Petitioner was also noted to walk with an antalgic gait and to exhibit some right ankle stiffness. Dr. Coe observed limitations of range of motion in the right ankle as compared to the left but measurements of the size of the right and left calf were mostly symmetrical. Dr. Coe reached a diagnosis that Petitioner was status post rupture of the right Achilles tendon. He opined that ongoing treatment for the right Achilles tendon to the right ankle region would be conservative and no future surgery was necessary. He indicated that the Petitioner should treat with some physical therapy and antiinflammatory medications as needed and recommended by Dr. Keene. Dr. Coe testified there would be residual thickening and scarring of the right lower leg and some stiffness of the right ankle, particularly with inversion and eversion type stiffness.

The Petitioner testified that his ankle continues to be painful and that he continues to experience swelling in the right ankle. He testified that his symptoms are exacerbated by running, squatting, or walking for extended periods of time. The Petitioner testified that he has pain at all times and that it interferes with his employment and his "relations" with his wife.

14IWCC0805

CONCLUSIONS:

In Support of the Arbitrator's Decision relating to (F.), Is Petitioner's current condition of ill-being causally related to the injury, and (L.), What is the nature and extent of the injury, the Arbitrator finds and concludes as follows:

The primary issue in dispute between the parties is the causal relationship between the Petitioner's current subjective complaints of ongoing pain and the Achilles tendon rupture. While the Petitioner maintains he had a poor result, the Respondent contends that the Petitioner had a good recovery with the only objective residual findings being related to loss of sensation at the surgical site rather than any loss of function, chronic objective pain or hypersensitivity.

The Arbitrator finds that the Petitioner's current condition of ill-being is causally related to his work injury of November 2, 2009. The Arbitrator relies upon the records of the treating physicians and examining physician, which evidence that the Petitioner has complaints of ongoing symptoms in his right ankle following his undisputed work injury. The Petitioner testified that he continued to be symptomatic after he was released from care by Dr. John, and he continued to report symptoms consistent with his injury to Dr. Vinci, the University of Wisconsin Clinic, and Dr. Coe. The Arbitrator also notes that both of the physicians who examined the Petitioner opined that the Petitioner's ongoing complaints would be permanent.

The Arbitrator notes that the Petitioner has been working his full duty without lost time for approximately three years. Both Dr. John's and Dr. Vinci's physical evaluation were reported to reveal no limitations related to the repair of the Petitioner's Achilles tendon. Dr. John released the Petitioner to return back to full duty work and found him to be at maximum medical improvement with need of no further physical therapy or treatment. Dr. Vinci found the Petitioner to have had a good surgical result and he opined that the Petitioner's complaints were unrelated to any objective physical finding. The Petitioner's own examining physician, Dr. Coe, noted primarily subjective complaints and minimal limitations of range of motion in the right ankle as compared to the left.

Based upon the foregoing, and having considered the totality of the credible evidence adduced at hearing, the Arbitrator finds that the Petitioner's current condition of ill-being is causally related to the undisputed work injury of November 2, 2009. The Arbitrator further finds that as a result of the Petitioner's undisputed work injury of November 2, 2009 the Petitioner sustained a 22.5% disability to his right foot.

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

MICHELE MCNEASE,

Petitioner,

vs.

NO: 12 WC 02970
12 WC 44170

WAL-MART ASSOCIATES, INC.,

14IWCC0806

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

The Commission reverses the Arbitrator's decision regarding the causal connection of her right hand carpal tunnel syndrome and find that Petitioner's testimony, her job description, and the opinion of Dr. Beatty are sufficient to causally relate her right hand condition to her employment. However, we affirm the denial of causation regarding the left hand.

Contrary to the Arbitrator's conclusion, we find that Petitioner's testimony that she opened and stocked 30 to 60 boxes per shift to be credible. Petitioner testified that she worked from 10 p.m. to 7 a.m. with two 15-minute breaks and an hour for lunch. (T.16-17). This equates to stocking four to eight boxes per hour (30 boxes / 7.5 work hours = 4; 60 boxes /7.5 = 8).

Although Petitioner did not open boxes in an "assembly line" fashion and there were additional duties that Petitioner performed including using a "rocket cart" to move boxes to the

various aisles and climbing ladders, Petitioner testified that there was no part of her job that didn't involve using her arms or hands. (T.17). Her system was to unload a pallet by putting the boxes in the appropriate aisles and then open one box at a time to stock the shelves. (T.28). Petitioner testified that the most difficult part of her job on her arms and hands was opening the boxes. (T.12). She was able to use a cutting knife for the taped ones but for the glued boxes she had to grip the corner, wedge her fingers in, and pull the boxes on each side because the glue was so strong that it would break the blade. (T.12-13). Petitioner testified that she started getting pain, tingling, and numbness from her fingertips to her elbows but the pain was worse in the right hand because she is right-handed and used that hand predominantly while performing her job. (T.14-15).

Dr. Beatty opined that, based on Petitioner's history and the job description form she completed, her job duties would be a causative basis for carpal tunnel syndrome or for a worsening of preexisting carpal tunnel syndrome. (Px6 at 12). He testified that the nature of the work was repetitive and that Petitioner related having symptoms while she performed her job, which involved flexion/extension, repetitive motion, using the upper extremities against resistance, and lifting. (Id. at 16). Dr. Beatty believed that the fact that Petitioner did most of her work with her right hand lends support to his opinion that it is work-related. (Id. at 38).

We find that Dr. Beatty's opinion is more credible than that of Dr. Beyer and, based on the above, we find that Petitioner's job duties were at least a contributing factor in her developing right hand carpal tunnel syndrome.

However, we affirm the Arbitrator's denial of causation regarding the left hand. At hearing, Petitioner testified that she actually has more pain and tingling in her left hand than her right hand. (T.34). This would be inconsistent with Dr. Beatty's opinion that her right carpal tunnel syndrome is causally related due to the fact that she predominantly used her right hand. There is no explanation as to why Petitioner's left hand would be worse if she used it significantly less. We also note that Petitioner was given light duty restrictions by Dr. Rostovtseva on January 16, 2012. It isn't clear whether Petitioner's restrictions were accommodated and, if so, what job duties she was performing after that date. We also cannot find anything in the record to support Petitioner's alleged manifestation date of November 13, 2012. However, there was a negative nerve conduction test on December 13, 2012. Regardless, we find that Petitioner's job duties were not a contributing factor in her developing left carpal tunnel syndrome and hereby deny the medical expenses associated with the left hand. Therefore, the following medical expenses related to the right hand are awarded:

1/12/12	Anderson Hospital	$1,217.00
1/12/12	Tri-City Neurology Assoc.	774.00
1/16/12	Dr. Rostovtseva	85.00
2/21/12	Dr. Beatty	150.00
		$2,226.00

We note that the Fox Med-Equip Services, Inc. bill in the amount of $124.00 is only a statement from July 31, 2013, and does not indicate a date of service or what services were provided. There is no medical record in evidence to support this bill. We also note that no medical records are in evidence to support the other office visits with Dr. Rostovtseva.

14IWCC0806

We hereby award the prospective right carpal tunnel surgery as recommended by Dr. Beatty.

All else is affirmed and adopted.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $2,226.00 for medical expenses under §8(a) of the Act pursuant to the fee schedule in §8.2 of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall authorize and pay for prospective right hand carpal tunnel surgery with Dr. Beatty under §8(a) of the Act pursuant to the fee schedule in §8.2 of the Act.

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

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

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

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $2,300.00. 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: SEP 2 2 2014

Charles J. DeVriendt

Daniel R. Donohoo

SE/
O: 8/26/14
49

DISSENT

I respectfully dissent from the majority opinion. The majority affirmed the portion of the Decision of the Arbitrator finding that Petitioner failed to prove her right-sided carpal tunnel syndrome was caused by her work activities, but reversed his decision finding that she failed to prove that her left-sided carpal tunnel syndrome was caused by her work activities. I would have affirmed and adopted the well-reasoned Decision of the Arbitrator which denied compensation.

In this case, I find the causation opinion of Respondent's Section 12 medical examiner, Dr. Beyor, considerably more persuasive than that of Petitioner's treating doctor, Dr. Beatty. Dr. Beatty seemed unaware of Petitioner's actual work activities, referring to them only as "repetitive." All he knew about Petitioner's job was that "she stocked something." He also did not even adequately explain his definition of repetitive activities. In addition, Dr. Beatty testified that genetic factors could not have been a factor in Petitioner's developing carpal tunnel syndrome even though both her mother and sister suffered from the condition. He was also unaware of the association between obesity and the onset of carpal tunnel syndrome, which is well documented in current literature. Notably, in this case Petitioner was nearly 300 pounds. Dr. Beatty was also unaware that Petitioner had an EMG of her left median nerve, which was negative. Finally, Dr. Beatty indicated that Petitioner was right-hand dominant and used her right hand substantially more in her work activities than her left and that, therefore, the right side should be more symptomatic. However, Petitioner testified that her left side was more symptomatic, a fact which in itself would tend to militate against causation.

On the other hand, Dr. Beyor opined that Petitioner's bilateral carpal tunnel syndrome was not caused by her work activities. Dr. Beyor appeared to have a better understanding of Petitioner's actual work activities and of the current state of the scholarly literature on the subject of the causes of carpal tunnel syndrome. In addition, Dr. Beyor's practice is more concentrated in the field of hand/wrist pathology. In short he is more of an expert in the field of carpal tunnel syndrome and its etiology than Dr. Beatty. I would have afforded his opinion greater weight that that of Dr. Beatty, as did the Arbitrator. Therefore, I would have affirmed and adopted the Decision of the Arbitrator.

For the reasons specified above, I respectfully dissent.

Ruth W. White

Ruth W. White

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

McNEASE, MICHELE
Employee/Petitioner

Case# **12WC002970**

12WC044170

WAL-MART ASSOCIATES INC
Employer/Respondent

14IWCC0806

On 11/25/2013, 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

0560 WIEDNER & McAULIFFE LTD
MARY C SABATINO
ONE N FRANKLIN ST SUITE 1900
CHICAGO, IL 60606

14IWCC0806

STATE OF ILLINOIS)
)SS.
COUNTY OF MADISON)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

Michele McNease
Employee/Petitioner

v.

Wal-Mart Associates, Inc.
Employer/Respondent

Case # 12 WC 02970; 12 WC 044170

Consolidated cases:

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Gerald Granada**, Arbitrator of the Commission, in the city of **Collinsville**, on **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. [x] **Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?**

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

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

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

G. [ ] What were Petitioner's earnings?

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

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

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

K. [x] **Is Petitioner entitled to any prospective medical care?**

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

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

N. [ ] Is Respondent due any credit?

O. [ ] Other

FINDINGS

On the date of accident, **1/16/12; 11/13/12**, 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 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 **$20,974.95**; the average weekly wage was **$403.36**.

On the date of accident, Petitioner was **38** 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 $ **n/a** under Section 8(j) of the Act.

ORDER

As petitioner failed to prove a work-related accident, all benefits are denied.

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

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

Signature of Arbitrator

11/19/13
Date

ICArbDec19(b)

NOV 25 2013

14IWCC0806

FINDINGS OF FACT

Petitioner is a 38 year old overnight stocker for Wal-Mart who, by Application, alleges repetitive trauma to her right hand in the form of carpal tunnel syndrome, manifesting on January 16, 2012 and to her left hand in the form of carpal tunnel syndrome, manifesting on November 13, 2012. Petitioner testified she had been working as an overnight stocker for Wal-Mart for approximately 10 years; in the few years preceding her alleged manifestation dates, petitioner testified she worked in the infant department, meaning she was responsible for stocking all items related to infants, e.g. diapers, bottles, baby furniture, baby clothing, etc.

Petitioner testified that in an eight-hour shift she typically will open anywhere between 30 and 60 boxes. She further testified that she had other job duties. She indicated she was required to load and unload pallets onto a rocket cart, at which point, she would roll the rocket cart over to where she was stocking, open a box, and then put away the merchandise inside. Petitioner also testified to bending to pick up boxes and stock shelves, and stooping to stock bottom shelves. Petitioner explained that she was required to "grasp boxes all throughout my shift and open them." On cross examination, she acknowledged she will typically take a box, open the box, and then unload what is in the box before stocking a second or third box. Sometimes she will unload a few boxes from a rocket cart and cut them open all at one time. Additionally, petitioner gave testimony about delivering the boxes to the area of the store where she was required to stock and then returning to open them and stock the merchandise away. Petitioner would also sometimes use a box cutter if a box was taped closed as opposed to using her hands if a box was glued closed. Petitioner also acknowledged that the merchandise that she stocked varied in size and weight, as her department includes anything related to infants, which can vary greatly from bottles to diapers to clothing to furniture.

Petitioner reported to her primary care physician, Dr. Sophia Rostovtseva, on January 16, 2012 complaining of right hand pain. (PX 4) The symptoms were noted to have begun three months prior. Dr. Rostovtseva's earlier records from December of 2011 note petitioner's job consisted of repetitive vibration exposure. Petitioner clarified on cross examination that she had never told her physician that her job included any type of vibration exposure nor vibratory tools, and that, therefore, she was not sure why that was contained within her primary care physician's history of her job. Dr. Rostovtseva had recommended an EMG study, and on the date of the visit on January 16, 2012, the physician reviewed the EMG study from January 12, 2012, which was positive for right carpal tunnel syndrome of moderate severity. (PX3, PX4). Dr. Rostovtseva recommended the petitioner follow up with a plastic surgeon.

On February 21, 2012, petitioner came under the care of Dr. Michael Beatty at Southwestern Illinois Plastic and Hand Surgery on referral from her attorney, Tom Rich. (PX5). She was noted to be 5' 8", 270 pounds. According to the records from her initial visit with Dr. Beatty, he stated, "The patient is in with the complaint of carpal tunnel syndrome and [she] feels that it is work related." In petitioner's intake form for Dr. Beatty, she noted her hands go numb after short periods of use whether she is trying to open a box or even eating her food. Petitioner acknowledged at trial on cross examination she was experiencing pain complaints both at work and at home. Petitioner completed a written job description at Dr. Beatty's office, indicating the onset of her symptoms as June, 2011. She gave a history of using a pallet jack and rocket cart at work and opening boxes and stocking the merchandise therein. She also reported use of a ladder at work. Petitioner was noted to have high blood pressure at this visit, and under family history, it was reported petitioner's mother and sister both have carpal tunnel syndrome. At this first visit with Dr. Beatty, he indicated petitioner was a candidate for surgery. (PX5). On November 27, 2012, she presented that day complaining of left hand complaints. Dr. Beatty was recommending a left hand nerve conduction EMG study. He also gave her a prescription for a splint. (PX5). She underwent a left EMG study at Anderson Hospital on December 13, 2012. (PX3). The study was noted to be entirely normal with no evidence of left carpal tunnel syndrome. The final note in Dr. Beatty's records is from Dr. Beatty's nurse on December 27, 2012. (PX5). On that day, petitioner was called

and told her nerve conduction EMG study of the left hand was normal. She was told that if she continued with complaints, she could follow back up. The plan was to wait to hear from the patient. (PX5).

On June 26, 2012, Dr. Craig Beyer saw the Petitioner for an independent medical examination. Dr. Craig Beyer is an orthopedic surgeon at Illinois Southwest Orthopedics. (RX 1) Petitioner presented with complaints of bilateral hand numbness and tingling, right greater than left. She noted nocturnal awakening, as well as symptomatology when she feeds herself. She indicated to the doctor at times she drops utensils. (RX1). On this date, petitioner was noted to be 5' 7", 294.6 pounds, putting her at approximately double an ideal body weight for her height. Dr. Beyer also noted a family history of carpal tunnel syndrome in both her sister and her mother. Dr. Beyer reviewed both a written job description from the employer, as well as petitioner's own written job description that she had provided to Dr. Beatty. Dr. Beyer diagnosed petitioner as having carpal tunnel syndrome on the right side and likely carpal tunnel syndrome on the left side as well. He stated petitioner was of the opinion that her condition was work related. Petitioner testified Dr. Beyer had been her surgeon for a prior shoulder surgery.

Dr. Beyer went into great detail regarding the risk factors for development of carpal tunnel syndrome, many of which petitioner had, to include her female gender, morbid obesity, and her genetic predisposition to the same. Specifically, in support of the latter, he stated petitioner's mother and sister both have been diagnosed with carpal tunnel syndrome. After reviewing petitioner's treatment records, EMG studies, and job descriptions, Dr. Beyer concluded he did not believe petitioner's carpal tunnel syndrome was in any way related to her occupation. Instead, he felt petitioner's carpal tunnel syndrome was a result of obesity, genetic predisposition, and female gender. While Dr. Beyer concluded petitioner was likely a candidate for right carpal tunnel release, and possibly bilateral carpal tunnel releases, pending an EMG study, he did indicate that the need for potential surgery would not be related to her work as an overnight stocker.

On September 14, 2012, Dr. Beyer testified via evidence deposition. His testimony was consistent with his IME report. He reviewed both a job description from the insured, as well as petitioner's own written job description that she had provided to Dr. Beatty (RX2, p. 11). Dr. Beyer stated he came to the conclusion petitioner's job activities at Wal-Mart do not cause, aggravate, or exacerbate the diagnosis of bilateral carpal tunnel syndrome based on many factors. (RX1, p. 11). He stated petitioner's three main predisposing factors for carpal tunnel syndrome were the fact that she was female, obese, and also that she had a genetic predisposition as evidenced by the fact that her sister and mother both had carpal tunnel syndrome. Dr. Beyer also reference a number of medical publications to support his opinions. Dr. Beyer testified there are certain instances where carpal tunnel syndrome could be work related, but those job activities would have to involve what he deemed to be provocative maneuvers. (RX2, p. 23). He defined provocative maneuvers as tasks where there were prolonged periods of time utilizing maximum grip or pinch force. He stated, based upon his review of petitioner's job descriptions, petitioner did not fall into that category, as none of her job duties involved these provocative maneuvers. (RX2, p. 23). Without proof of forced gripping or otherwise repetitive hand motion, Dr. Beyer could not conclude petitioner's activities were work related.

On July 25, 2013, Dr. Beatty testified via evidence deposition. Dr. Beatty began by stating he had seen petitioner for the first time on February 21, 2012. He also stated he was provided with EMG studies and a copy of the IME report from Dr. Beyer. (PX6, p. 6). Dr. Beatty was asked for factors which could predispose a person to carpal tunnel syndrome, and he outlined that those include systemic problems, e.g. illness such as thyroid disease, as well as diabetes and rheumatoid arthritis. When asked whether petitioner has any co-morbid risk factors for the development of carpal tunnel syndrome, other than the fact that she is a female, Dr. Beatty answered, "No." (PX6, p. 8). Dr. Beatty did discuss the fact that petitioner had filled out a patient information sheet regarding her job activities at Wal-Mart. He acknowledged he relied on that in forming his causation

opinions in this case. (PX6, p. 9). Dr. Beatty stated that when he is asked to render an opinion on causation, he bases his opinion not just on the history but also on the viewing of diagnostic studies and the patient's clinical examination and presentation. (PX6, p. 10). Dr. Beatty stated during his deposition that he did review the January 12, 2012 EMG study, which confirmed right carpal tunnel syndrome. When asked whether the left hand was tested, Dr. Beatty testified her left hand had not been tested. (PX6, p. 11). When asked again later on in the deposition whether any testing had been done on the left hand, Dr. Beatty once again stated to his knowledge no EMG testing had been done to the left hand. (PX6, p. 12). The petitioner's medical records show that petitioner did undergo a left EMG study on December 13, 2012, which was actually ordered by Dr. Beatty. (PX 3) This was later cleared up on cross-examination, see PX 5, pg. 18. Based on petitioner's written job description, Dr. Beatty gave the opinion that "the information provided to me by Ms. McNease would be consistent with a causative basis for carpal tunnel syndrome or worsening of preexisting carpal tunnel syndrome." (PX6, p. 13). When asked by petitioner's attorney what it was about petitioner's job, specifically using a pallet jack, a rocket cart, lifting, stacking, and opening boxes (repeatedly with both hands) that would cause compression of the median nerve, Dr. Beatty responded that the nature of the work itself in a repeated way would be supportive of the diagnosis. (PX6, p. 16).

When asked what Dr. Beatty meant by repetitive, he stated, "Well, repetitive generally would mean more than once, I think. Two, three, four, five times would be repetitive in the sense of the work situation." He went on to state, "It's not the number. It is just things that occur that lead to symptomatology." (PX6, p. 31). On cross-examination, Dr. Beatty testified that he did not know how often petitioner would have to open boxes, whether she used any tools, what she would have to stock, how often she would have to utilize a ladder or how often she would have to do her other job duties. He also acknowledged that obesity would be a predisposing factor for carpal tunnel syndrome.

CONCLUSIONS OF LAW

1. Petitioner has failed to meet her burden of proof regarding the issues of accident and causation. In that regard, the Arbitrator is persuaded by the opinions of Dr. Beyer as supported by the evidence adduced at trial. Petitioner's testimony as well as the documents setting forth her job description, clearly show that the Petitioner had various jobs she would perform throughout the day that were not as repetitive and as hand-intensive as she originally claimed. For example, she estimated opening and stocking approximately 30 to 60 boxes per eight hour shift. However, this claim lacks credibility because the evidence show that her job tasks involved going to get the boxes, lifting them on to rocket carts from pallets, rolling the rocket carts over to the area of the store where she was stocking, opening boxes one at a time and then stocking the items that were in the boxes. She was not required to repetitively cut open boxes with a box cutter or rip open boxes with her hands, but that typically she would open a box, stock what was inside, and then return for another box. She also acknowledged that the weights and sizes of the items she was stocking varied depending on the aisle she was required to stock that day. Although petitioner did obtain a favorable opinion regarding causation from Dr. Beatty, this opinion was based on Dr. Beatty's limited understanding of Petitioner's job duties, which do not appear to be as accurate as adduced at trial. The Arbitrator finds it more likely that the petitioner's carpal tunnel condition was due to her co-morbid factors including her obesity, gender and genetics. Even more telling is the fact that the Petitioner's initial physician, Dr. Rostovtseva made no mention of causation and that the Respondent's IME, Dr. Beyer was previously one of the Petitioner's treating physicians. Given all these facts, the Arbitrator finds that the Petitioner did not prove she sustained an accident or that her current condition of ill-being is causally related to her employment with the Respondent.

2. Based on the Arbitrator's findings regarding the issues of accident and causation, all other issues are rendered 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	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☒ Modify Down	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

MAURO RAMOS,

Petitioner,

14IWCC0807

vs.

NO: 11 WC 25595

MILLARD REFRIGERATION,

Respondent.

DECISION AND OPINION ON REVIEW

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

Respondent paid temporary total disability benefits from the day of the accident, June 19, 2011, to the date after the first Section 12 medical examination report of Dr. Jay Levin, January 18, 2012. The Arbitrator clearly found that Petitioner was temporarily totally disabled from the date of the accident through the date of Arbitration. However, he noted that Petitioner only asked for temporary total disability benefits from January 18, 2013 and the Arbitrator awarded benefits from that date to the date of arbitration. The Commission notes that the Commission is directed to review all issues in the record whether or not properly preserved. See, *Klein Construction.* The Commission finds the Petition for Review notation was a clerical error and corrects the Decision of the Arbitrator to reflect his finding regarding temporary total disability.

The Arbitrator awarded only nominal penalties and fees because at that time that was all Petitioner sought. However, the Arbitrator made clear that awarding "substantial attorney fees and penalties" was warranted because in his opinion the Section 12 opinions by both Dr. Jay Levin and Dr. Karen Levin were "obviously and plainly not credible" and Respondent's reliance on their reports to terminate Petitioner's benefits was not reasonable. The Commission finds it certainly likely that the Arbitrator will award such substantial penalties and fees upon remand. Upon its review of the entire record the Commission finds that the award of penalties and fees was not appropriate in this case and accordingly vacates that portion of the Decision of the Arbitrator.

Dr. Jay Levin performed a medical examination under Section 12 of the Act with regard to Petitioner's alleged orthopedic conditions of ill-being. Dr. Karen Levin performed a medical examination under Section 12 of the Act regarding Petitioner's alleged post-concussion syndrome and psychological/psychiatric conditions of ill-being. Unlike the Arbitrator, the Commission does not find the opinions of the Drs. Jay and Karen Levin to be inherently not credible. The Commission notes that there was no objective findings corroborating many of Petitioner's complaints or of acute or even significant pathology. Dr. Karen Levin specifically found that Petitioner exhibited non-organic responses and Dr. Jay Levin found no objective evidence to support Petitioner's continued orthopedic complaints.

In addition, The Commission finds that Petitioner was less than forthright regarding his previous treatment. Petitioner testified that he did not have previous treatment for his back or for dizziness. He also related that "fact" to the Section 12 medical examiners, both those hired by Respondent and those hired by his own lawyer. Dr. Karen Levin testified that she specifically asked Petitioner whether he had seen or had been treated with a neurologist prior to the accident and Petitioner answered in the negative.

However, the record clearly indicates that Petitioner had been previously treated for a back condition and for dizziness and was seen by a neurologist prior to the accident. Finally, it appears that Petitioner may even have tried to conceal his past treatment by refusing, or at least delaying, authorization for Respondent to obtain his medical records from before the accident. Accordingly the Commission finds that the actions of Respondent in terminating benefits after the Section 12 examinations was not so unreasonable as to warrant the imposition of penalties and fees.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent shall pay to the Petitioner the sum of $330.67 per week for a period of 95 weeks, that being the period of temporary total incapacity for work under §8(b), and that as provided in §8(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.

14IWCC0807

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent to authorize and pay for prospective medical treatment prescribed by Dr. Sachin Mehta under §8(a) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent to pay for reasonable transportation costs to attend appointments with medical providers during such time as he is restricted from driving by an appropriate medical professional.

IT IS FURTHER ORDERED BY THE COMMISSION, that the Arbitrator's award of penalties and fees is vacated.

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: SEP 2 3 2014

Ruth W. White

Daniel R. Donohoo

Charles J. DeVriendt

RWW/dw
O-9/10/14
46

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

14IWCC0807

RAMOS, MAURO
Employee/Petitioner

Case# **11WC025595**

MILLARD REFRIGERATION
Employer/Respondent

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:

1380 MURPHY & MURPHY
DANIEL E MURPHY
39 S LASALLE ST SUITE 720
CHICAGO, IL 60603

1408 HEYL ROYSTER VOELKER & ALLEN
BRAD ANTONACCI
120 W STATE ST SUITE 2
ROCKFORD, IL 61105

14IWCC0807

STATE OF ILLINOIS)
)SS.
COUNTY OF Kane)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

Mauro Ramos,
Employee/Petitioner

v.

Millard Refrigeration,
Employer/Respondent

Case # 11 WC 25595

Consolidated cases: _____

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Arbitrator Falcioni**, Arbitrator of the Commission, in the city of **New Lenox**, on **November 14, 2013**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On the date of accident, **June 29, 2011**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$25,792.00**; the average weekly wage was **$496.00.**

On the date of accident, Petitioner was **50** years of age, ***married*** with **1** dependent children.

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

Respondent shall be given a credit of **$9,589.72** for TTD, **$0.00** for TPD, **$0.00** for maintenance, and $ for other benefits, for a total credit of **$9,589.72**.

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 $330.67/week for 43 weeks, commencing January 18, 2013 through November 14, 2013, as provided in Section 8(b) of the Act, because the injuries sustained caused the disabling condition of Petitioner, the disabling condition is temporary and has not yet reached a permanent condition, pursuant to Section 19(b) of the Act.

Respondent shall pay reasonable and necessary medical services of $203.40, as provided in Section 8(a) of the Act, and subject to and pursuant to the medical fee schedule created by the Act.

Respondent shall further authorize and pay for the medical treatment as prescribed by Dr. S. Mehta concerning physical and mental health care, including all temporary total disability and medical charges relating to the same and as further set forth herein.

Respondent shall further authorize and pay for transportation costs for petitioner to attend medical provider appointments during such time as he is not certified to drive by an appropriate medical professional.

Respondent shall pay $1.00 in attorney's fees pursuant to Section 16 or Section 16a and $1.00 in penalties pursuant to Section 19(k) or Section 19(l).

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

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

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

Robert E Dalton — December 9, 2013

Signature of Arbitrator — Date

ICArbDec19(b)

DEC 16 2013

FINDINGS OF FACT AND CONCLUSIONS OF LAW

Petitioner testified (through an interpreter) that he worked cleaning the refrigerated (below zero) warehouse of respondent from his hire in January 2007 until the work related accident of June 29, 2011 in which multiple 46 lbs boxes filled with frozen flour or pizza dough fell on him as he was standing emptying ice into a trash receptacle in the interior of respondent's warehouse while working his usual duties. Petitioner testified that he has not been returned to work in any capacity by his primary treating physician, Dr. S. Mehta, since the time of the accident to present.

Petitioner testified that he struck the back of his head on the concrete floor of the respondent's warehouse when the boxes fell upon him and that the three photos marked as PX 1 fairly and accurately depicted the scene immediately after the accident. Petitioner testified that his hard hat ended up on the ground as depicted in PX 1 and that he was lying on the warehouse floor after the accident. He testified that he sustained injury to his head, neck, mid and low back, left wrist, left leg and right ankle as a result of the trauma from the June 29, 2011 work related accident and that he did not suffer any subsequent accidents or injuries. Petitioner testified that he felt pain in all of the areas injured including burning pain and numbness at the time of the accident. Petitioner testified that his job duties at the time of the accident included emptying garbage into the dumpster, removing ice from the curtains of the warehouse by batting it, lifting and collecting broken pallet skids, sweeping the entire warehouse, cleaning up ice in the freezer by chipping it away and removing trash four or five times daily by using a lever type device to empty the heavy dumpster. Most significantly, petitioner testified that he does not believe that he can currently work his job with respondent because he cannot bend, cannot walk without a limp and cannot lift due to the pain he constantly feels in his back from the accident and also numbness in his left leg from the accident as well. He also testified that he feels that his right ankle is unstable. He appeared at the hearing with a straight cane to assist with his balance while walking.

Petitioner testified, and the parties stipulated, that he has not received a TTD check since January 18, 2012. AX1. He testified that as of that date that respondent also refused to pay for any additional medical expenses or prescriptions related to his injuries from the accident of June 29, 2011. He testified that he took the remaining prescriptions until they ran out. Petitioner testified that Dr. S. Mehta made arrangements to continue treating him even though respondent refused to pay for the treatment.

Petitioner was taken by ambulance from the warehouse to Delnor Community Hospital on June 29, 2011. PX2. He was admitted to ICU and eventually discharged on July 7, 2011 the admitted to Marianjoy Rehabilitation Hospital as an inpatient. PX2; PX3. Petitioner was discharged from Marianjoy Rehabilitation Hospital on July 20, 2011 and entered the day program at Marianjoy. PX3.

Petitioner testified that he has been treated by Dr. S. Mehta from July 7, 2011 to November 2013. Petitioner's medical records admitted into evidence reflect a multidisciplinary approach to his care coordinated by his PM&R physician, Dr. S. Mehta.

Medical opinion evidence was offered by Dr. S. Mehta of Marianjoy Medical Center who has treated petitioner from July 7, 2011 to the present time. PX12 at 6. Dr. S. Mehta is board certified in Physical Medicine & Rehabilitation and is on the staffs of Marianjoy Rehabilitation Hospital, Central DuPage Hospital, Good Samaritan Hospital, Rush Copley Medical Center, Delnor Community Hospital, Edward Hospital, Adventist GlenOaks Hospital and Adventist Hinsdale/LaGrange Memorial Hospitals. PX12 at 5 and Exhibit 1 to deposition. Dr. S. Mehta's note of June 28, 2013, which was never reviewed or considered by Dr. Jay Levin, Dr. Karen Levin or Dr. Jeffrey Coe, encapsulates his entire treatment history of petitioner--- MRI corroboration of cervical and lumbar spine abnormalities, a left distal radius fracture which was splinted, steroids to treat the spinal injuries at Delnor, transfer to Marianjoy inpatient and enrollment in Marianjoy's Day Rehab program on July 20, 2011 where he was noted to have significant vestibular and cognitive deficits and continued neck and low back pain being diagnosed with post concussion syndrome with myofascial neck and low back pain, treated with trigger point and facet injections into the lumbar spine in coordination with physical therapy, Cymbalta and Amitriptyline for pain issues and to treat petitioner's depression type symptoms. PX12-Exhibit 2 to deposition. Petitioner was seen in October 2012 by Dr. S. Mehta but had not been taking any medications due to his inability to pay for them. PX12-Exhibit 2 to deposition. Petitioner's chief complaint on June 28, 2013 was chronic neck and radiating low back pain with resulting gait dysfunction. PX12-Exhibit 2 to deposition.

On June 28, 2013, petitioner noted that he was still unable to pay for medications or for any therapy. PX12 at 14-15 and Exhibit 2 to deposition. Dr. S. Mehta indicated that petitioner's function is decreased, his mood has worsened and his sleep has worsened because of his chronic pain. PX12 at 14-15 and Exhibit 2 to deposition. His headaches are located in the posterior neck, worse with moving or bending over. PX12 at 14-15 and Exhibit 2 to deposition. His low back is worse with moving, walking, sitting for prolonged amounts of time and he reports being in continuous pain without being pain free for some time. PX12 at 14-15 and Exhibit 2 to deposition. Petitioner reported occasional radiation of pain from his low back and when standing his legs will occasionally fall asleep. PX12 at 14-15 and Exhibit 2 to deposition. Petitioner reported sleeping one to two hours per night. Petitioner denies memory problems and vestibular issues have been resolved according to Dr. S. Mehta. PX12 at 14-15 and Exhibit 2 to deposition. On exam on June 28, 2013 Dr. S. Mehta found tenderness to very light palpation of the neck and lumbar spine, significant difficulty bending at the waist to touch his toes which he was unable to do and significant difficulty with lumbar extension with tenderness over the right greater than left PSIS. PX12 at 16 and Exhibit 2 to deposition. Petitioner had several trigger and tender points in his cervical paraspinal muscles, upper trapezius muscles and rhomboids as well as

ar paraspinal muscles. PX12 at 16 and Exhibit 2 to deposition. Petitioner uses a straight cane and has an extremely antalgic gait with no loss of balance. PX12 at 16 and Exhibit 2 to deposition.

On June 28, 2013 Dr. S. Mehta opined in his note that his assessment is that petitioner has chronic low back pain, neck pain and headaches from the work related of June 2011. PX12-Exhibit 2 to deposition. He opined that the treatment significantly helped his pain but that the inability to afford the medications have exacerbated the pain making it more chronic and he has developed a chronic pain syndrome effecting petitioner from a psychological standpoint causing him significant depression which only compounds his chronic pain. PX12-Exhibit 2 to deposition. According to Dr. S. Mehta, petitioner requires significant therapeutic treatment to improve his pain including myofascial injections, possibly facet injections and sacroiliac joint injections in combination with physical therapy and would benefit from Cymbalta and Amitriptyline from both a psychiatric standpoint and to treat his chronic pain. PX12-Exhibit 2 to deposition. Dr. S. Mehta opined that the concussion he sustained which was not diagnosed until petitioner's release from Marianjoy's Inpatient Program has fully resolved. PX12-Exhibit 2 to deposition. Dr. S. Mehta opined on June 28, 2013 that petitioner is unable to work at this time because of his pain because he cannot sit for any significant amount of time without exacerbation of his pain which precludes him from even a sedentary job. PX12-Exhibit 2 to deposition. Dr. S. Mehta states that if workers compensation will not pay for the current therapies then exploration into Public Aid is necessary because petitioner "is very unlikely to make any progress in terms of pain management without continued physical therapy, medications, injections...." PX12-Exhibit 2 to deposition. Dr. S. Mehta also opines that petitioner requires a comprehensive pain management program based on the chronicity of his pain at this time and notes that his prognosis for recovery without the above treatments is poor. PX12-Exhibit 2 to deposition.

On August 23, 2013 Dr. S. Mehta's deposition was taken. PX12. He testified to a reasonable degree of medical certainty as follows:

- During the entire course of his treatment of petitioner, Dr. S. Mehta never released petitioner to light duty or full duty (at 11);
- All diagnoses and conditions for which he treated petitioner were caused by or related to the accident of June 29, 2011(at 12);
- The injuries petitioner sustained in the work related accident of June 29, 2011 prevented petitioner from returning to from the time of the accident all the way up until August 23, 2013(at 12);
- He concurred with the opinion of the therapist that petitioner should not be driving and petitioner is currently restricted from driving (at 13-14);
- The significant Depression is a result of the chronic pain syndromes and the issues that arose as a result of the trauma from the accident (at 18);
- Cymbalta and Amitriptyline are antidepressants which he should be on for six to twelve months or possibly longer but ideally petitioner should also receive some psychologic or psychiatric counseling as well (at 19-20);

- Dr. Mehta testified that he has treated petitioner for a long time and has no concerns that petitioner is fabricating, prevaricating, guilty of secondary gain or symptom magnification (at 22);
- Without treatment, Dr. S. Mehta does not expect any improvement in petitioner's pain (at 24);
- Dr. S. Mehta testified that his opinions do not change as to petitioner's current condition even after the date of the deposition because his condition will not change without treatment (at 24);
- Any preexisting conditions related to depression or degenerative findings in the back can be aggravated by the trauma from the accident (at 49);
- Based on the cross exam, Dr. S. Mehta did not change any of his opinions relating to causation or the conditions that petitioner currently has based on the last examination (at 51);
- Depression is an illness frequently seen in his practice and treated peripherally and it is a condition that can be aggravated or exacerbated by a chronic pain condition following a work related accident (at 51); and
- Dr. S. Mehta opined that the depression that petitioner exhibited over the two years which he has treated him relates to or was caused by the work related injuries from June, 2011 (at 52).

Petitioner testified that he has constant pain in the low back. Prior to the accident he slept eight hours nightly but now sleeps two to three hours per night due to back pain.

2011 AND 2012 MEDICAL EVIDENCE

The Tri-City Ambulance report of June 29, 2011 noted the chief complaint of left arm, head and back pain and further noted pain at multiple sites, hemiplegia/paralysis and unspecified back pain. PX2. The ambulance report states that coworkers stated that multiple boxes that weighed 30 lbs fell off a pallet striking the patient and knocking him to the floor. PX2. Petitioner rated his neck and shoulder pain at 10/10. Most significantly, the crew's initial neuro assessment noted that he could move his left leg, however, enroute to the hospital the patient was unable to move his left leg or foot at all though able to feel touch "but had no response to painful stimuli in his L leg or foot at all." PX2. The ambulance report indicates that petitioner denied being on medications and denied allergies. PX2.

Petitioner was admitted on June 29, 2011 to Delnor Hospital with left leg weakness and possible spinal cord injury. PX2. Right foot x-ray on admission showed no fractures. PX2. Left humerus x-ray showed no obvious fracture or dislocation. PX2. The CT of the brain on June 29, 2011 stated only one impression of "no acute abnormality of the brain" even though a prominent cistern magna versus a subarachnoid cyst was seen. PX2. The Delnor Triage Assessment reflects that he was on no medications and has no known allergies. PX2. The Delnor Nursing Documentation-Condensed notes from June 28 and 29, 2011 do not list symptomatic depression in the Heidrich II Fall Risk Assessment as being present. PX2.

Petitioner had slight numbness and dull sensation from left side from hips to foot. PX2. Patient has pain in lower back when both legs lifted. PX2. The consultation of Dr. Padma Srigiriraju on July 5, 2011 for petitioner's rehabilitation needs included medication for pain and Cymbalta for Depression. PX5.

Dr. V. Mehta, the orthopod, treated petitioner at Delnor Community Hospital noting a history of a gentleman at work on June 29, 2011 having heavy pallets, multiple packages and boxes fall on him, striking him. PX4. Dr. V. Mehta noted on July 1, 2011 that petitioner was brought to the emergency department and evaluated by the trauma team and the neurosurgeons were managing his spine and that he was treating the left wrist fracture and right ankle sprain which petitioner thought occurred when he twisted it during the fall. PX4. On exam on July 1, 2011 petitioner was splinted on the left wrist with radial tenderness and on the right ankle was found to have tenderness about the anterior lateral portion of the ankle and the area of the anterior talofibular ligament with a very small amount of swelling. PX4. Dr. V. Mehta noted no obvious abnormalities in x-rays of the right foot and a distal radial fracture with some intra-articular distention and a very minimal displacement. PX4. Dr. V. Mehta diagnosed right ankle sprain and a non to minimally displaced distal radius fracture of the left wrist. PX4. Dr. V. Mehta's plan on July 1, 2011 was to place the ankle in a cam boot with weight bearing as tolerated and if he continues to have significant symptoms and is not improving to consider obtaining an MRI to further evaluate the ankle. PX4. He also planned to keep him in a left wrist splint until swelling subsides and then switch him over to cast. PX4.

On admission, Marianjoy carried the following diagnoses for petitioner: cervical displacement; lumbar disc displacement; fracture distal radius nec-cl; muscle weakness (generalized); abnormality of gait/impaired balance; pterygium nos.; dis plas protein met nec; hypertonicity/spasm muscle; sprain of ankle nos; struck by object; swelling of limb; joint pain-ankle; backache nos; tinnitus nos; neuralgia/neuritis; dizziness/vertigo; unspec constipation; and rehabilitation proc nec. PX5. The History and Physical authored by Dr. S. Mehta on July 7, 2013 stated that following the accident petitioner had CT scanning of the abdomen, chest and pelvis which were negative for injury and MRI scanning of the cervical, thoracic and lumbar spine which showed C5-6 mild posterior disc indenting the thecal sac as well as an L4-L5 mild posterior disc bulge flattening the thecal sac. PX5. Petitioner complained of knee and mid-back pain, trouble walking, numbness in the left lower extremity. PX5. Dr. S. Mehta noted impaired ADLs and mobility secondary to multiple trauma and spinal cord injury after blunt trauma, gait dysfunction, neuropathic pain and hypoalbuminemia/hypoproteinemia. PX5.

On July 20, 2011 upon discharge from Marianjoy Rehabilitation Hospital to the day program, he was instructed to nonweight bear on left wrist, weight bearing on right ankle as tolerated, wear cam boot at all times, have a person to assist with transfers, one person supervision in shower and shower with chair or bench. PX5. He was given Tylenol two tabs every four hours for pain, Flexeril, 10 mg, three times daily, Norco every four hours as needed for pain. PX5. Petitioner treated with Dr. V. Mehta at Fox Valley Orthopedic from July 1, 2011 through January 12, 2012 for a left wrist distal radial fracture and severe sprain of the right ankle. PX4. A short arm cast was applied to petitioner's left wrist on July 28, 2011 and on August 11, 2011 he was

fitted with two braces (cock-up wrist and ASO for the ankle) at Fox Valley Orthopedic. PX4. X-rays were taken of the left wrist on July 28, 2011, August 11, 2011, September 9, 2011 and October 2011 while petitioner's right ankle was x-rayed on August 11, 2011 with a lower extremity MRI being taken on November 1, 2011. PX4.

Dr. V. Mehta ordered hand therapy and right ankle therapy on August 11, 2011. PX4.

Petitioner began on August 17, 2011 and was discharged from occupational therapy at Marianjoy for the left wrist only on September 12, 2011 having met goal of significant increased functional use of left upper extremity and without complaint of pain during AROM and PROM testing at that time. PX4.

Petitioner had physical therapy from July 21, 2011 to October 31, 2011. PX4,5,10. Petitioner reported to Marianjoy occupational therapy that he had a lot of pain in his back and his head from the trauma and could not move his head for a few days. PX 4,5,10. He reported paralysis in the left lower extremity after the injury but regained motion after massage. PX 4,5,10. He reported neck, mid back and low back pain with tightness and pulling in the neck and burning pain in the low back. PX4,5,10 . His sleep is interfered. PX 4,5,10 .

Dr. S. Mehta on August 30, 2011 sought treatment for petitioner for vestibular dysfunction for post concussion syndrome. PX5.

On September 8, 2011 Dr. S. Mehta signed a Family Medical Leave Act form for a serious health condition stating that his "estimate for the beginning and ending dates for the period of incapacity: present-2/1/12." RX7. Dr. S. Mehta added that "Mr. Ramos will need a graduated return to work plan beginning 2/1/12." RX7. Dr. S. Mehta stated that the treatment schedule included "PM&R Follow up every three months for 1 year." RX7. Dr. S. Mehta certified at that time that petitioner "cannot work at this time." RX7.

On September 9, 2011 Dr. V. Mehta of FVOI stated that petitioner could return to light duty "from the wrist and ankle standpoint" so long as he did not operate heavy machinery and did not engage in rapid use of the left hand but qualified this statement by stating "***[w]e realize he is being treated for other injuries. Therefore, please honor his other work notes which state he may not work.**" [Emphasis added.] PX4. On January 27, 2012 Dr. V. Mehta released petitioner to light duty with the same restrictions and indicated that the expected duration of disability was unknown and that petitioner next visit would be for MRI. PX4.

He was prescribed trigger point injections for myofascial pain on September 13, 2011. PX5.

On October 18, 2011 his physical therapy was curtailed because he had a trigger point injection that day and petitioner reported on October 21, 2011 to the therapist that Dr. S. Mehta gave him trigger point injections "all over" noting that the burning pain is better since the injections and the pain is smoother. PX 4. On October 18, 2011 Dr. S. Mehta examined petitioner and carried a diagnosis of impaired balance, headaches, and myofascial pain secondary to post concussive syndrome. PX5. Petitioner complained at that time that he has neck, head and lower back pain

rated at a 5/6 out of 10 everyday and the medications (Cymbalta, Topamax, Flexeril and Amitriptyline) are effective. PX5. On exam on October 18, 2011 Dr. S. Mehta found positive trigger points in his left splenis capitis right cervical paraspinal muscle, right upper trapezius, left rhomboid as well as multiple areas in his lumbar paraspinal muscles, cervical range of motion is limited in all planes and observation of his gain reveals slight imbalance making use of a straight cane appropriate. PX5. Dr. S. Mehta weaned him off of the Scopolamine patch for balance. PX5. On this date trigger point injections were given in the cervical and lumbar regions. PX5.

Because the ankle remained symptomatic, Dr. V. Mehta ordered an MRI on October 20, 2011. PX4. The November 1, 2011 MRI of the right ankle revealed edema in the superior aspect of Kager's fat triangle extending more proximally with unclear etiology as well as some subcutaneous edema overlying the medial aspect of the ankle in a cephalad direction out of the field of view. PX4.

Cymbalta was prescribed on December 13, 2011 by Dr. S. Mehta. PX5. On the same date, Dr. S. Mehta counseled petitioner not to drive a vehicle until he received an evaluation from Marianjoy occupational therapy. PX5.

Dr. S.Mehta ordered a lumbar spine MRI for radiating low back pain and urinary retention on December 26, 2011. PX5.

On January 10, 2012 Dr. S. Mehta performed bilateral facet joint injections at L4-L5 and L5-S1 and prescribed 30 tabs of Cymbalta, 90 tabs of Amitriptyline and 120 tabs of Hydrocodone/APAP for petitioner. PX 5,10.

On January 12, 2012 petitioner complained of difficulty grabbing and turning a handle and Dr. V. Mehta ordered an MRI to evaluate TFCC status post radial styloid fracture. PX4.

On January 26, 2012 petitioner was fitted by Fox Valley Ortho with a small size ASO brace. PX6.

On February 15, 2012, Dr. S. Mehta of Marianjoy examined petitioner who had chief complaint of low back pain and post concussive syndrome secondary to work related injury. PX5. At that time petitioner stated that his low back pain improved after the facet joint injection but continues to experience pain on bending and left sided low back pain radiating into the left leg. PX5. Petitioner denied imbalance or dizziness and stated that the Cymbalta has improved his depressive symptoms very well. PX5. Dr. S. Mehta did not release petitioner to work indicating instead that a functional capacity evaluation would need to be performed. PX5.

On April 5, 2012 the left wrist MRI ordered on January 26, 2012 was denied by workers compensation according to Lisa Long of Fox Valley Orthopedic Institute. PX6.

On April 9, 2012 petitioner stated that he was using the TENS unit at home for assistance in pain control. PX10.

On October 19, 2011, a day after having trigger point injections by Dr. S. Mehta, petitioner was examined by Dr. Jay Levin of Adult & Pediatric Orthopedics, S.C. on behalf of respondent for orthopedic conditions only "for his cervical spine, lumbar spine, left hand and right ankle." PX6; RX6; RX3 at 54. Petitioner complained of neck pain, low back pain with stiffness in the low/mid/upper back areas, bilateral hip pain. PX6; RX6. He testified that petitioner complained of neck pain radiating to both shoulders, low back pain, difficulty sleeping due to pain, hip pain, weakness in the right foot, numbness and tingling in the toes. RX3 at 14-15. On exam of the left wrist Dr. Jay Levin found "some discomfort at the radial or proximal radiolunar joint" noting that x-rays he took that day revealed "sclerotic changes in the mid-portion of the radial articular surface consistent with a healed…fracture of the central and ulnar aspects of the articular surface." PX6; RX6.

Dr. Jay Levin concludes that the only injuries petitioner sustained in the June 29, 2011 accident "were an undisplaced left radius fracture and a contusion to the thoracolumbar area." PX6; RX6. He concludes that he finds no information in the records which support the examinee's continued subjective complaints referable to his cervical spine, lumbar spine or left wrist and therefore petitioner could return to full duty. PX6; RX6. On exam, Dr. J. Levin found left midline posterior cervical tenderness, medial trapezial tenderness and anterior cervical tenderness. RX3 at 17-18. Range of motion was limited in the cervical exam and he had point tenderness at the base of the neck, midline and cervical thoracic area. RX3 at 18. Midline central lower thoracic tenderness was also present. RX3 at 18. There was upper lumbar, midline lumbar, midlumbar midline and lower lumbar midline tenderness. RX3 at 18. There was tenderness on the ulnar aspect of the proximal elbow and over the anterior radius. RX3 at 19. Straight leg raise elicited low back pain on the right at 55 degrees and on the right 25 degrees elicited pain vibrating down the low back. RX3 at 21. Right ankle revealed tenderness over the calcaneofibular ligament. RX1 at 21. Reduced range of motion was noted in the right ankle when compared to the left (10 degrees less dorsiflexion, 10 degrees less plantar flexion). RX3 at 22. Dr. J. Levin testified that it was his opinion that petitioner could have returned to work 14 days to 28 days following the accident. RX3 at 48-49. He testified that petitioner did not injure his right ankle in the accident. RX3 at 50. Dr. J. Levin testified that petitioner did sustain contusions to the cervical, thoracic and lumbar spine from the accident. RX1 at 52. The Arbitrator finds Dr. Levin's conclusions not credible for reasons so obvious they need no explanation, and notes specifically his conclusion that Petitioner did not injure his right ankle in the alleged accident as an example.

Dr. Coe examined petitioner on May 8, 2012. PX11 at 9. The exam revealed at that time that petitioner walked with a limp marked by limited right leg weight bearing, tenderness was found as trigger points bilaterally in the posterior cervical musculature (muscles, tendons and ligaments) which are a hallmark of myofascial pain, with the goniometer his cervical range of motion in flexion was reduced by 5 degrees, extension reduced by 10 degrees, right and left lateral rotation was reduced by 20 degrees in each direction, reflecting mild to moderate stiffness in petitioner's neck on exam. PX11 at 14-20. On exam, Dr. Coe also found tenderness over the ulnar border of petitioner's left wrist consistent with his intra-articular fracture suffered in the June 29, 2011 accident, reduced extension in the left wrist by 20 degrees, reduced radial deviation of 15 degrees in the left wrist and a reduction of 10 degrees in ulnar deviation in the

left wrist. PX11 at 17-18. Dr. Coe found stiffness in the left wrist and petitioner complained of pain in the top of the wrist with range of motion testing. PX11 at 18. In the mid and lower back exam, Dr. Coe found trigger points bilaterally in the paralumbar and parathoracic musculature again suggesting myofascial pain. PX11 at 18. Range of motion of the lumbar spine revealed 30 degrees less in flexion, 20 degrees reduced motion in extension and 15 degrees in reduction in right and left bending, all with moderated stiffness and complaints of pain with range of motion testing. PX11 at 18-19. Dr. Coe found tenderness over the sacroiliac joints bilaterally as well as tenderness over the lateral malleolus of the right ankle (outer bony projection). PX11 at 19. Plantar flexion was reduced by 10 degrees on the right only and was reduced by 10 degrees only in inversion on the right with moderate stiffness in the right ankle and complaints of pain with range of motion testing. Px11 at 19-20. Dr. Coe opined that as a result of the trauma of the accident petitioner sustained a comminuted intra-articular fracture of the left distal radius, an internal derangement of the right ankle with chronic synovitis and tendinitis, chronic cervical, thoracic and lumbar myofascial pain with associated cervicogenic headaches arising from the cervical musculature, a post concussion syndrome, a post head injury syndrome with elements including dizziness, anxiety and insomnia and such conditions continued to be symptomatic when Dr. Coe examined petitioner. PX11 at 21-22. Dr. Coe opined that the right sided limp is associated with the chronic tendinitis and synovitits in the right ankle as well as the sacroiliac joint pain. PX11 at 22. Dr. Coe testified that his review of the records revealed that petitioner did not pass his driving evaluation on February 2, 2012 due to the injuries sustained in the work related accident of June 29, 2011. PX11 at 22-23. Dr. Coe also opined that transportation and translation should be provided for effective future medical care and treatment of petitioner. PX11 at 23-24. Dr. Coe testified that petitioner had a limited ability to work with significant restrictions in walking, bending, kneeling, stooping, reaching or climbing and requires specific functional testing. PX11 at 24. Dr. Coe opined that petitioner could not return to work as a warehouseman and disagrees with the opinions of Dr. Jay Levin. PX11 at 25-26. Dr. Coe opined that the refrigerated setting in the warehouse would tend to aggravate the myofascial pain in the neck, mid and lower back. PX11 at 25-26. Dr. Coe opined that petitioner requires follow up care with his rehabilitation specialist, Dr. S. Mehta, to undergo additional pain management therapies including trigger point injections, sacroiliac joint blocks, medications and physical therapies. PX11 at 27. Dr. Coe felt that petitioner was forthright and credible. PX11 at 27-29.

The second IME physician for respondent, Dr. Karen Levin, examined petitioner on August 1, 2012 and limited her testimony to a neurologic standpoint. RX1 at 8. No translator was provided but petitioner's daughter translated and even answered questions on his behalf without his input according to Dr. K. Levin who herself does not speak Spanish. RX1 at 9, 34. She testified that her 13 year old son would remember if he ever had been to a doctor for something in response to a question regarding the extent of petitioner's education or lack of education. RX1 at 46. Her examination was in the nature of a "drunk driver test" although petitioner had not been drinking. RX1 at 19, 46. In her opinion, petitioner's injuries from the accident were "minor", "way out of proportion for the type of injury he had" with no true neurological problems. RX1 at 27. According to Dr. K. Levin, petitioner's original injury "is a minor injury" and "at best, should have been sore for a short period of time after [the accident] with no continued neurological problems." RX1 at 28. She stated that Petitioner had merely fallen from ground level and not from 50 feet up in the air, and that therefore an concussion he would have sustained would have been minor. Dr. K. Levin testified that "some of the rehab,

Marianjoy rehab might be a bit excessive for the injury he had", "he shouldn't have even caused a concussion but if it did, it would have been minor and self-limiting within a very short period of time" which is a matter of weeks or "if we pushed it a little bit, maybe three months but not much longer than that." RX1 at 29, 30. Dr. K. Levin's opinions with respect to headaches was not based on medical records but only the billing records from before the accident and she had no information that would reflect the location or frequency of the headaches petitioner had prior to the accident. RX1 at 39-44. Dr. K. Levin testified that the headaches prior to the accident were located in the left temporal area and that petitioner complained of occipital headaches after the accident but change in location does not matter because headache syndrome change location. RX1 at 54. Dr. K. Levin agrees that petitioner sustained mild post concussion syndrome. RX1 39-40. Dr. K. Levin testified that petitioner could work "only from a neurologic standpoint." RX1 at 30. Dr. K. Levin failed to comment or state any opinion relating to petitioner's Depression even though he complained to her about it. RX1 at 17. Once again the Arbitrator finds respondent's IME doctor not credible, as her testimony is completely at odds with the facts in this case and specifically notes her testimony that a fall from ground level could not cause a serious concussion as one of many non credible conclusions stated by the doctor..

RX13 suggests that respondent has failed to pay TTD from January 19, 2012 to present and that no medical expense has been paid since January 26, 2012 but there was no Respondent witness to explain the redactions or how to accurately read this Financial Log Results. The Arbitrator notes that Petitioner, in the Request for Hearing form, only requested TTD from January 18, 2013 to the date of hearing.

With regard to the contested issue in this case, the Arbitrator specifically finds as follows:

1. Petitioner sustained multiple injuries, as set forth above, including a fracture of the left distal radius, a severely sprained ankle requiring a CAM boot, a post concussion syndrome, spinal cord injuries, headaches, myofascial pain in the cervical, thoracic, lumbar and sacroiliac spine, Chronic Pain Syndrome and depression as a direct and proximate result of the accident occurring on June 29, 2011 while working for respondent. The medical evidence of record confirms that petitioner sustained these injuries and virtually all of the above save for the depression, *are clearly documented from the time of the alleged injury forward*. The myofascial cervical, thoracic and lumbar spine injuries were corroborated by the physical findings on exam by Dr. S. Mehta, Dr. Jay Levin and Dr. Jeffrey Coe. Accordingly, acausal connection exists between the aforesaid injuries and work related accident of June 29, 2011.

2. Dr. S. Mehta is a treating physician most familiar with petitioner over the course of time as well as currently who has treated him from July 7, 2011 to present and is therefore the most qualified physician to opine on petitioner's current condition and inability to work. Dr. S. Mehta has not returned petitioner to any duty, light or full, since the work related accident of June 29, 2011. Dr. S. Mehta's opinions are the most credible and entitled to the greatest weight of all of the physicians including the three independent medical examiners named above. Consequently, petitioner is entitled to payment of temporary

total disability commencing from January 18, 2013 to the date of trial at a rate of $330.67 per week. Petitioner is entitled to TTD benefits from January 18, 2013 through November 14, 2013. ARBX1 reflects that Petitioner only claimed this period of TTD at trial.

3. Petitioner is entitled to the prospective medical care which as prescribed by Dr. S. Mehta including but not limited to prescriptions, physical and occupational therapies, mental health counseling, office visits at Marianjoy Medical Group for follow up care, trigger point and other injections. Respondent shall pay all charges therefor including any amounts paid or to be paid by Public Aid. Respondent shall pay transportation costs of petitioner's medical visits if he is still unable to drive safely as certified by an occupational therapist.

4. Petitioner is entitled to have the medical services set forth in PX13 paid by respondent pursuant to the fee schedule set forth in the Workers Compensation Act. PX13 provides a balance due of the amount of $203.40 which shall be paid by respondent if said amount is properly due under the fee schedule.

5. Request for attorneys fees and penalties is granted as to respondent's failure to continue to pay TTD after January 18, 2013 based solely on the orthopedic opinions of Dr. Jay Levin. Respondent eventually recognized that a multidisciplinary review was necessary and scheduled Dr. Karen Levin's IME in August, 2012. Based on these IMEs, Respondent terminated TTD and medical benefits. As stated above, the Arbitrator finds both of Respondent's IME witnesses to be obviously and plainly not credible and further finds that it was not reasonable for the Respondent to rely on their opinions in terminating TTD and medical benefits for the Petitioner . While substantial attorneys fees and penalties for such conduct is warranted and because petitioner has only requested these nominal amounts at this juncture, the award for attorneys fees is $1.00 under Section 16 or 16 a and the penalties assessed are $1.00, however the Arbitrator has no authority to award to Petitioner the added expenses incurred by petitioner for having Dr. Coe sit a second time for deposition or $ 1000as requested by Petitioner.

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

Rogelio Ramos,

Petitioner,

14IWCC0808

vs.

NO: 12 WC 43992

Oak State Products,

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, 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 22, 2014, is hereby affirmed and adopted.

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

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

14IWCC0808

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

DATED:
8/26/14
RWW/rm
046

SEP 2 3 2014

Ruth W. White

Daniel R. Donohoo

DISSENTING OPINION

I must respectfully dissent. I would find that Petitioner's right shoulder condition of ill-being is causally related to his employment with Respondent. Petitioner testified that 11% to 33% of his job involved reaching above shoulder level. The Job Analysis (Px2) indicates that the duties of a "packer" involve reaching at shoulder height 11 to 33% of the time and reaching above shoulder height 11 to 33% of the time. This is consistent with Petitioner's testimony. Respondent's witness, Pat Donnelly, agreed that the job involved some reaching above shoulder level but that the percentage is closer to 11 to 15% of the time.

Petitioner's Dr. Sinha opined that Petitioner's condition of shoulder impingement syndrome was consistent with repetitive motion of the shoulder over many years. He testified that Petitioner's rotator cuff tear was not age-related but rather "has something to do with the activity on the job...." (Px8 at 37).

Respondent's examining physician, Dr. Cohen, did not believe that Petitioner's shoulder condition was related to his work activities, but this opinion was based upon his understanding that Petitioner was not doing any overhead or shoulder height work. He admitted that if Petitioner worked at shoulder height or above it could change his opinion. Dr. Cohen testified that he communicated with Petitioner regarding his work activities and that he reviewed the job analysis provided to him by Respondent. However, Petitioner testified that Dr. Cohen did not ask him any questions about his work activities, the examination only took two to three minutes, and he did not have the benefit of a translator.

The testimony of Petitioner and Mr. Donnelly along with the Job Analysis shows that Petitioner did, in fact, perform work above shoulder level. Therefore, Dr. Cohen's causation opinion is not based on accurate facts. I would find Dr. Sinha's opinion more credible and would reverse the Arbitrator's decision to find a causal relationship between Petitioner's work activities and his shoulder condition of ill-being.

Charles J. DeVriendt

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

14IWCC0808

RAMOS, ROGELIO
Employee/Petitioner

Case# **12WC043992**

OAK STATE PRODUCTS
Employer/Respondent

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:

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

1337 KNELL & KELLY LLC
CHARLES D KNELL
504 FAYETTE ST
PEORIA, IL 61603

14IWCC0808

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)

ROGELIO RAMOS
Employee/Petitioner

v.

OAK STATE PRODUCTS
Employer/Respondent

Case # **12** WC **43992**

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**, on **December 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 June 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 not*** sustain an accident that arose out of and in the course of employment.

Timely notice of the *alleged* accident ***was*** given to Respondent.

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

In the year preceding the injury, Petitioner earned **$24,687.00**; the average weekly wage was **$474.75**.

On the date of accident, Petitioner was **59** years of age, ***married*** with **0** children under 18.

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

Respondent shall be given a credit of **$3,165.00** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$3,165.00**.

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

ORDER

Denial of benefits

The Arbitrator denies the petitioner's claim for medical bills incurred and not paid totaling $37.73 for a prescription bill. Further denies any claim for temporary total disability benefits and further denies any prospective medical treatment for the petitioner's right shoulder on the basis the petitioner failed to prove that the petitioner sustained an accident that arose out of and in the course of the employment and further denies the claim based on the fact the petitioner failed to prove causal connection.

No benefits are awarded.

Credits

Respondent shall be given a credit of **$3,165.00 for disputed temporary total disability benefits paid**.

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

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

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

Signature of Arbitrator

January 2, 2013
Date

ICArbDec19(b)

JAN 22 2014

14IWCC0808

FINDING OF FACTS

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?**

The petitioner was hired by Oak State Products in 2002. He was initially hired to work in sanitation. (A.T. 9) He was in that position for 5 years. He then became a packer. He has been a packer since 2007. (A.T. 10) Petitioner's Exhibit #1 and Respondent's Exhibit #3 is a job description of a packer at Oak State Products. Petitioner's Exhibit #2 and Respondent's Exhibit #4 is the job analysis of a packer for Oak State Products. Both of those documents were introduced into evidence by both the petitioner and respondent at the time of trial. The petitioner testified that 67% of his time as a packer he worked below shoulder level. He indicated that 11 to 33% of the time as a packer he would work above shoulder level. The petitioner is right-hand dominant. (A.T. 15/16)

The petitioner testified that he was hurt on June 5, 2012. The arbitrator notes that the alleged date of loss is June 7, 2012. The petitioner testified in June 2012 he was packing cookies. (A.T. 16) He testified he had to pack them over 6 feet. (A.T. 17) He indicated he talked to Christopher Smith about his problems with his right shoulder. He was sent to Illinois Valley Community Hospital on June 8, 2012 and received physical therapy. (A.T. 18/19) He indicated therapy did not help him. (A.T. 22) He went to see Dr. Sinha on July 30, 2012. (A.T. 22) He received 2 injections. He indicated those injections did not help. Dr. Sinha put him on light duty and ordered an MRI of the right shoulder. (A.T. 23) Dr. Sinha recommended surgery. (A.T. 23) At the time of trial he was still on restrictions. (A.T. 24)

He indicated he wanted to have surgery on the right shoulder. (A.T. 24) He was also seen by Dr. Cohen in Joliet at the request of the employer. The petitioner testified he had no translator present with him at the time of the IME. (A.T. 25) He indicated Dr. Cohen took no history from him. (A.T. 25 & 26)

In June of 2012 he was working on B line. (A.T. 26) He indicated each box had 12 cookies. They were not very heavy. (A.T. 26 & 27) He worked first shift in June of 2012 starting at 6:00 a.m. (A.T. 28)

The petitioner testified that on June 7, 2012 he did not have a specific incident where he felt immediate pain in his shoulder. His response was as follows: "The pain started on June 4 & 5 and then June 7th I couldn't stand the pain." (A.T. 30) Petitioner testified prior to June 4, 2012 he had pain in his right shoulder. (A.T. 31) He indicated that he had no pain in his right shoulder in May of 2012. (A.T. 31-32) The petitioner testified that the first time that he looked at the job description and Petitioner's Exhibit #1 and #2 was the morning of trial. (A.T. 32 & 33) The petitioner testified that he would take cookies inside the box and then put the box on top of the belt and that the box and the cookies were moving along at the same time and they were moving on a lower belt. (A.T. 33) Petitioner testified that he worked on B line for only 7 days. (A.T. 35) Prior to working on B line he worked on C line where they had him take out bad cookies on the belt.

The petitioner was asked the following question:

Q. When you were working on C line you are not working above shoulder level, is that a fair statement? (A.T. 37)

A. I still had to move both arms to pull all the bad cookies. (A.T. 37)

The petitioner last saw Dr. Sinha on December 3, 2012. (A.T. 34) He has had no medical treatment since December 3, 2012. (A.T. 35) The Arbitrator notes that Petitioner's testimony in court was often difficult to follow, and seemingly inconsistent. Per the Arbitrator's notes, Petitioner never testified to how many times he would have performed the job duties that he tried to describe in a typical day. The Arbitrator further notes that he did not develop a clear understanding of what actually may have been involved in Petitioner's job until Pat Donnely, witness for Respondent, testified.

The respondent called Pat Donnelly, the CFO from Oak State Products. He has been in that position for 24 years. (A.T. 44)

Oak State Products is a manufacturer of cookies for major food companies in the United States. He has reviewed Petitioner's Exhibits #1 & #2. He is familiar with those job

descriptions. (A.T. 44/45) Mr. Donnelly testified that the packers are at the end of the wrapper. The cookies are counted out, displayed right in front of them. They shingle them together and then a tray is coming by and they put them in the tray. On B line Mrs. Fields Cookies are in 12 packs.

They have a stool available to stand on to make them more comfortable so that everybody is at the same height. The wrapper that the cookies come out on are right at waist height. The packers are picking up cookies slightly higher than waist high, maybe belly button high. (A.T. 46 & 47) They take 12 cookies. The machine counts the cookies and displays them like a deck of cards laid out 12. (A.T. 47) Based on the testimony at the time of trial the only thing that Mr. Ramos was doing was the 12 pack convenient store type of cookie and then putting it into the box. (A.T. 48) The packer then pushes 6 boxes of cookies into a larger box on line B. (A.T. 50)

The packers during the day are rotated from various jobs so they are not doing any one job for an extended period of time. (A.T. 51) Oak State Products has approximately 15 to 20 different positions for packers. (A.T. 52) They rotate on a 30 minute to an hourly basis from those positions. (A.T. 52) The petitioner would have also been a case packer. (A.T. 53 & 54) 6 cartons of cookies are presented to them and they push them into a carton or 8 of them, depending on what product they are making. The packer does not physically lift those boxes but merely pushes them. (A.T. 54)

Mr. Donnelly was asked whether or not the packer who was working on B line would physically pick up the product that is going to the consumer in the C store and was asked whether they would physically pick that up and reach above shoulders to place it into the boxes for purposes of shipment. (A.T. 55) The answer was no. The packer does not have to lift the larger box as it is on a line and it goes to the warehouse. (A.T. 56)

Pat Donnelly identified Petitioner's Exhibit #2 which is the job analysis that indicated the job requires the petitioner to reach above shoulder 11 to 33% of the time. He believes that it is closer to 11 to 15% but not a third of the time. (A.T. 58/59)

On cross examination Mr. Donnelly testified that to convey cookies over to the case packing it is slightly higher than to the belt line in front of him but less than chest height. (A.T. 59/60) Pat Donnelly, in reviewing Petitioner's Exhibit #2 agreed that there is some

reaching above shoulder level but it is at a lower percentage than that as set forth in Petitioner's Exhibit #2. The cookies are light weight. (A.T. 63) It is like I Love Lucy. (A.T. 64)

At page 66 the arbitrator made inquiry with Mr. Donnelly regarding the job. Mr. Donnelly states as follows: "What happens is they are taking the 12 cookies and they are putting them into a tray and then they are taking that tray and putting it up 6 to 8 inches higher onto this other belt.

Then that belt goes down the line into a case packaging position where they take 6 of them individual actually it goes through a shrink tunnel wrap and then it goes down to the case packing where they are presented and they just push them together and slide them into a case." (A.T. 66 & 67)

Dr. Sinha's deposition was taken and it was introduced into evidence as Petitioner's Exhibit #8. The petitioner had treated with Dr. Sinha back in 2007 and 2008 for a left knee problem. (Pet Exh #8, pgs 5 & 6) Petitioner first saw Dr. Sinha on July 20, 2012. (Pet Exh #8, pg 8) As a part of the history the doctor wrote: "hurt his right shoulder on job June 7, 2012 but there was no particular any particular one incident of injury, there was not. (Pet. Exh. #8, pg 11) The doctor did not recall by way of history the particular activity the petitioner was performing. He indicated it was moderate manual type of work. (Pet. Exh. #8, pg. 12) The doctor further noted as a part of the history that the petitioner was packaging cookies and that was up to 30 to 35lbs. occasional overhead reaching also. (Pet. Exh. #8, pg. 12) The initial diagnosis was impingement syndrome of the right shoulder. Dr. Sinha testified that impingement syndrome can develop without having to work over his head. (Pet Exh #8, pg. 15) The doctor noted the petitioner had chronic change in the shoulder joint and the x-rays showed arthritis. (Pet Exh #8, pg. 16) The doctor noted that after the age of 40 to 45 in human beings the blood supply in the shoulder area where the supraspinatus part of the cuff is attached looses blood supply. (Pet Exh #8, pg 17)

He further indicated that millions of people on the planet walking with a torn partial tear of the cuff and no symptoms. (Pet Exh #8, pg. 17) The petitioner was diagnosed with a full thickness tear.

Dr. Sinha indicated "and as time goes on these patients, especially this age group, as the time goes on they are going to get a bigger and bigger tear." (Pet Exh #8, pg. 18)

When the petitioner was seen on September 25, 2012 Dr. Sinha recommended an MRI of the right shoulder. The MRI was done on October 3, 2012. The petitioner had a complete tear of the anterior aspect of the supraspinatus tendon with a .8 centimeter retraction. It was a complete tear. (Pet Exh #8, pgs 29 & 30)

Dr. Sinha indicated at pages 30 and 31 of his evidence deposition that you cannot tell whether it is a chronic, an old, a year or two years old versus something that happened relatively recently. He indicated there is no way you can tell for sure. (Pet Exh #8, pg 31)

Dr. Sinha at page 32 of his deposition indicated this is more like a thing that is going on for a long time because a lot of structures are involved.

He looked at the MRI and at page 32 of his evidence deposition stated: "Like arthritis of the AC joint is there for a long time. It is a very slow process. Every one of us will develop. Normally we don't see the fibrous tissue beyond that area. Normally we see the spur, which is the bony overgrowth. That is the repair process in nature and gives more problem. But cuff, we that fibrous tissue behind the acromion and AC joint that impinges or reduces the space more. The patient gets more impingement and sometimes we call it the mass effect, and that impinges on the puts pressure on the cuff and then there is more chance of tear because of the cuff and then try to alleviate more than 90 and it pushes there and the more blood I mean blood supply is decreased and there is more chance of a tear.

He further testified at page 33: "The subluxation of the biceps tendon with a lot of fluid there, that looks like chronic. Subluxation you know has to have a roof of the bicipital groove has to be really weakened and in the post traumatic events like if some time you see a complete dislocation of tendon that is post traumatic event. He has subluxation. It looks like slowly and slowly stretching and the roof of the bicipital groove is getting weaker and then the more inflammation.

He also went on to testify at page 33: "*The tear of the subscap, that it is very unusual for this age group unless you have a blunt trauma.*"(emphasis added)

Dr. Sinha further stated at page 32 he has some chronic pre-existing changes, but I think that the fibrous tissue, that bothers me there, and the tear of the cuff, anterior half is torn, so it has to be, you know, repetitive use of the cuff that it is torn. It is not an age related partial tear. It is more than that. It has to do with the activity of the job or hobby or whatever he does."

On cross examination the only history portion that Dr. Sinha wrote down was the fact the petitioner was a cookie factory worker. (Pet Ex. #8, pg. 41) Dr. Sinha at page 42 and 43 of his deposition did not know the percentage of the petitioner's work overhead. He did not know what percentage of work is done at shoulder level.

He further indicated some factory work which does not involve heavy lifting you know or those kinds of things. Probably moderate physical activity on that kind of job.

The respondent presented the medical testimony of Dr. Michael Cohen from an independent medical evaluation of the petitioner that was performed on November 8, 2012. Dr. Cohen is board certified in orthopedic surgery with an added qualification in the hand. (Resp. Exh. #8, pg. 5) He actively treats shoulders and arms including surgical repairs of shoulders and arms.

As a part of the evaluation Dr. Cohen reviewed medical records from Illinois Valley Community Hospital and medical records from Dr. Sinha, an MRI of the shoulder and x-ray films and he also took a history and performed a physical examination. Dr. Cohen testified that he obtained a history from Dr. Ramos regarding his work activities. (See Resp. Exh. #8, pg 7) Dr. Cohen made a diagnosis of rotator cuff tear, impingement syndrome, AC arthritis and chronic biceps tendon rupture. (Resp. Exh. #8, pg. 7) Dr. Cohen testified that the retract and rotator cuff tear with atrophy in the muscle of that tendon with supraspinatus muscle shows that it is chronic. The AC joint arthritis is something that is chronic. The cyst in the humeral head is evidence of chronic tendonitis. (Resp. Exh. #8, pgs 8 & 9) Dr. Cohen testified he had a clear description of the understanding of what the petitioner did for a living. He was basically packing boxes. He also had a job analysis that he reviewed. Dr. Cohen's understanding of the job was that the petitioner was not doing overhead, shoulder height work and it was his opinion that he did not believe that the petitioner's condition was related to his work activities.

(Resp. Exh. #8, pg. 10) Dr. Cohen further testified that work at waist level would not be a mechanism of injury for the petitioner's condition of ill-being. (Resp. Exh. #8, pg 11) Impingement syndrome has to do with bringing the prominent portion of the humeral head so the top of the arm bone, if you will, the ball on the top which is not perfectly spherical up underneath the acromion, which is the bone that you feel on the top of the shoulder impingement the rotator cuff and the bursa in between there. Well, in order for that to occur, the arm has got to be at least shoulder height in order to do that. So if he is doing that with his arm next to his side and if you will internally and externally rotating in and out to do what he has got to do, that doesn't put the stress on the right level to cause that." (Resp. Exh. #8, pgs 11 & 12) Dr. Cohen did agree that the petitioner would need surgical management of his medical condition. On cross examination Dr. Cohen indicated he did communicate with the petitioner about the history of his work. (Resp. Exh. #8, pgs 14 & 15) Dr. Cohen also indicated he reviewed the job analysis provided to him by the employer. Dr. Cohen told him that he did not work at shoulder height or above. There is nothing in his office notes to indicate in his handwritten notes of that fact. Dr. Cohen did testify that if the petitioner worked at shoulder height or above it could change his opinions regarding causation. Dr. Cohen indicated if you are talking about reaching at shoulder height or above then that could change his opinion. If he is reaching at waist level that would not change his opinion even if it was a repetitive basis. (See Resp. Exh. #8, pgs 19 & 20) On redirect examination Dr. Cohen reiterated the fact that it was no doubt in his mind that he obtained a history from the petitioner. (See Resp. Exh. #8, pg. 37)

The Arbitrator notes that the petitioner, during the course of the hearing the petitioner did use an interpreter to translate his testimony. The arbitrator also notes that at times during the hearing the petitioner seemed to understand English.

The Arbitrator notes that the testimony of Pat Donnelly the CFO for Oak State Products is important in this case. He described the physical activities required for someone to be a packer far more clearly and in far more detail than did the Petitioner. The petitioner's own testimony he only worked for 7 days on line B in this job prior to the developments of his complaints of pain in the right shoulder that according to the petitioner's testimony

occurred on June 4 or 5th and not June 7th as alleged in the Application for Adjustment of Claim. Furthermore, Mr. Donnelly's testimony based on his knowledge of the job the petitioner was performing evidenced that the work performed by the petitioner was not above shoulder level in the performance of this job even though the job analysis as set forth in Petitioner's Exhibit #2 and Respondent's Exhibit #4 indicates that a certain percentage of the type may involve work above shoulder level. It is also important to note as evidenced by the testimony of Pat Donnelly that the packers are rotated every 30 to 60 minutes throughout the day so they are not performing the same job during the entire shift. As stated above, the Arbitrator notes the difficulty making heads or tails out of Petitioner's description of his job duties, and further notes, again, that witness Donnely provided the clearest idea of what exactly was involved in working on the B line, the line Petitioner was working on when he developed his injury as alleged herein. Based on Donnely's description, and t he Arbitrator having considered all the evidence the Arbitrator denies the claim on the basis that the petitioner failed to prove that he sustained an accident arising out of and in the course of his employment on June 7, 2012 and further failed to prove causal connection between any alleged work activities and the petitioner's current condition of ill-being. Claim for compensation is hereby denied.

J. **Were the 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

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

KIM DARLING N/K/A KIM HAMMERQUIST,

Petitioner,

14IWCC0809

vs.

NO: 02 WC 066348

MARYVILLE ACADEMY,

Respondent.

DECISION AND OPINION ON REMAND

This matter comes to the Commission on remand from the Circuit Court of Cook County. At arbitration Respondent argued that it should not be liable for medical expenses incurred after April 19, 2005, the date its Section 12 medical examiner, Dr. An, declared Petitioner to be at maximum medical improvement ["MMI"]. The Arbitrator denied medical expenses incurred after April 19, 2005 but not based on Dr. An's declaration that Petitioner was at MMI. As the Arbitrator noted, Dr. An recommended additional pain treatment and exercises, which was contrary to his MMI declaration. Rather, the Arbitrator noted that the treatment after April 19, 2005, including procedures that were administered previously during Petitioner's treatment without benefit, most notably numerous epidural injections. The Arbitrator concluded "that it was not reasonable to expect that continued lumbar and cervical injections would be of any benefit because numerous prior treatments had demonstrated that the procedures would neither cure Petitioner nor provide her any relief from the effects of her injuries."

The Commission agreed with the sentiment of the Arbitrator as quoted above. Nevertheless, the Commission believed his denial of all medical expenses was overbroad. The Commission finds that Petitioner should be entitled to reimbursement for expenses for her pain medications, and for the EMGs, MRIs, and CT scan performed after April 19, 2005. The Commission concludes that the pain medication was prescribed to alleviate Petitioner's symptoms and did provide some benefit. In addition, the tests were administered to better diagnose Petitioner's current condition in order to try to determine a more beneficial treatment plan. The Commission modified the Decision of the Arbitrator to award the specified medical expenses. Respondent appealed the Decision of the Commission to Circuit Court.

In its remand order the Circuit Court of Cook County directed the Commission to "specifically articulate the basis for its findings regarding its decision to affirm in part and reverse in part the arbitrator's decision denying compensation for medical expenses incurred after April 19, 2005. The Commission is also to specify whether its decision bars Petitioner from medical benefits for future treatment. If the Commission's decision on remand includes findings on credibility of evidence or witnesses, the Commission shall articulate the basis for these findings as well."

The Commission based its decision to modify the Decision of the Arbitrator on the Arbitrator's correct characterization concerning the ineffective nature of the numerous injections Petitioner had prior to April 19, 2005 and that it would be unreasonable to continue such treatments. Nevertheless, in looking at the record as a whole the Commission found that certain diagnostic tests were reasonable to formulate a treatment plan and the administration of pain medication was effective in treating Petitioner's condition of ill being. Therefore, the Commission awarded these medical expenses. Petitioner can seek ongoing prescribed pain medication as long as it is shown to be beneficial in treating her condition of ill being. Again, the Decision of the Commission on review was based on its determination of the effectiveness and therefore reasonableness of specific medical procedures and treatment and not specifically on the credibility of evidence or witnesses.

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $20,000.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: SEP 2 3 2014

Ruth W. White

Daniel R. Donohoo

Charles J. DeVriendt

RWW/dw
O-9/10/14
46

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

Shanon Taylor,

Petitioner,

14IWCC0810

vs.

NO: 13 WC 14057

Alton Mental Health Center,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by the Respondent and Petitioner herein and notice given to all parties, the Commission, after considering the issues of accident, causal connection, temporary total disability, prospective medical treatment and §19(k) and §19(l) penalties and being advised of the facts and law, modifies 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 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, a 46-year-old support services worker, alleged that while washing dishes on March 1, 2013 a rubber floor mat slid on the wet floor and caused her to slip and fall. She attempted to catch herself and in doing so "jammed" her right thumb, right hip and knee. We note that Petitioner never sought treatment for any of those body parts; Petitioner's claim for prospective medical benefits and temporary total disability benefits is in relation to neck and back injuries also allegedly sustained as a result of the accident. For the reasons set forth below, we find that Petitioner failed to prove that her current neck and back conditions are related to the March 1, 2013 accident and we reverse the Decision of the Arbitrator on the issue of causal connection with respect to Petitioner's neck and back.

Petitioner testified that she did not believe she needed medical treatment following the accident, but wished to have the accident documented for her employee file and immediately went to the office of her supervisor, Ms. Marcoot. Petitioner's report from the date of accident states that she was "doing dishes and emptying trays, went to step back to the sink and the mat went one way and she went the other," and that she injured "multiple parts." Ms. Marcoot testified for Respondent. Ms. Marcoot recalled that Petitioner rushed into her office on March 1, 2013 and stated that she slipped on the "flooded" kitchen floor and injured her knee and her thumb. Ms. Marcoot observed Petitioner's right knee and testified that the skin appeared reddened but intact, and that Petitioner did not appear to have any difficulty walking and did not wish to go to the emergency room. Within one minute of Petitioner leaving her office, Ms. Marcoot followed Petitioner back to the kitchen. Ms. Marcoot testified that she saw no water on the floor in the kitchen and that Petitioner explained that she already cleaned up the water. Ms. Marcoot testified that Petitioner continued working and made no further complaints that day. Petitioner agreed on cross-examination that she did not report any injury to her back or her neck on the date of accident. Petitioner testified that the accident was witnessed by Ms. Busby, a coworker and friend. In a witness statement, Ms. Busby wrote that she did not remember seeing any water on the floor at the time of the accident. Ms. Busby's report states that while she was "busy washing dishes," Petitioner fell at the sink and hurt her knee. Ms. Busby wrote that Petitioner then left to go report the incident to her supervisor. Ms. Busby's statement does not make it clear whether she personally saw Petitioner slip and fall. Ms. Busby was no longer employed by Respondent on the date of hearing and she was not called to testify.

Records offered into evidence by Respondent show that Petitioner began calling in sick to work on the day after the accident. However, there is no evidence that Petitioner's daily absences in the weeks following the accident were in any way related to the accident. Attendance and disciplinary records offered into evidence by Respondent show that Petitioner had a history of attendance problems and was frequently absent from work during the months prior to the accident. The records of Dr. Boyd from that time period show that Petitioner frequently requested work excuse slips and expressed that she was extremely distressed about her job and having been disciplined for her absences. Petitioner admitted at hearing that as of the date of accident she was in fact facing termination. On March 5, 2015 Petitioner called the office of her primary care physician, Dr. Boyd, seeking cough medication. On March 11, 2013 she called in for a refill of her Norco prescription. Petitioner was first examined in person subsequent to the accident on March 14, 2013. The records show that Dr. Boyd did not record any history of recent injury or any back or neck pain symptoms on that date. Instead, Petitioner complained of gastrointestinal problems and she requested a medical excuse slip for the day.

The records and testimony of Petitioner reveal that Petitioner had a prior work-related injury to her head and neck with a cervical fusion in 2009 and hardware removal surgery in 2010. Petitioner's medical treatment for the prior injury resulted in extensive time off of work. Petitioner was released at maximum medical improvement in August of 2011 and agreed to a settlement of her workers' compensation case. However, the records show that Petitioner

continued to take narcotic pain medication and follow up with Dr. Boyd and her chiropractor, Dr. Eavenson, throughout 2012 for complaints including severe neck and back pain. Petitioner denied that she had been experiencing ongoing neck pain prior to the accident, and we find this denial clearly contradicted by the medical evidence. On April 5, 2013 Petitioner first complained of neck pain following the accident; however Petitioner still did not mention any injury to Dr. Boyd. On April 15, 2013 Petitioner completed additional workers' compensation paperwork for Respondent, indicating that on March 1, 2013 she injured her neck, hip and low back. Dr. Boyd signed the Initial Workers' Compensation Medical Report several days later, explaining Petitioner's condition of "chronic neck pain worsened by conditions at work (job requirements)." Dr. Boyd answered "chronic" where the form requested an accident date. He wrote that Petitioner had pain with lifting or movement of her neck. Dr. Boyd's report does not mention the March 1, 2013 accident.

Petitioner returned to Dr. Boyd on April 23, 2013. Dr. Boyd noted that Petitioner was "basically relating that she would like to be off work indefinitely." He noted that Petitioner did not believe that she was capable of working and complained of severe pain in almost all of her joints. Dr. Boyd suspected that stress was a large part of Petitioner's condition and he recommended a psychological and neurological examination. On the following day, Petitioner saw her chiropractor, Dr. Eavenson. She reported that in March of 2013 she was carrying a stack of dishes when she slipped on a rug and fell to her right side, hitting her shoulder and right hip on the ground. We note that during Petitioner's cross-examination she admitted that she did not actually strike her shoulder. On April 25, 2013 Petitioner was examined by Dr. Gornet, the surgeon who performed her hardware removal. Petitioner reported that she was doing well until she sustained a fall on a wet floor in "mid-March." Dr. Gornet noted that he was dismayed to learn from a narcotics registry that Petitioner had in fact been obtaining substantial amounts of narcotics for "quite some time." Nevertheless, Dr. Gornet accepted Petitioner's history of falling at work and opined that the accident was related to her neck and back complaints. Dr. Gornet was not deposed in this case. We do not find Dr. Gornet's opinion to be reliable or persuasive with respect to the mechanism of injury where it is based on incomplete and misleading history.

We find no credible evidence supporting Petitioner's claim that her current neck and back conditions are in fact related to the accident of March 1, 2013. Petitioner sustained, at most, minimal temporary injuries to her right thumb, knee and hip, for which she sought no medical treatment and lost no time from work. We remand this case to the Arbitrator for a determination of permanent partial disability, if any, with respect to the right thumb, knee and hip.

14IWCC0810

IT IS THEREFORE ORDERED BY THE COMMISSION that the Arbitrator's award of temporary total disability benefits, medical expenses and prospective medical treatment is vacated and this case is remanded to the Arbitrator for a determination of permanent partial disability, if any, with respect to the injury sustained by the Petitioner to the right thumb, knee and hip on March 1, 2013.

DATED: SEP 2 3 2014
RWW/plv
o-7/22/14
46

Ruth W. White

Charles J. DeVriendt

Daniel R. Donohoo

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

TAYLOR, SHANON
Employee/Petitioner

Case# **13WC014057**

ALTON MENTAL HEALTH
Employer/Respondent

14IWCC0810

On 11/25/2013, 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:

4463 GALANTI LAW OFFICE PC
LESLIE COLLINS
PO BOX 99
EAST ALTON, IL 62024

1745 DEPT OF HUMAN SERVICES
BUREAU OF RISK MANAGEMENT
PO BOX 19208
SPRINGFIELD, IL 62794-9208

3291 ASSISTANT ATTORNEY GENERAL
DIANA E WISE
201 W POINTE DR SUITE 7
SWANSEA, IL 62226

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

NOV 25 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)

14IWCC0810

SHANON TAYLOR
Employee/Petitioner

v.

ALTON MENTAL HEALTH
Employer/Respondent

Case # **13** WC **14057**

Consolidated cases: ___

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **GERALD GRANADA**, Arbitrator of the Commission, in the city of **COLLINSVILLE**, on **9/27/13**. 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 ___

14IWCC0810

FINDINGS

On the date of accident, **3/1/13**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$29,458**; the average weekly wage was **$566.51**.

On the date of accident, Petitioner was **46** years of age, ***married*** with 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 $377.67/week for 22 2/7 weeks, commencing 4/25/2013 through 9/27/2013, as provided in Section 8(b) of the Act.

Respondent shall pay reasonable and necessary medical expenses, subject to the fee schedule and in accordance with Sections 8(a) and 8.1 of the Act.

Respondent shall pay for the prospective medical treatment proposed by Dr. Gornet, including, but not limited to the CT Myelogram, all in accordance with the fee schedule.

Penalties and attorneys fees are not awarded 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.

Signature of Arbitrator

11/21/13
Date

ICArbDec19(b)

NOV 25 2013

14IWCC0810

FINDINGS OF FACT

Petitioner, Shanon Taylor, is a 46 year old support service worker at Alton Mental Health. Her job duties include, but are not limited to, sorting and cleaning dishes. Petitioner testified that on March 1, 2013 she was sorting dishes in the wash station when she slipped and sustained injuries. Petitioner testified at trial her back was not hurting prior to coming to work on March 1, 2013. She further testified she had been treated for back pain prior to March 1, 2013 and that she had surgery for a previous work related injury. Specifically, she had a fusion at C6-7 performed by Dr. Gornet. Petitioner testified she was able to work full duty after said procedure was taking pain medications prescribed by her primary care physician to be used in conjunction with her medication for treatment of migraine headaches. Petitioner would see her primary care physician for back spasms relating to her job and he had prescribed pain medicine for that purpose.

Petitioner testified that she was carrying a stack of dishes to be put in a bus tub filled with water. As she leaned toward the bus tub, she slipped on the mat beneath her and fell on her right side hitting her knee, shoulder, and right hip on the ground. She reported the injury to her supervisor and filled out an accident report. She initially did not seek medical assistance, but she testified that her symptoms progressed. After the accident, Petitioner suffered neck pain with stiffness, particularly to the left shoulder and left arm, right shoulder and right arm. She also testified that she suffered low back pain to the right hip and right leg.

Christine Busby, Petitioner's co-worker, witnessed the accident. Ms. Busby filled out a witness report where she stated that she saw Shanon fall at the sink while they were both in the dishwashing area. (See Petitioner's Exhibit 1)

Petitioner first saw Dr. Boyd, her primary care physician, after the accident. She complained of neck pain and tremors during the April 5, 2013 visit. She reported joint pain and continued tremors on April 23, 2013. On May 16, 2013 Dr. Boyd noted that Dr. Gornet had diagnosed Petitioner with herniated discs in her back causing her pain, and exacerbating her tremors.

Petitioner began treatment with Dr. Eavenson on April 24, 2013. Petitioner provided a consistent history to Dr. Eavenson regarding her accident of March 1, 2013 and reported neck pain with radiation into the right upper extremity, low back pain with right lower extremity. Dr. Eavenson diagnosed Cervicalgia with history of fusion, right cervical radiculitis, thoracic pain, lumbar disc protrusion, lumbar radiculitis and possible carpal tunnel. Dr. Eavenson ordered an MRI which was performed on April 25, 2013.

Petitioner was also treated by Dr. Gornet on April 25, 2013. Dr. Gornet had previously treated her in 2010 and performed a spinal fusion to repair a failed fusion at C6-7. She was released back to work full duty with no restrictions, on December 12, 2010 and doing well. Petitioner reported neck pain with stiffness, particularly to the left shoulder and left arm, right shoulder and right arm. Dr. Gornet initially held Petitioner off work. Dr. Gornet reviewed her lumbar MRI scan which showed facet arthropathy on the right L5-S1, which he found to correlate to her symptoms and right buttock pain. Plain radiographs of Petitioner's cervical and lumbar spine were reviewed and showed a loosening of her prosthesis with some changes with bone sliding up into the bone at the C4-5 level, when compared to her previous films of August 8, 2011. Dr. Gornet also noted that her previous pain diagram did not show any significant symptoms in her low back. Dr. Gornet opined that Petitioner's current symptoms are causally connected to her workplace accident. Dr. Gornet ordered injections and conservative treatment. When Petitioner returned to Dr. Gornet on June 24, 2013, she reported having the injections which only provided temporary relief. Dr. Gornet ordered facet rhizotomies, and they provided no

significant relief as reflected in his office note of August 29, 2013. Dr. Gornet has ordered a CT Myleogram for which Petitioner seeks authorization.

Respondent's witness, Linda Marcoot, testified Petitioner came to her after she fell. She testified that Petitioner's knee was red. She further testified that she completed a Review of Incident Form and did not witness Petitioner fall. She mentioned nothing in her Review of Incident Form, completed March 1, 2013 about the condition of the floor. However, Ms. Marcoot testified that when completing her Supervisor Report of Injury and Statement dated April 29, 2013 and April 25, 2013 respectively, she went into great detail reporting that Petitioner reported the floor being flooded on March 1, 2013. This statement was completed after Petitioner filed her claim with Respondent. No evidence introduced at trial suggested Petitioner had an accident after the reported accident of March 1, 2013.

At trial, Petitioner raised the issue of penalties and the intent of filing a Penalties Petition against Respondent for its failure to offer evidence in its possession for the record and consideration by the Arbitrator at trial. Petitioner advised the Arbitrator that a Penalties Petition would be filed.

CONCLUSIONS OF LAW

1. Petitioner suffered a work related accident when she fell on March 1, 2013. No evidence was offered that rebut Petitioner's testimony or the witness statements regarding her fall on March 1, 2013.

2. Petitioner gave proper notice to Respondent when she filled out a short form on March 1, 2013.

3. Petitioner's current condition of ill-being is causally related to her accident of March 1, 2013. Dr. Gornet is Petitioner's treating physician in this case. Dr. Gornet is very familiar with Petitioner and her previous surgery and work injury was he performed a corrective fusion on Petitioner at C6-7. Dr. Gornet opines that Petitioner's current condition of ill-being is directly related to her work accident and is consistent with her testimony at trial lending to her credibility. Dr. Gornet is the only doctor in this case who offers causation. There is no doctor to rebut this causation conclusion by Dr. Gornet.

4. Petitioner was temporarily totally disabled from April 25, 2013 thru September 27, 2013, representing 22 and 2/7 weeks. Respondent shall pay Petitioner TTD benefits in the amount of $8,416.64.

5. Respondent shall pay for all reasonable and necessary medical treatment to date relating to the March 1, 2013 accident together with prospective medical as proposed by Dr. Gornet, including but not limited to, the CT myleogram all in accordance with the fee schedule.

6. Penalties and attorney fees are not awarded in this case as Respondent raised a number of credibility issues during trial. These credibility issues relate to the Petitioner's prior injuries as well as some work-related disciplinary matters, all of which provided Respondent a good-faith basis for its defense of this claim.

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

Howard Shoultz,
Petitioner,
vs.

NO: 09 WC 29043

State of Illinois/ Illinois State University,
Respondent.

14IWCC0811

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, notice, 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.

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 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 23 2014

O: 8/28/14

MB/jm

43

Mario Basurto

David L. Gore

Stephen Mathis

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

SHOULTZ, HOWARD
Employee/Petitioner

Case# **09WC016241**

08WC037782
09WC029043

ILLINOIS STATE UNIVERSITY
Employer/Respondent

14IWCC0811

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:

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

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

4138 ASSISTANT ATTORNEY GENERAL
TERESA OMACHI
500 S SECOND ST
SPRINGFIELD, IL 62706

0903 ILLINOIS STATE UNIVERSITY
JULIE RICH
1320 ENVIRONMTL HEALTH SAFETY
NORMAL, IL 61790

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

MAY 31 2013

KIMBERLY B. JANAS Secretary
Illinois Workers' Compensation Commission

14IWCC0811

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

HOWARD SHOULTZ,
Employee/Petitioner

v.

Case # 09 WC 16241

Consolidated cases: 08 WC 37782 and 09 WC 29043.

STATE OF ILLINOIS/ILLINOIS STATE UNIVERSITY,
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 consolidated with claim nos. 08 WC 37782 and 09 WC 29043 and heard by the Honorable **Joann M. Fratianni**, Arbitrator of the Commission, in the city of **Bloomington**, on **October 12, 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: _____

14IWCC0811

FINDINGS

On **September 25, 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 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 **$32,574.75**; the average weekly wage was **$626.44**.

On the date of alleged accident, Petitioner was **59** years of age, ***married*** with **no** dependent children.

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

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

Respondent shall be given a credit of **$ 0.00** 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 an accidental injury that arose out of and in the course of his employment with Respondent on **September 25, 2008.**

Petitioner further failed to prove that the conditions of ill-being complained of were causally related to any work activities performed on behalf of Respondent as it may pertain to an alleged date of injury of September 25, 2008.

All claims for compensation made by Petitioner in this matter are thus hereby denied.

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

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

Signature of Arbitrator JOANN M. FRATIANNI

May 24, 2013
Date

MAY 31 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 testified that he sustained bilateral repetitive trauma injuries to his hands and wrists on September 25, 2008. This occurred while he was working light duty with a 35 pound lifting restriction from an accidental injury to his left shoulder on Jul 25, 2008 (see findings of this Arbitrator in case no. 08 WC 37782 which was consolidated and heard with this matter).

On September 26, 2008, Petitioner saw Dr. Chow, who imposed a lifting restriction of 25 pounds to the left arm. Petitioner did not report any symptoms to either of his hands under after Dr. Kolb performed surgery to his left shoulder on October 2, 2008 (see findings of this Arbitrator in case no. 08 WC 37782 which was consolidated and heard with this matter). On December 12, 2008, Petitioner complained of pain in his left hand radiating distally to the thumb to Mr. Shaun Rudicil, the physician assistant to Dr. Kolb.

Later, Dr. Kolb performed an EMG/NCV study that was performed on February 3, 2009 by Dr. Pegg. Dr. Pegg noted bilateral median nerve entrapment at the wrists that he described as being moderately severe. Dr. Kolb's office then prescribed wrist braces and would consider surgery if the symptoms did not improve in 4-6 weeks.

Later, Dr. Kolb prescribed and performed surgery for a left carpal tunnel release and a few weeks later, another surgery for right carpal tunnel release. Post surgery, Dr. Kolb prescribed physical therapy.

Petitioner was examined by Dr. Robert Martin at the request of Respondent on June 24, 2009. Dr. Martin reviewed a job description. Dr. Martin diagnosed bilateral carpal tunnel syndrome but indicated that he did not believe that Petitioner performed repetitive work with his hands significant enough to cause these conditions. Dr. Martin also noted that Petitioner was on certain blood pressure medication.

The Arbitrator notes that Petitioner did not complain of left wrist and hand symptoms until December of 2008, or nearly three months after he stopped working no September 25, 2008. No complaints were made of right hand symptoms until even later.

Based upon the above, the Arbitrator finds that Petitioner failed to prove that he sustained an accidental injury through repetitive trauma to his right and left hands in this matter.

Based further upon the above, the Arbitrator finds that Petitioner failed to prove that the conditions of ill-being to the right and left hands were not causally related to any work activities performed on behalf of this Respondent.

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

See findings of this Arbitrator in "C" and "F" above.

Petitioner also filled out a Notice of Injury form on March 30, 2009 claiming repetitive trauma to both hands due to loading cardboard. (Rx3)

14IWCC0811

Based upon the above, the Arbitrator finds that Petitioner more or less gave Respondent notice of an alleged work injury in this matter, as defined by 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?

See findings of this Arbitrator in "C" and "F" above.

See also the findings of this Arbitrator in case no. 08 WC 37782 which was consolidated and heard with this matter.

Based upon said findings, all claims for medical expenses made by Petitioner in this matter are thus 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 claims made by Petitioner in this matter for permanent partial disability benefits are hereby denied.

N. Is Respondent due any credit?

See findings of this Arbitrator in "C" and "F" above.

Based upon said findings, all claims made by Respondent for credit in this matter are hereby denied.

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Howard Shoultz,
Petitioner,
vs.

NO: 09 WC 16241

14IWCC0812

State of Illinois/ Illinois State 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 accident, causal connection, notice, 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.

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 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 2 3 2014

O: 8/28/14

MB/jm

43

Mario Basurto

David L. Gore

Stephen Mathis

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

SHOULTZ, HOWARD
Employee/Petitioner

Case# **09WC016241**

08WC037782
09WC029043

ILLINOIS STATE UNIVERSITY
Employer/Respondent

14IWCC0812

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:

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

0499 DEPT OF CENTRAL MGMT SERVICES
MGR WORKMENS COMP RISK MGMT
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1320 ENVIRONMTL HEALTH SAFETY
NORMAL, IL 61790

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

MAY 31 2013

KIMBERLY B. JANAS Secretary
Illinois Workers' Compensation Commission

14IWCC0812

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

HOWARD SHOULTZ
Employee/Petitioner

v.

STATE OF ILLINOIS/ILLINOIS STATE UNIVERSITY,
Employer/Respondent

Case # 09 WC 16241

Consolidated cases: 08 WC 37782 and 09 WC 29043.

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was consolidated with claim nos. 08 WC 37782 and 09 WC 29043 and heard by the Honorable **Joann M. Fratianni**, Arbitrator of the Commission, in the city of **Bloomington**, on **October 12, 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 14IWCC0812

On **September 25, 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 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 **$32,574.75**; the average weekly wage was **$626.44**.

On the date of alleged accident, Petitioner was **59** years of age, ***married*** with **no** dependent children.

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

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

Respondent shall be given a credit of $ **0.00** 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 an accidental injury that arose out of and in the course of his employment with Respondent on **September 25, 2008.**

Petitioner further failed to prove that the conditions of ill-being complained of were causally related to any work activities performed on behalf of Respondent as it may pertain to an alleged date of injury of September 25, 2008.

All claims for compensation made by Petitioner in this matter are thus hereby denied.

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

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

Signature of Arbitrator **JOANN M. FRATIANNI**

May 24, 2013
Date

MAY 31 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 testified that he sustained bilateral repetitive trauma injuries to his hands and wrists on September 25, 2008. This occurred while he was working light duty with a 35 pound lifting restriction from an accidental injury to his left shoulder on Jul 25, 2008 (see findings of this Arbitrator in case no. 08 WC 37782 which was consolidated and heard with this matter).

On September 26, 2008, Petitioner saw Dr. Chow, who imposed a lifting restriction of 25 pounds to the left arm. Petitioner did not report any symptoms to either of his hands under after Dr. Kolb performed surgery to his left shoulder on October 2, 2008 (see findings of this Arbitrator in case no. 08 WC 37782 which was consolidated and heard with this matter). On December 12, 2008, Petitioner complained of pain in his left hand radiating distally to the thumb to Mr. Shaun Rudicil, the physician assistant to Dr. Kolb.

Later, Dr. Kolb performed an EMG/NCV study that was performed on February 3, 2009 by Dr. Pegg. Dr. Pegg noted bilateral median nerve entrapment at the wrists that he described as being moderately severe. Dr. Kolb's office then prescribed wrist braces and would consider surgery if the symptoms did not improve in 4-6 weeks.

Later, Dr. Kolb prescribed and performed surgery for a left carpal tunnel release and a few weeks later, another surgery for right carpal tunnel release. Post surgery, Dr. Kolb prescribed physical therapy.

Petitioner was examined by Dr. Robert Martin at the request of Respondent on June 24, 2009. Dr. Martin reviewed a job description. Dr. Martin diagnosed bilateral carpal tunnel syndrome but indicated that he did not believe that Petitioner performed repetitive work with his hands significant enough to cause these conditions. Dr. Martin also noted that Petitioner was on certain blood pressure medication.

The Arbitrator notes that Petitioner did not complain of left wrist and hand symptoms until December of 2008, or nearly three months after he stopped working no September 25, 2008. No complaints were made of right hand symptoms until even later.

Based upon the above, the Arbitrator finds that Petitioner failed to prove that he sustained an accidental injury through repetitive trauma to his right and left hands in this matter.

Based further upon the above, the Arbitrator finds that Petitioner failed to prove that the conditions of ill-being to the right and left hands were not causally related to any work activities performed on behalf of this Respondent.

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

See findings of this Arbitrator in "C" and "F" above.

Petitioner also filled out a Notice of Injury form on March 30, 2009 claiming repetitive trauma to both hands due to loading cardboard. (Rx3)

14IWCC0812

Based upon the above, the Arbitrator finds that Petitioner more or less gave Respondent notice of an alleged work injury in this matter, as defined by 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?

See findings of this Arbitrator in "C" and "F" above.

See also the findings of this Arbitrator in case no. 08 WC 37782 which was consolidated and heard with this matter.

Based upon said findings, all claims for medical expenses made by Petitioner in this matter are thus 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 claims made by Petitioner in this matter for permanent partial disability benefits are hereby denied.

N. Is Respondent due any credit?

See findings of this Arbitrator in "C" and "F" above.

Based upon said findings, all claims made by Respondent for credit in this matter are hereby denied.

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Howard Shoultz,
Petitioner,

vs.

NO: 08 WC 37782

14IWCC0813

State of Illinois/ Illinois State University,
Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of causal connect 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 sustained an accidental injury arising out of his employment on July 23, 2008. The Petitioner alleged that he injured his left shoulder and neck as a result of the July 23, 2008 accident. Having reviewed the record, the Commission finds that while Petitioner's left shoulder condition is causally related to the July 23, 2008 work accident, the evidence does not support the fact that Petitioner's neck condition is causally related to the July 23, 2008 work accident. More specifically, the Commission assigns more weight to Dr. Pineda's causal connection opinion than to Dr. Kattner's causal connection opinion. The Commission bases its decision on the following evidence.

The Petitioner testified that at the time of the July 23, 2008 accident he felt and heard his left shoulder pop. At the October 12, 2012 arbitration hearing, Petitioner testified that on July 27, 2008 he did not have pain other than the left shoulder. He never had a whole lot of neck pain. He had some pain but it was mainly in his left shoulder. When he was asked if he recalled having pain in his neck Petitioner answered no, not definitely. Petitioner also testified he was told by his doctor to complete an accident report once he found out that he had neck problems.

On August 29, 2008 Petitioner was seen by Dr. Kolb's physician assistant and when Petitioner was asked if he had neck pain he denied he was experiencing any neck pain and stated

that the majority of the pain was in his left shoulder. In a follow up visit with Dr. Kolb's office on December 12, 2008 it was noted that Petitioner had some tenderness over the cervical spine and pain with active range on motion. A cervical x-ray taken at that time revealed he had diffuse degenerative changes throughout the cervical spine. The cervical x-ray was followed the same day by a cervical MRI that indicated that the C5-6 level had a shallow mixed biformainal protrusion as well as inconvertebral hypertrophic degenerative changes and facet arthropathy contributing to mild canal stenosis and an abutment of the ventral dorsal portion of the cord as well as an abutment of bilateral exiting C6 nerves. After Petitioner complained of pain in his neck that was radiating down into two fingers of his left hand, an EMG/NCV was performed on February 3, 2009 and it showed no evidence of cervical radiculopathy. The following month Petitioner was given an injection into his neck and it was reported that he had little relief.

Dr. Kattner, a board certified neurological surgeon, was deposed on November 22, 2010. He first saw Petitioner on July 16, 2009. At that time Petitioner only gave him a history of experiencing left shoulder and arm pain after the July 23, 2008 accident which occurred when he was loading cardboard onto a truck. On July 28, 2009, Dr. Kattner issued a letter to Petitioner's attorney in which he stated that from a causation standpoint Petitioner likely had foraminal stenosis that is pre-existing but was aggravated when he moved the cardboard on the truck. Dr. Kattner noted that Petitioner's cervical MRI showed a lot of bony spurring that occurred in the neck at C4-5 and C5-6. He ordered a cervical myelogram which showed a disc at C4-5 on the left side as well as bony spurring in the foramens/nerve canal at C5-6 on both sides. Dr. Kattner opined that the C4-5 level can enervate the shoulder area. If a person is complaining of shoulder pain it could or might indicate that they have a disc problem at C4-5. He stated that sometimes it gets very confusing as to what's coming from the shoulder and what's coming from a pinched nerve at that level. He was treating the two cervical levels because Petitioner had a generalized weakness in his arm with the majority of the pain overlying the shoulder region. With a decreased grip strength, Dr. Kattner noted that it can result from a lower nerve such as C5-6. On December 5, 2009 Petitioner underwent surgery where he removed the discs at C4-5 and C5-6, freed up the nerve canals and put pieces of allograft or cadaver bone in those levels followed by a plate on the front of the vertebral bodies. Dr. Kattner noted that he did not find a herniated disc at C4-5. All he found was narrowing bony spurs at C4-5 and C5-6. He last saw Petitioner on June 10, 2010 at which time Petitioner reported he was still experiencing left arm pain. Dr. Kattner opined that this was residual radiculopathy from his compressed nerves. Dr. Kattner opined that Petitioner probably had those cervical spurs before the injury but his injury resulted in his condition of ill-being, necessitating his treatment he had afterwards. The surgery was reasonable because he had weakness and intractable pain. He had severe nerve compression from his bony spurs. Dr. Kattner testified that it is not uncommon for people to have a missed diagnosis between shoulder pathology and C4, C5 radiculopathies. Dr. Kattner testified that he would not say that Petitioner has classic symptoms of cervical radiculopathy. Rather, he had a more generalized pain that was going over his shoulder and he had weakness in his grip strength Dr. Kittner testified that was possible Petitioner could have gone on to develop radiculopathy without a traumatic event. His cervical spondylosis or his arthritis in his neck is part of the normal aging process.

Dr. Pineda a board certified orthopedic surgeon, testified he evaluated Petitioner on March 22, 2010. Upon reviewing Petitioner's cervical films he thought he had some disc disease

or bulges at C4-5 and C5-6 along with some foraminal narrowing at C5-6. Petitioner did not give a history of developing pain in the neck as a result of the July 23, 2008 work accident. Dr. Pineda diagnosed Petitioner as having degenerative disc disease at C4-5 and C5-6 and he opined that the degenerative disc disease predated July 23, 2008. Dr. Pineda opined that Petitioner's cervical pain did not develop immediately after the July 23, 2008 work accident. He based his opinion on Petitioner's medical records, the doctors' notes, his own notes as well as the EMG which showed no radiculopathy. Dr. Pineda stated that to the extent there was a neck problem, it would have developed downstream. He testified that his causation opinion was based on four factors. One, Petitioner was examined roughly a month after the July 23, 2008 accident and he gave no report neck pain. Dr. Pineda testified that secondly as long as an EMG was done three weeks later one would have radicular pain and Petitioner did not have radiculopathy. Three, his pain was always focused on the shoulder. Four, Petitioner did not he get better after the cervical surgery.

Having reviewed the medical records and comparing the same to the doctors' opinions, the Commission finds that Dr. Kattner presented a position that is without support from the medical documentation or Petitioner's testimony. It appears that Dr. Kattner's causation opinion is speculative at best. Petitioner testified that after the onset of the injury he did not have neck pain and the medical records show that Petitioner was not complaining of neck pain and was only complaining of left shoulder pain. Additionally the EMG showed that there was no cervical radiculopathy. Dr. Kattner testified that he performed the cervical surgery as a result of Petitioner's pain complaints and based on Petitioner's history. However, Petitioner's testimony and the medical histories do not support a finding that Petitioner was having neck pain. The doctors all agree that ultimately upon testing Petitioner was found to have at least two levels of degenerative disc disease that predated the July 23, 2008 work accident. It is evident that Dr. Kattner in his deposition shows he did not have a good understanding of Petitioner's job tasks. Yet, he opines that Petitioner's pre-existing cervical condition was aggravated by the July 23, 2008 work accident. The Commission finds based on the above that Dr. Kattner's causation opinion is based on speculation and not supported by either Petitioner's testimony or the medical records.

Conversely, Dr. Pineda finds that there is not a causal relationship between Petitioner's cervical condition and the July 23, 2008 work accident. He provided four bases in which to support his opinion. One, being that after the accident Petitioner did not express any neck pains. Two, his EMG showed there was no radiculopathy attributed to Petitioner's cervical area. Three, Petitioner's pain was always focused on the left shoulder and four, even after the cervical surgery Petitioner indicated his condition didn't get any better and he was still having the same problems. As such the Commission assigns more weight to Dr. Pineda's than to Dr. Kattner's causal connection opinion and reverses the Arbitrator's finding that Petitioner's cervical condition is causally related.

The Commission notes that when the medical amounts listed in the Arbitrator's decision totals $222,285.70 and not $151,275.81 as indicated by the Arbitrator. Petitioner submitted PX16 as a total of the medical bills that are outstanding and it shows a total of $217,045.45. The difference appears to be Applied Pain Institute bill which Arbitrator listed as $10,155.16 and PX16 listed as $4,915.00. A review of the medical bills appears to show that they relate both to

14IWCC0813

the left shoulder and cervical areas. Additionally, the Arbitrator found that the parties did not indicate what was paid by Petitioner's group health insurance and what was paid by the workers' compensation carrier. Based on the above, the Commission corrects the Arbitrator's total and awards all medical expenses attributed to the left shoulder subjected to 8.2 of the Act.

Based on its causation finding above, the Commission finds that only Petitioner's left shoulder condition is causally related to the July 23, 2008 work accident. The evidence further demonstrates that while Petitioner expresses ongoing left shoulder complaints he last treated for his left shoulder on February 13, 2009, which is approximately four months after his October 2, 2008 left shoulder surgery. As such the Commission finds that temporary total disability benefits ended on February 13, 2009 when Petitioner last treated for his left shoulder condition with Dr. Kolb. The Commission award temporary total disability benefits from September 26, 2008 through February 13, 2009 for a total of 20-1/7 weeks under Section 8(b) of the Act.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $414.50 per week for a period of 20-1/7 weeks, that being the period of temporary total incapacity for work under §8(b) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner all medical expenses attributed to the left shoulder subjected to §8(a) and §8.2 of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that commencing on March 10, 2010, Respondent pay to Petitioner the sum of $183.58 per week for the duration of his disability, as provided in §8(d)1 of the Act, for the reason that the injuries sustained permanently incapacitate him from pursuing the duties of his usual and customary line of employment.

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 2 3 2014

O: 8/28/14

MB/jm

43

Mario Basurto

David L. Gore

Stephen Mathis

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

SHOULTZ, HOWARD
Employee/Petitioner

Case# **08WC037782**

09WC016241
09WC029043

ILLINOIS STATE UNIVERSITY
Employer/Respondent

14IWCC0813

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:

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

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

4138 ASSISTANT ATTORNEY GENERAL
TERESA OMACHI
500 S SECOND ST
SPRINGFIELD, IL 62706

0903 ILLINOIS STATE UNIVERSITY
JULIE RICH
1320 ENVIRONMTL HEALTH SAFETY
NORMAL, IL 61790

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

MAY 31 2013

KIMBERLY B. JANAS Secretary
Illinois Workers' Compensation Commission

14IWCC0813

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

HOWARD SHOULTZ,
Employee/Petitioner

v.

Case # 08 WC 37782

Consolidated cases: 09 WC 16241 and 09 WC 29043.

STATE OF ILLINOIS/ILLINOIS STATE UNIVERSITY,
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 consolidated with claim nos. 09 WC 16241 and 09 WC 29043 and heard by the Honorable **Joann M. Fratianni**, Arbitrator of the Commission, in the city of **Bloomington**, on **October 12, 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: _____

14IWCC0813

FINDINGS

On **July 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 **$32,331.00**; the average weekly wage was **$621.75**.

On the date of accident, Petitioner was **59** years of age, *married* with **no** dependent children.

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

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

Respondent shall be given a credit of **$20,311.04** for TTD, **$ 0.00** for TPD, **$ 0.00** for maintenance, and **$54,100.89** for other SURS benefits, for a total credit of **$74,411.93**.

Respondent is entitled to a credit of **$42,511.49** under Section 8(j) of the Act.

ORDER

Respondent shall pay Petitioner temporary total disability benefits of **$414.50**/week for **75-4/7** weeks, commencing **September 26, 2008** through **March 9, 2010**, as provided in Section 8(b) of the Act.

Commencing **March 10, 2010**, the respondent shall pay the petitioner the sum of **$183.58**/week for the duration of his disability, as provided in Section **8(d)1** of the Act, because the injuries sustained caused **a loss of earnings rendering him to become permanently partially incapacitated from pursuing his usual and customary employment**.

Respondent shall pay to Petitioner reasonable and necessary medical services, pursuant to the medical fee schedule, of **$24,800.00** to **Central Illinois Neurohealth Sciences, $46,209.89** to **Ireland Grove Center for , $2,612.12** to **Ambulatory Anesthesiology, $10,155.16** to **Applied Pain Institute, $3,153.65** to **OSF Occupational Health, $34,416.88** to **Orthopedic & Sports Medicine Center, $2,336.45** to **Dr. Edward Pegg, $1,949.00** to **Fort Jesse Imaging, $183.00** to **Diagnostic Technologies, $87,230.55** to **OSF St. Joseph Medical Center, $7,889.00** to **Eastland Medical Plaza Surgicenter**, and **$1,350.00** to **McLean County Anesthesiology**, as provided in Sections 8(a) and 8.2 of the Act.

Respondent shall be given a credit for all medical bills listed above that may have been previously paid by them. Respondent shall be further given a credit of **$42,511.49** for medical charges or benefits that have been paid by group health insurance and Respondent shall hold Petitioner safe and harmless from any claims by any providers of the service 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 **JOANN M. FRATIANNI**

May 24, 2013
Date

MAY 31 2013

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

Petitioner was engaged in picking up recyclables for Respondent. His job duties included loading cardboard into trucks and driving the trucks. On July 23, 2008, while loading cardboard boxes, Petitioner lifted and threw one box over his head into the truck, and then experienced left shoulder pain. These were compressed cardboard boxes that were in 4 foot by 8 foot sheets that weighed approximately 30-40 pounds.

Prior to this accident, Petitioner did not experience any symptoms to his left shoulder or neck, nor did he ever undergo medical treatment for same.

Following this accident, Petitioner sought treatment at OSF Occupational Health, where he came under the care of Dr. Mary Yee Chow on July 25, 2008. Dr. Chow recorded a history of injury similar to Petitioner's testimony and noted complaints to the left shoulder. Examination revealed tenderness in the left superior aspect with a small palpable bump adjacent to the bicep, along with a positive Hawkins and empty can test. Dr. Chow prescribed an MRI. (Px9) Petitioner returned to see Dr. Chow on August 4, 2008. Dr. Chow noted limited range of motion with pain and prescribed medical work restrictions and physical therapy. When seen on August 18, 2008, Petitioner was referred to Dr. Kolb, an orthopedic surgeon. (Px9)

Petitioner saw Dr. Kolb on August 19, 2008. Dr. Kolb reviewed the MRI and felt it revealed mild degenerative changes at the AC joint. Examination revealed limited range of motion with pain, loss of strength, and positive Neer's, empty can and speeds testing. Dr. Kolb administered a steroid injection to the left shoulder. (Px10) Petitioner returned to see Dr. Kolb on September 16, 2008 and reported difficulty sleeping. Dr. Kolb following examination prescribed surgery.

On October 2, 2008, Dr. Kolb performed surgery in the form of a left shoulder arthroscopy with debridement of torn labrum, decompression of the left shoulder and open biceps tenodesis. Noted during surgery was fraying in the anterior and superior labral tissues and in the glenoid. (Px7)

Post surgery, Petitioner was prescribed physical therapy and limited lifting involving the left arm. On November 14, 2008, Dr. Kolb restricted Petitioner to no lifting over 20 pounds and limited overhead activity. By December 12, 2008, Dr. Kolb found pain radiating distally to the radial aspect of the left hand. Dr. Kolb prescribed an MRI of the cervical spine.

Following the MRI, Petitioner returned to see Dr. Kolb on December 19, 2008, who felt it revealed spinal stenosis at C5-C6 with abutment of the bilateral C6 nerve root. Dr. Kolb referred Petitioner to see Dr. Ji Li. (Px10)

Petitioner saw Dr. Li on January 15, 2009, who diagnosed cervical radiculopathy. On January 23, 2009, Dr. Li performed a cervical epidural steroid injection. A second injection was performed on March 13, 2009. On March 16, 2009, Dr. Li felt that Petitioner was unable to perform any work and continued to keep him off of work through July 16, 2009. (Px16)

Petitioner on July 16, 2009 was examined by Dr. Kattner. Dr. Kattner noted left upper extremity pain and weakness, especially with gripping. Dr. Kattner prescribed a myelogram with a post-myelogram CT scan. (P13) In a report dated July 28, 2009, Dr. Kattner noted the symptoms commenced in July of 2008 when loading cardboard into a truck and experiencing sharp pain down his left arm. Examination revealed substantial weakness in the left arm. Dr. Kattner felt the cervical MRI revealed foraminal stenosis at C4-C5 and C5-C6. Dr. Kattner felt that Petitioner likely has foraminal stenosis that was pre-existing but aggravated when he moved the cardboard into the truck. (Px13)

Petitioner returned to see Dr. Kattner on October 15, 2009. Dr. Kattner again prescribed a myelogram and post-myelogram CT scan. Following these tests, Dr. Kattner on November 3, 2009 diagnosed a disc protrusion in the foramen at C4-C5 along with bilateral foraminal stenosis at C5-C6. Dr. Kattner prescribed a C4-C5 and C5-C6 cervical fusion. (Px13)

Petitioner underwent surgery with Dr. Kattner on November 13, 2009 in the form of an anterior cervical discectomy and fusion at C4-C5 and C5-C6. (Px8)

Post surgery, Petitioner remained under the care of Dr. Kattner, who prescribed physical therapy. Dr. Kattner prescribed a functional capacity evaluation on February 8, 2010, and on March 4, 2010, Dr. Kattner felt that Petitioner would be unable to return to work with his restrictions of no overhead lifting and no lifting above 20 pounds. The FCE was never authorized by Respondent.

On January 4, 2010, Petitioner saw Dr. Li who noted radiation to the left arm with hypersensitivity, aching and burning.

Dr. Kolb authored a report dated January 29, 2010 in which he felt the need for surgery was related to the work incident of July 23, 2008. (Px2) Dr. Kattner authored a report dated March 4, 2010 in which he felt Petitioner was totally and permanently disabled with shoulder pathology that inhibits his ability to perform the type of work he previously performed. (Px4)

Dr. Kattner testified by evidence deposition (Px1) that he is a board certified neurosurgeon. Dr. Kattner testified the myelogram revealed disc protrusion at C4-C5 on the left with bony spurring at the foramens at C5-C6 bilaterally. Dr. Kattner testified the level of C4-C5 enervates the shoulder area, and complaints of shoulder pain may be a sign of a disc problem. Dr. Kattner testified Petitioner has a permanent plate at the fusion site of the cervical spine that causes a limitation of neck motion in flexion and extension. Dr. Kattner testified that Petitioner would have difficulty in using his left arm at work and would be unable to perform any type of heavy manual labor. At best he could perform some sedentary work. Dr. Kattner diagnosed cervical radiculopathy of the left upper extremity at C5 and possibly C6. Dr. Kattner felt spinal surgery was necessary due to weakness and intractable arm pain. During surgery he noted severe nerve compression. Dr. Kattner felt that Petitioner could at best lift 30 pounds repetitively and 50 pounds once in a while.

Petitioner was examined by Dr. Pineda on behalf of Respondent. Dr. Pineda noted limited flexion of the arm and neck which he felt was permanent with tenderness in the AC joint. Dr. Pineda testified by evidence deposition that he felt that someone with a two level cervical fusion should not participate in contact sports, should not lift more than 40-50 pounds over shoulder level and avoid head whipping type movements. Dr. Pineda testified that Petitioner's accidental injury could or might aggravate the condition as diagnosed by Dr. Kolb. Dr. Pineda felt that Petitioner was doing well from a cervical point of view but not with the left shoulder. Dr. Pineda agreed with Dr. Kattner that someone could have radicular type of pain from C5 without experiencing neck pain.

Petitioner testified that prior to this accident he did not experience symptoms to his neck or left shoulder.

Based upon the above, the Arbitrator finds that a causal connection exists between the left shoulder and cervical spine conditions as diagnosed above, and the accidental injury of July 23, 2008 accidental injury at work.

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?

Petitioner incurred the following medical charges after this accidental injury:

Central Illinois Neurohealth Sciences	$24,800.00
Ireland Grove Center for Surgery	$46,209.89
Ambulatory Anesthesiology	$ 2,612.12
Applied Pain Institute	$10,155.16
OSF Occupational Health	$ 3,153.65
Orthopedic & Sports Medicine Center	$34,416.88
Dr. Edward Pegg	$ 2,336.45
Fort Jesse Imaging	$ 1,949.00
Diagnostic Technologies	$ 183.00
OSF St. Joseph Medical Center	$87,230.55
Eastland Medical Plaza Surgical Center	$ 7,889.00
McLean County Anesthesiology	$ 1,350.00

These charges total $151,275.81.

The parties are unsure as to which medical charges are outstanding and which charges were paid by either Respondent's group health insurance carrier and/or workers' compensation fund.

In addition, all charges noted above that may pertain to treatment for bilateral carpal tunnel syndrome are hereby denied. See findings of this Arbitrator in case no. 09 WC 16241 and 09 WC 29043, which were consolidated and heard with this matter.

See also findings of this Arbitrator in "F" above.

Based upon said findings, Respondent is found to be liable to Petitioner for the above medical charges that total $151,275.81, excluding the carpal tunnel syndrome treatment charges. The parties shall have the responsibility for determining which of the above charges pertain to the bilateral carpal tunnel syndrome treatment, which charges that do not pertain to such treatment remain outstanding and which of those charges were previously paid as the Arbitrator is completely unable to render such a determination or findings from the evidence presented by both parties.

K. What temporary benefits are in dispute?

See findings of this Arbitrator in "J" above.

Based upon said findings, the Arbitrator further finds that as a result of this accidental injury, Petitioner became temporarily and totally disabled from work commencing September 26, 2008 through March 9, 2010, and is entitled to receive compensation from Respondent for this period of time.

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

Petitioner claims he is entitled to receive a wage differential award pursuant to Section 8(d)1.

Dr. Kattner testified by evidence deposition that Petitioner is medically limited from performing his previously work for Respondent, and can lift at best 30 pounds on a repetitive basis and 50 pounds occasionally with no overhead work. Dr. Pineda testified that Petitioner can lift 40-50 pounds but without overhead lifting, pushing or pulling.

Respondent has not accommodated those work restrictions. A job description in evidence (Rx10) reflects that Petitioner would be required to lift between 50-70 pounds twice daily and reach above shoulder level for up to two hours a day.

Mr. Dennis Gustafson testified on behalf of Petitioner. Mr. Gustafson testified he is a certified rehabilitation counselor with 38 years experience in the field. He holds a masters of science degree. Mr. Gustafson testified he met with Petitioner on July 15, 2011, and recorded his work and educational history. Dr. Gustafson concluded that Petitioner would not be able to perform his usual work for Respondent and ruled out other occupations such as delivery truck driver work due to overhead lifting.

Mr. Gustafson felt that Petitioner may be able to perform some industrial work including light assembly or inspection tasks which would be from the minimum wage up to $10.00 an hour. He did not note any restrictions as to the number of hours worked. He noted Petitioner graduated high school in 1968 with one year of experience in the Navy. Later, Petitioner worked as buffer for Eureka Williams Company, as a section gain number for a railroad, as a machine operator for General Electric, and as a tool grinder for Caterpillar. He also worked truck route deliveries for 11 years. He has been employed with Respondent since 2002.

The Arbitrator find that Petitioner has met his burden of proof that he is entitled to an award pursuant to Section 8(d)1, and that he is not capable of returning to his usual and customary work for Respondent. Petitioner was earning $621.75 per week for Respondent at the time of his injury and the current union rate of pay for his former job is $18.01 per hour, for a 37.5 workweek, or a weekly salary of $675.37. Based upon the average wages of $360.00 per week he is currently earning, this results in a wage differential rate of $183.58 per week.

N. Is Respondent due any credit?

See findings of this Arbitrator in "J" above.

Respondent is entitled to receive a credit for the medical charges it may previously paid or which were paid by group health insurance. Respondent shall be given a credit of $42,511.49 for medical charges paid by its group health insurance carrier and shall hold Petitioner safe and harmless from all attempts at reimburments of such payments in accordance with Section 8(j) of the Act. The parties are charged with determining such payments and credits as based on the evidence submitted, the Arbitrator is unable to render any specific findings or determinations of the individual charges, other than the total gross payment figure provided.

STATE OF ILLINOIS)
) SS.
COUNTY OF PEORIA)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Tammy Gravitt,

Petitioner,

vs.

NO: 10 WC 39154

14IWCC0814

PETCO,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner and Respondent herein and notice given to all parties, the Commission, after considering the issues of causal connection, reasonableness and necessity of medical expenses, penalties, attorneys' fees and interest under §8.2(d)(3) and being advised of the facts and law, clarifies the Decision of the Arbitrator as stated below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

The Commission notes that on the face sheet of her Decision, the Arbitrator gave credit of $1,839.00 to Respondent for TTD benefits paid and gave Respondent §8(j) credit of $6,780.53 for group health insurance payments. However, the Arbitrator then on the face sheet gave Respondent §8(j) of $8,619.53, which is an error as this amount is a total of the prior §8(j) credit to Respondent of $6,780.53 and the general credit of $1,839.00. The Commission clarifies the face sheet of the Arbitrator's Decision to state that Respondent is entitled to §8(j) credit of $6,780.53 for group health insurance payments and a general credit of $1,839.00 for TTD payments made. The Commission also clarifies the face sheet to state that Petitioner sustained repetitive trauma accidental injuries arising out of and in the course of her employment manifesting on September 7, 2010. The Commission otherwise affirms and adopts the Decision of the Arbitrator.

14IWCC0814

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed January 27, 2014 is hereby affirmed and adopted with the above noted clarifications.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $245.33 per week for a period of 46-4/7 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 shall pay to Petitioner the sum of $188,284.27 for medical expenses 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 pay to Petitioner the sum of $245.33 per week for a period of 30.75 weeks, as provided in §8(e) of the Act, for the reason that the injuries sustained caused the permanent loss of use of her right hand to the extent of 15%.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $245.33 per week for a period of 30.75 weeks, as provided in §8(e) of the Act, for the reason that the injuries sustained caused the permanent loss of use of her left hand to the extent of 15%.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $245.33 per week for a period of 37.95 weeks, as provided in §8(e) of the Act, for the reason that the injuries sustained caused the permanent loss of use of her right arm to the extent of 15%.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $245.33 per week for a period of 37.95 weeks, as provided in §8(e) of the Act, for the reason that the injuries sustained caused the permanent loss of use of her left arm to the extent of 15%

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent is entitled to a credit in the amount of $6,780.53 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 $1,839.00 in TTD benefits.

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

14IWCC0814

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $75,000.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: SEP 2 3 2014
MB/maw
o08/28/14
43

Mario Basurto

Stephen J. Mathis

David L. Gore

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

GRAVITT, TAMMY
Employee/Petitioner

Case# **10WC039154**

14IWCC0814

PETCO
Employer/Respondent

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

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

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

1824 STRONG LAW OFFICES
TODD A STRONG
3100 N KNOXVILLE AVE
PEORIA, IL 61603

0980 HASSELBERG WILLIAMS ET AL
BOYD ROBERTS
124 S W ADAMS ST SUITE 360
PEORIA, IL 61602-2321

14IWCC0814

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

TAMMY GRAVITT,
Employee/Petitioner

v.

PETCO,
Employer/Respondent

Case # 10 WC 39154

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 **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: Is Petitioner entitled to interest under Section 8.2(d)(3) of the Act?

FINDINGS

On **September 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*** 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 **$15,688.90**; the average weekly wage was **$301.71**.

On the date of accident, Petitioner was **38** years of age, ***single*** with **one** dependent child.

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 $ **1,839.00** for TTD, $ **0.00** for TPD, $ **0.00** for maintenance, and $ **0.00** for other benefits in the form of short term disability benefits, for a total credit of $ **1,839.00**.

Respondent is entitled to a credit of $ **8,619.53** under Section 8(j) of the Act.

ORDER

Respondent shall pay Petitioner temporary total disability benefits of **$245.33**/week **46-4/7** weeks, commencing **November 6, 2010** through **February 23, 2011,** and again commencing **February 7, 2012** through **September 19, 2012,** as provided in Section 8(b) of the Act.

Respondent shall pay Petitioner permanent partial disability benefits of **$245.33**/week for **30.75** weeks, because the injuries sustained caused the **15%** loss to her **right hand,** as provided in Section 8(e) of the Act.

Respondent shall pay Petitioner permanent partial disability benefits of **$245.33**/week for **30.75** weeks, because the injuries sustained caused the **15%** loss to her **left hand,** as provided in Section 8(e) of the Act.

Respondent shall pay Petitioner permanent partial disability benefits of **$245.33**/week for **37.95** weeks, because the injuries sustained caused the **15%** loss to her **right arm,** as provided in Section 8(e) of the Act.

Respondent shall pay Petitioner permanent partial disability benefits of **$245.33**/week for **37.95** weeks, because the injuries sustained caused the **15%** loss to her **left arm,** as provided in Section 8(e) of the Act.

Respondent shall pay to Petitioner reasonable and necessary medical services of **$188,284.27**, pursuant to Section 8(a) of the Act, and subject to the medical fee schedule as created by Section 8.2 of the Act.

Respondent shall also hold Petitioner safe and harmless at all attempts at reimbursement of the medical charges that were paid by Respondent's group health insurance company in the amount of **$6,780.53** pursuant to 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.

JOANN M. FRATIANNI
Signature of Arbitrator

January 17, 2014
Date

JAN 27 2014

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

Petitioner testified that on September 7, 2010, she worked for Respondent as a dog groomer. Petitioner is now 40 years of age with an 11th grade education, and is right hand dominant.

On November 6, 2010, Petitioner underwent a right carpal tunnel and cubital tunnel surgical release with Dr. Rhode. On February 7, 2012, Petitioner underwent a left carpal tunnel and cubital tunnel surgical release with Dr. Rhode. In the interim between surgeries and following her release from her first surgery, Petitioner returned to full duty work for Respondent as a dog groomer. Following her second surgery, Petitioner developed a post-operative infection and was treated through an irrigation and debridement with Dr. Rashid.

On August 7, 2012, Petitioner underwent a functional capacity evaluation (FCE). The FCE revealed decreased bilateral upper extremity strength, and that she was capable of working at the light physical demand level, consistent with her dog grooming position. Dr. Rhode last saw Petitioner on September 19, 2012. At that time he released her to return to work and from any further medical care. Dr. Rhode testified by evidence deposition that he agreed with the results of the FCE.

On January 22, 2013, Petitioner was examined by Dr. Gregory Brown. This was at the request of Respondent. Dr. Brown in his report indicated that Petitioner reported no physical limitations during the examination, and the symptoms had resolved. Petitioner reported new symptoms in both upper extremities, which she blamed resulted from the surgeries performed by Dr. Rhode. She also reported that she wished she never had the surgeries performed in the first place. Dr. Brown felt there was no objective or functional reason why she could not return to work and felt any subjective complaints would resolve over time.

Dr. Rhode testified that it was also possible that the symptoms would continue to improve over time and resolve completely. Dr. Rhode also testified a more recent physical exam is a better judge of an injured worker's current capabilities, functionality and strength than one performed several months earlier.

Petitioner testified at the hearing she generally feels fine and has occasional symptoms of pain with certain activities. She is no longer working but serves as a caregiver to a family member. Petitioner testified she would be looking for a job but for her caregiver status, and feels capable of working with no restrictions or limitations.

Based upon the above, the Arbitrator finds the conditions of ill-being as diagnosed and treated to be now permanent in nature.

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

Petitioner introduced into evidence the following medical expenses that were incurred as a result of this accidental injury:

Ambrose Group	$ 1,594.58
Dr. William Crevier	$ 426.47
Memorial Medical Center	$ 1,389.00
Methodist Medical Center	$34,293.58
Orland Park Orthopedics	$86,832.86

Bob Rady, Inc.	$ 5,080.00
Dr. Jonathon Renkas	$ 9,096.98
South Chicago Surgical Solution	$45,590.80
Dr. Edward Trudeau	$ 3,980.00

These charges total $188,284.27.

See findings of this Arbitrator in "L" above.

Based upon said findings, the Arbitrator further finds the above charges represent reasonable and necessary medical are and treatment designed to cure or relieve the conditions of ill-being caused by this accidental injury, and further finds Respondent to be liable to Petitioner for same, subject to the provisions of the medical fee schedule as created by the Act.

K. What temporary benefits are in dispute?

See findings of this Arbitrator in "L" above.

Petitioner underwent surgery to her right carpal and cubital tunnel syndrome with Dr. Rhode, and was off of work commencing November 6, 2010, the date of her first surgery, through February 23, 2011, when she was released to return to modified work by her surgeon.

Petitioner then worked full time for Respondent until her next surgery.

On February 7, 2012, Petitioner lost time from work when she underwent her left carpal and cubital tunnel syndrome surgery with Dr. Rhode. She remained off work until September 19, 2012. On that date she was released from the care of Dr. Rhode.

Based upon the above, the Arbitrator finds that as a result of this accidental injury, Petitioner became temporarily and totally disabled from work commencing November 6, 2010 through February 23, 2011, and again commencing February 7, 2012 through September 19, 2012, and is entitled to receive compensation from Respondents for these periods of time.

M. Should penalties or fees be imposed upon Respondent?

It is the burden of Petitioner to prove that Respondent was unreasonable or vexatious in delaying payment of benefits under the Act. Petitioner must show evidence she specifically requested or demanded that Respondent pay benefits, and must prove Respondent has no basis for not paying such benefits or delayed payment of it.

Petitioner did not specify which medical charges she is seeking penalties and fees for non-payment or delay in payment. No written demand was introduced into evidence.

Based upon the above, the Arbitrator finds that the claims for penalties and fees made by Petitioner in this matter are thus hereby denied.

N. Is Respondent due any credit?

The parties in the Request for Hearing or Stipulation sheet stipulated that Respondent is not entitled to credit for medical bills. Evidence was produced that Respondent in fact paid $6,780.50 in such charges for which it is entitled to credit.

The parties also stipulated that Petitioner received the sum of $1,839.00 in temporary total disability benefits. Respondent is entitled to credit for such payments as against the award of temporary total disability benefits.

O. Is Petitioner entitled to interest under Section 8.2(d)(3) of the Act?

Section 8.2(d)(3) provides for interest for non-payment or late payment of medical bills incurred for compensable injuries and treatment of it. The Act also provides that the provider or Petitioner submit medical bills with certain information and coding so that they may be processed.

Petitioner failed to prove that she met the requirements of the Act concerning this issue.

All claims for such interest in this matter are thus hereby denied.

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

Steven Schuck,
Petitioner,

vs.

NO: 11 WC 46601

Securitas Security Services, USA,
Respondent,

14IWCC0815

DECISION AND OPINION ON REVIEW

Respondent appeals the decision of Arbitrator Zanotti finding Petitioner sustained an accidental injury arising out of and in the course of his employment on February 14, 2011. As a result Petitioner was temporarily totally disabled from October 1, 2012 through October 21, 2013 for 55-1/7 weeks under Section 19(b) of the Act, is entitled to the medical expenses set forth in Petitioner's PX15 and modified by Respondent's RX9 pursuant to Sections 8(a) and 8.2 of the Act and is entitled to $2,780.25 for out-of-pocket medical expenses. In addition, Respondent is ordered to pay for the functional capacity evaluation recommended by Dr. Idusuyi. Respondent is credited with $31,689.93 for payment of temporary total disability benefits. Per the agreement of the parties, the $6,651.71 permanent disability advance is not being credited at this time and the credit is being held in abeyance. The Issues on Review are whether a causal relationship exists between Petitioner's present condition of ill-being and the February 14, 2011 work accident and/or need for current or prospective medical expenses , and if so, the extent of Petitioner's temporary total disability. After reviewing the entire record, the Commission affirms the Arbitrator's conclusion as to causation and further expands on the same. The Commission additionally 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

The Commission finds:

1. Petitioner, a 52 year old armed security guard, sustained an accident on February 14, 2011 when he was on patrol. Petitioner testified he was walking between buildings and fell on a snow drift. His right foot twisted but his boot did not move.

2. Two days later Petitioner sought treatment at Memorial Medical Center's Emergency Room where right foot x-rays were taken and he was diagnosed with a non-displaced fracture at the base of fifth metatarsal.

3. On April 11, 2011 Petitioner was seen at SIU Health Care by Dr. Moore, an assistant professor of vascular surgery. The doctor noted that Petitioner sustained a closed Jones fracture of his right fifth metatarsal. He has been in a cast for several weeks and at a recent evaluation we felt he is developing a non-union with sclerosis of the fracture ends. Petitioner had been previously diagnosed with Buerger's disease in his right lower extremity. He was advised to seek an evaluation of his lower extremity peripheral vascular disease and to stop smoking. He has some symptoms of claudication prior to his injury. We discussed the potential etiologies of his decreased pulses in the right lower extremity and we discussed his treatment options which are to proceed with angiography with possible intervention or having a duplex ultrasound of the aorta/iliac system and right lower extremity. At this time, Petitioner has opted for the non-invasive scan.

4. On June 28, 2011 Petitioner was seen at SIU Health Care. He reported that he has smoked one pack of cigarettes a day and has smoked for forty years. Currently, Petitioner has a known occlusion of the distal right superficial femoral artery which is preventing normalization of blood flow, but he appears to have adequate perfusion to support wound healing at this time.

5. On September 27, 2011 Dr. Moore noted that the ultrasound demonstrated an acute deep venous thrombosis in the right popliteal, posterior tibial and peroneal veins. Likely etiologies for deep vein thrombosis include prolong immobilization and trauma as well as calf muscle pump dysfunction.

6. On October 6, 2011, Petitioner underwent surgery consisting of an open reduction, internal fixation of the right fifth metatarsal fracture with an iliac crest bone graft.

7. On November 8, 2001, Petitioner began seeing Dr. Idusuyi after he began experiencing pain and redness at the surgical site. He reported that his incision has been draining for approximately two to three weeks. The doctor opined that Petitioner's surgical site was

infected. On November 9, 2011, Petitioner underwent a surgical procedure consisting of an excisional debridement of the right foot.

8. On November 29, 2011 Petitioner followed up with Dr. Moore who noted that Petitioner's surgery has been complicated by a post-operative infection and removal of the hardware. While Dr. Idusuyi debrided the wound and replaced the hardware, Petitioner has had persistent wound complication and is now being referred for hyperbaric oxygen therapy.

9. On December 13, 2011, January 20, 2012, February 24, 2012, March 2, 2012, March 16, 2012, March 30, 2012, April 13, 2012 and May 4, 2012 Petitioner underwent excisional debridement of the right foot.

10. On June 4, 2012 Petitioner again saw Dr. Idusuyi who noted that Petitioner has had multiple debridements with hyperbaric oxygenation and the fracture has finally healed. Currently, Petitioner has some continued pain along the lateral aspect of his right foot. On examination, he walks with an antalgic gait. He is tender over the lateral aspect of the foot in the region of the fifth metatarsal. He had diminished pedal pulses and diminished sensation. Petitioner was fitted with a custom-molded arch support. He was prescribed a Jobst stocking. He was given medication and advised to participate in physical therapy for nerve desensitization followed by work hardening and then a functional capacity evaluation.

11. On June 24, 2012 Petitioner was evaluated by Dr. Camins, a doctor who is board certified in infectious diseases and internal medicine. The doctor noted that Petitioner has a healed fracture of the fifth metatarsal and osteomyelitis that is in remission due to a healing and closure of the wound. Petitioner has three out of the five criteria for Buerger's disease. The doctor opined that Petitioner has peripheral vascular insufficiency to his lower extremities either from Buerger's disease or from atherosclerosis. Dr. Camins stated that there is no doubt the fifth metatarsal fracture was a result of the February 14, 2011 work accident. In addition, his peripheral vascular insufficiency played a significant role in the prolonged non-union of the fracture, the poor wound healing after the first surgical procedure and the ensuing surgical site infection with osteomyelitis that developed. He opined that the cause of Petitioner's current pain is multi-factorial. He has ischemic neuropathy because of a poor vascular supply. He most likely also has osteoarthritis of the fifth metatarsal. Finally, he has a very high arch which was probably pre-existent but has been exacerbated by the inactivity due to the fracture. He does have vascular insufficiency on the left leg as well.

12. On July16, 2012, Petitioner follow up with Dr. Idusuyi who noted that today Petitioner is complaining of global foot pain. On examination he has a cavus foot deformity. There is tenderness along the surgical scars. The patient is walking with an antalgic gain. He has diminished sensation and pedal pulses. Dr. Idusuyi diagnosed Petitioner as having a right fifth metatarsal nonunion fracture which is healed, neuropathy and vasculopathy. He recommended treating the condition with physical therapy and physiotherapy with scar desensitation.

13. On August 20, 2012, Dr. Idusuyi noted that Petitioner has some significant neuropathic foot pain and is having difficulty getting around. The Petitioner felt that the therapy was a little bit aggressive and he reported experiencing more pain. He is currently complaining of some numbness. His fracture is healed but he has some significant neuropathic foot pain. Dr. Idusuyi recommended Petitioner go to a pain clinic for pain control and participate in physical therapy and rehabilitation. He was given a script for sedentary type work only and for a custom-molded arch support with a therapeutic shoe.

14. On September 17, 2012 Petitioner was seen at the Memorial Medical Center Pain Clinic. It was noted that Petitioner's wound eventually healed. However, he continues to have severe intractable pain in the right foot that limits his ability to walk or bear weight. He describes the pain as a throbbing along the bottom right hand portion of the foot. He has stabbing, burning pain along the top of the foot as well as medially. The diagnosis is neuropathic right foot pain and possible CRPS. Petitioner was given medication and a possible lumbar sympathetic block was mentioned.

15. On October 1, 2012, Dr. Idusuyi noted on examination Petitioner is quite tender over the lateral ankle. There are atrophic skin changes. There is a cavovarus foot deformity. He has diminished sensation to light touch and proprioception. He walks with a severe antalgic gait. He noted that at this point orthopedically there is nothing he can offer the Petitioner in terms of medical care. He will let Petitioner finish up with physical therapy. At the end of five weeks of physical therapy he will recommend a functional capacity evaluation and he will perform an assessment to determine if he has reached maximum medical improvement.

16. On April 1, 2013, Petitioner saw Dr. Fortin for a neurological consultation. The doctor noted that the sensory exam demonstrated a stocking hypesthesia to pin prick. There was 1+ pitting edema on the distal right leg only. There was no peripheral pulse noted bilaterally. Hyperpathia was noted in the right foot which was a bit cyanotic bilaterally. Petitioner has an antalgic limp. He diagnosed Petitioner with peripheral vascular disease, Raynaud's disease and neuralgia.

17. Petitioner testified his current work restrictions are sedentary and he is able to take his shoes/socks off when needed. He has not returned to work. Currently, he is in constant pain. He is taking morphine sulfate at this time and he is still treating.

18. Dr. Idusuyi was deposed on December 3, 2012. He is a board certified orthopedic surgeon and he is a member of the American Orthopedic Foot and Ankle Society. He testified that over 70% of his practice pertains to ankle and foot problems. His opinion is that Petitioner's right foot non-healing surgical wound was causally related to the February 14, 2011 work accident. By May 4, 2012, Petitioner's fracture was healed but he was having neuropathic pain. The pain was not coming from the fracture anymore. Rather, I believe it was coming from the fact that the patient had multiple operations in the same area and he had numbness

and tingling. Neuropathic pain is just pain from the nerves that causes one not to be able to explain what is going on. It is very difficult to treat. You cannot cast it or inject it. Therapy can be done. It is all related to what we call reflex sympathetic dystrophy (RSD). Petitioner did not have a history of neuropathic pain prior to the February 14, 2011 accident. Anytime you have a trauma to the foot you have a chance of getting RSD. He has not seen anything that states smoking causes or contributes to neuropathic pain. Buerger's disease is a disease of vasculitis which is associated with smoking. Petitioner told Dr. Moore about claudication symptoms, which is pain after walking awhile. He recorded a diagnosis of Raynaud, which is another form of vasculitis. Petitioner had a history of deep vein thrombosis which would be one component of him not being able to heal. Smoking also affects and delays the healing process as well as making one susceptible to infections. He has vascular and neuropathic issues simultaneously. The vascular pain is probably pre-existing. He is more likely suffering neuropathic foot pain from the fracture rather than vascular pain.

19. Dr. Schmidt was deposed on May 17, 2013. He is a board certified orthopedic surgeon who sub-specializes in foot and ankle problems. He evaluated Petitioner on September 6, 2012. He noted Petitioner sustained a fifth metatarsal fracture as a result of an injury which was initially treated conservatively but went on to develop a non-union. Petitioner was subsequently casted and later given a bone stimulator, but it still did not heal. He underwent surgery which resulted in a wound infection and more surgical interventions and hyperbaric oxygen treatment. In May of 2012, Petitioner had healed satisfactorily enough to start physical therapy. He reported more wound problems when he started work hardening. Petitioner reported pain with every step. He felt the prominence of a screw head on the side of his foot, pain at the incision and burning on the outside part of his foot. He rated his pain as being 5 out of 10 on a 10 point scale. He felt he is limited in his ability to stand, walk, lift, carry, bend, push, pull, climb, squat and kneel. He reported attempting to return to light duty work but he felt that there was only a 50% chance of doing so. He reported smoking 6-7 cigarettes a day over the last year and a half and reported being a heavy smoker prior to that time. On examination, he did not notice any increased skin sensitivity. He did exhibit dependent rubor, which means when you hang your foot down it gets very red. There was no abnormal nail or hair growth. An x-ray of his right foot did not show that the screw was prominent. Based on Petitioner's history, examination, x-rays and medical records, he diagnosed Petitioner as status post fifth metatarsal fracture. He believes Petitioner needs more medical treatment because he has severe vasculopathy and documented severe peripheral vascular disease. He had a diagnosis of Berger's disease, which is severe vasculopathy. He has arterosclerosis to the extent where he's becoming ischemic. He's not getting enough blood flow to his lower extremities. An additional diagnosis is peripheral vascular disease based on the fact that he has dependent rubor and no pulses. The significance of having no pulses is that he is not getting enough blood flow to his foot to cause an impulse in his dorsalis pedis or posterior tibial pulse which signifies very poor inflow to that area and is a significant problem. He had pre-existing vascular issues. He has Berger's disease which is a severe form of artherosclerotic disease which is usually very aggressive and is found only in smokers. His understanding is that Petitioner was a 2 to 2-1/2

pack a day smoker for an extended period of time. While he doesn't know the direct cause of Berger's disease the recipient has extreme hardening of the arteries or arteriosclerosis. It is found only in smokers and will typically lead to amputation. It causes extreme pain. Dr. Schmidt does not feel that Petitioner's vascular disease was caused or aggravated by the February 14, 2011 work injury since there's no relationship between breaking the fifth metatarsal and developing severe artherosclerosis, especially when it's has been documented prior to the fracture. In terms of the fifth metatarsal fracture, Petitioner has reached maximum medical improvement. At the time he saw Petitioner, he believed Petitioner's complaints were not related to the fracture metatarsal injury. He does not believe Petitioner would require any additional treatment or work restrictions for the fractured metatarsal. In terms of additional care for his vascular condition he would need to see a vascular surgeon. The only objective verifiable sign of permanent impairment resulting from the fifth metatarsal is that his sural nerve probably got knocked out from the repair and he has some anesthesia over the sural nerve distribution. The sural nerve condition would not have an effect on his ability to function, walk or run. The sural nerve condition is not causing any of Petitioner's current complaints. His current condition is likely due to his vascular problem and ischemic pain, which is not enough blood flow. Petitioner did not report having been diagnosed with RSD prior to his evaluation. He does not believe Petitioner has RSD because he didn't demonstrate any clinical signs of RSD. He has a cavus foot, which is a high arch. He did not meet the criteria for a diagnosis of Charcot-Marie-tooth. Petitioner did walk with a limp favoring his right side. He agreed that a slight decreased range of motion in his mid foot could have been caused by a fracture. He agreed that Berger's disease is somewhat rare and he agreed that it is possible that it can be mimicked by a wide variety of other diseases but it is not his area of expertise. The diagnosis of Berger's disease comes from Petitioner's history. He did not personally conduct a test to see if Petitioner had Berger's disease. It is not his area of expertise. A functional capacity evaluation may be appropriate at this time. He is not aware of Petitioner having any neuropathic pain in his medical records prior to February 14, 2011. It is incredible rare but one could get RSD from trauma, a fracture and surgery to the foot. A common symptom of neuropathic pain would be generalized numbness and tingling throughout the whole foot. It is possible that Petitioner has neuropathic pain, but he did not find any evidence of the same during his evaluation. In his September 6, 2012 evaluation report Dr. Schmidt did opine that the severe vasculopathy and possible diagnosis of Berger's disease obviously played a significant role in his non-healing, his required surgery and his wound difficulties that he suffered.

The Arbitrator found that Petitioner's current neuropathic pain condition is causally related to the February 14, 2011 work accident. Specifically, the Arbitrator found that the medical evidence supports Dr. Idusuyi's opinion that Petitioner's current pain is neuropathic in nature and that there is a causal connection between Petitioner's current neuropathic pain and his work related injury given the fact that Petitioner suffered a trauma as a result of the original injury and the numerous surgeries thereafter. Additionally, Petitioner's prior medical records do not support a history of neuropathic pain. The Arbitrator found that Dr. Schmidt's theory that Petitioner's current problem is related to his pre-existing vascular

condition rather than the work accident is not supported by Petitioner's medical records which show Petitioner was diagnosed with but not treated for vascular problems. Dr. Schmidt testified that neuropathic pain would include generalized numbness and tingling throughout the foot and Petitioner has complained to Dr. Idusuyi of global pain in his right foot.

The Commission finds that after Dr. Idusuyi treated Petitioner, he was sent to Dr. Fortin for a neurological consultation. The Commission notes that Dr. Fortin saw Petitioner on April 1, 2013. After performing a clinical examination, Dr. Fortin diagnosed Petitioner as having peripheral vascular disease, Raynaud's disease and neuralgia. Additionally, Petitioner was seen for a post surgical evaluation by Dr. Camins, an infectious disease and internal medicine doctor, who opined that Petitioner has ischemic neuropathy because of poor vascular supply, osteoarthritis of the fifth metatarsal, a pre-existing high arch that was exacerbated by inactivity due to the fracture, and vascular insufficiency. It appears based on these two exams that post surgery Petitioner was demonstrating both current vascular and neuropathic symptoms. Where Drs. Idusuyi and Schmidt differ is which condition they attribute to Petitioner's current condition of ill-being. More specifically, Dr. Idusuyi opines that Petitioner has a current neuropathic condition, which is a diagnosis is in line with Dr. Camins. Conversely, Dr. Schmidt opines that Petitioner has a current vascular condition and his diagnosis is in line with Dr. Fortin. In the end the Commission finds that medical evidence demonstrates Petitioner has both current vascular and neuropathic symptoms.

Having found that Petitioner has both current vascular and neuropathic symptoms, the Commission next considers what, if any, causation exists between Petitioner's current conditions and his work related accident. In terms of the neuropathic symptoms, Dr. Idusuyi opines that Petitioner's current neuropathic pain resulted from initial work trauma and the multiple surgical traumas and as such he expresses a positive causal connection between Petitioner's current condition of ill-being and the February 14, 2011 work accident.

Additionally, the Commission finds that this fact scenario parallels that as set forth in Sisbro v. Industrial Commission, 207 Ill.2d 193 (2003) where there is a claimant with a pre-existing condition who sustains a minor trauma while at work resulted in a condition caused by the underlying neurological involvement. Like the claimant in Sisbro who had a pre-existing diabetic condition, sustained a trauma to his ankle, which resulted in residual swelling and a diagnosis of Charcot, Petitioner, is this case, has pre-existing vasculopathy and possible Berger's disease. He sustained a trauma to his foot, which, among other things, resulted in ischemic neuropathy because of a poor vascular supply. As such, it appears that the trauma which initiated the onset of these conditions in Petitioner right foot was the February 14, 2011work-related accident. Thus, the Commission finds that Petitioner had underlying vasculopathy but had not developed the ischemic neuropathy prior to February 14, 2011. As such, the accident triggered the acute onset of this condition. Additionally the Commission finds that there is no evidence that Petitioner's health had deteriorated so that any normal daily activity was an overexertion or such that the activity engaged in presented

risks no greater than those to which the general public is exposed. The evidence sufficiently shows that Petitioner proved that some act or phrase of his employment was "a" causative factor of the resulting injury. Given the totality of the evidence and taking into consideration Drs. Camins' and Fortin's medical reports as well as Dr. Idusuyi's opinions and the fact that the work accident need be only "a" cause in the resulting condition of ill-being, the Commission finds that the Arbitrator reached the correct conclusion in terms of the causation issue in this case but further expansion on the same needed to be performed.

Based on the threshold issue of causation, the Commission affirms the underlying issues of temporary total disability and medical expenses.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $350.00 per week for a period of 55-1/7 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. Respondent shall pay portions of said award for temporary total disability benefits as required by Respondent's exhibits 3 and 4 to the Nebraska Department of Health and Human Services Office of Child Support Enforcement Services.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay Petitioner's outstanding medical bills, as set forth in Petitioner's PX15 and as modified by Respondent's RX9, directly to the providers, according to the medical fee schedule in §8.2 of the Act. Respondent shall reimburse Petitioner for out-of-pocket medical expenses paid by him in the amount of $2,780.25, as set forth in Petitioner's PX15. Lastly, Respondent shall pay for the functional capacity evaluation recommended by Dr. Idusuyi, directly to the provider and in accordance with the medical fee schedule as set forth in §8(a) and 8.2 of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that this case is remanded to the Arbitrator for further proceedings consistent with this Decision, but only after the latter of expiration of the time for filing a 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 of $31,689.13 paid for temporary total disability benefits to or on behalf of Petitioner on account of said accidental injury. Per the agreement of the parties, the $6,651.71 permanent disability advance is not being credited at this time and the credit is being held in abeyance.

14IWCC0815

The party commencing the 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 2 3 2014

Mario Basurto

David L. Gore

Stephen Mathis

MB/jm

O: 8/28/14

43

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Dwight Hayes,

14IWCC0816

Petitioner,

vs. NO: 03 WC 46523

Citgo Petroleum Corporation,

Respondent.

DECISION AND OPINION ON REMAND

This matter had previously been heard and the Decision of the Arbitrator had been filed April 11, 2011. Respondent filed a timely Petition for Review. The Commission affirmed in part and reversed in part the Decision of the Arbitrator, affirming accident and causal connection, and affirming the awards of 23 weeks of temporary total disability benefits (3/1/03 through 4/20/03; and 12/29/03 through 4/16/04) at a rate of $750.98 per week, $13,941.55 for reasonable and necessary medical expenses, and an award of 25% loss of use of each hand under §8(e) of the Act (95 weeks at $542.17 per week = $51,506.15 total PPD). However, the Commission reversed the Arbitrator's denial of §8(j) credit to Respondent for short term disability payments and awarded $18,299.92 in §8(j) credit. In so finding, the Commission based the reversal on the fact that Petitioner admitted receiving short term disability benefits from Respondent while he was off of work. The Commission cited to §8(j) of the Act, which states that if a claimant receives group disability benefits while medically authorized off of work, a credit may be claimed for these payments against liability for temporary total disability benefits existing under the Act.

Respondent subsequently sought review in the Cook County Circuit Court, which reversed the Commission's award of §8(j) credit and remanded the case for further calculation.

FACTUAL BACKGROUND

From 2001 through 2003 Petitioner was a Chief Operator for Respondent. His duties required the use of an impact gun and an 8-pound coker bolt and stud, as well as a coker top and

14IWCC0816

bottom. The impact gun vibrates and takes 1 minute to screw in bolts which are 1-18 inches in length. He also used a jet pump and 3,500 pounds of water pressure to cut cokers from a drum. He also worked with valves and valve wrenches.

In 2002 he began having problems with his right hand. He then began using his left hand to work. Eventually he began waking up out of his sleep with numbness in both hands.

A March 2003 EMG revealed that Petitioner had bilateral carpal tunnel syndrome. In December 2003 an orthopedic surgeon recommended bilateral median nerve decompression surgeries. Petitioner underwent a left carpal tunnel release on December 29, 2003, and a right carpal tunnel release on February 16, 2004. Petitioner testified that he was off of work from December 29, 2004 through April 16, 2004. During this time he received short-term disability pay from Respondent. However, Respondent was unable to prove the exact amount of short term disability paid to Petitioner during this time.

ORDER ON REMAND

The Commission finds the Order of the Circuit Court reversing the Commission's award of an §8(j) credit and remanding the matter to the Commission for recalculation of the §8(j) credit to be internally inconsistent. The Commission, however, based upon its interpretation of the Courts' inconsistent order, as well as the parties' stipulation at oral arguments that short term disability payments had been made, remands this matter to the Arbitrator for calculation of the §8(j) credit due Respondent.

IT IS THEREFORE ORDERED BY THE COMMISSION that the case be remanded to the Arbitrator for a determination of §8(j) credit due Respondent.

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

DATED: SEP 2 3 2014

David L. Gore

Mario Basurto

Stephen Mathis

DLG/wde
O: 5/10/12
45

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

Richard Jankowski,

Petitioner,

14IWCC0817

vs.

NO: 10 WC 48866

Dean Dairy Holdings LLC-Huntley, Illinois,

Respondent.

DECISION AND OPINION ON REMAND

This matter had previously been heard and the Decision of the Arbitrator had been filed January 31, 2013. Petitioner filed a timely Petition for Review. The Commission affirmed the Decision of the Arbitrator, finding no causal connection to Petitioner's current cervical condition. The Arbitrator also found that all temporary total disability benefits and medical expenses had been paid through the maximum medical improvement date of July 16, 2010.

Petitioner subsequently sought review in the Cook County Circuit Court, which reversed the Commission's ruling, finding that Petitioner suffered a permanent aggravation and acceleration of his preexisting degenerative cervical condition as a result of the accident in question.

FACTUAL BACKGROUND

Beginning in 2001, Petitioner's job duties for Respondent included loading and unloading trailers, putting empty pallets in the machine that cleans the cases, cleaning out cases, pulling bars out and picking up skids. Initially, the majority of his job was loading and unloading trailers with full cases of milk, sour cream and other dairy products. As time progressed, he ended up in the empty case department, unloading empty cases on skids with forklifts. Frequently, these empty cases came back with old product in between them. Thus, Petitioner would have to lift up the cases and slide the product out. Occasionally he would have to remove full container of milk, weighing 25-30 pounds. Empty containers weighed 2-3 pounds.

Petitioner suffered a work-related neck and upper back injury in 2003 while lifting and throwing 50-60 pound skids. Conservative treatment worked up until a re-injury in May 2005, which occurred while pushing stainless steel carts holding 80 gallons of milk. Ultimately, Petitioner underwent a cervical fusion at C5-6 and C6-7 in December 2005. He returned to full duty in early 2006.

On October 5, 2009 Petitioner was pushing a fully loaded stainless steel cart, which suddenly got stuck, causing him to jerk. At that time he felt pain in his neck and upper back. On October 16, 2009 Petitioner treated with Dr. Wollin, who took x-rays and returned Petitioner to work with restrictions of pushing and pulling up to 50 pounds and 20-30 pounds floor to waist lifting. In August 2007, Dr. Liu, Petitioner's prior surgeon, indicated that the Petitioner had non-union syndrome and that he might require additional surgery. The evidence prior to the accident indicated a non-union/failed fusion, pseudoarthrosis. For a period of approximately two months prior to the October 5, 2009, accident, there is no evidenced treatment. Diagnostics prior and subsequent to the accident did not indicate any change in petitioner's condition, only the failed fusion, pseudoarthrosis. Further, when Petitioner saw Dr. Wollin, he acknowledged that he had had cervical pain on and off since the cervical fusion in 2005. In January 2010 Petitioner underwent MRI and CT scans of his neck. Diagnostic evidence in 2010-2011 did not evidence further degeneration or a significant change in Petitioner's condition other than natural progression. In March 2010 Dr. Liu recommended aggressive neck exercises and stated that if conservative care failed, surgery would be contemplated. Petitioner continued treating until July 5, 2010. At that time he was advised that his restrictions would be permanent.

Throughout 2011, Petitioner continued with therapy, and also underwent epidural injections, an EMG/NCV and pain management treatment. Petitioner was taken off work on February 8, 2011. On October 31, 2011 a Dr. McNally advised Petitioner that a fusion surgery was needed and opined that Petitioner's current condition was causally related to the accident in question.

Respondent's §12 examiners, Drs. Butler and Anderson both opined that there was no causal connection to Petitioners current condition of ill being. Both examiners noted Dr. Liu's prior findings as well as the diagnostics indicating no significant change between 2007 and 2009-2010. Neither examiner found any permanent aggravation, exaggeration, or acceleration from this accident but rather a temporary strain/sprain type injury. They noted the diagnostics indicated no significant change between the prior studies to the one subsequent to the injury and that indicated no pain generator related to the accident. While surgery may have been indicated for a non-union, it was noted that was for the preexisting condition and in no way affected by the accident of October 5, 2009. Dr. Andersson indicated Petitioner's revision surgery would be indicated regardless of this accident.

ORDER ON REMAND

The Commission finds no basis in the record or the law to alter its original Decision. However, pursuant to the Circuit Court's Order, the Commission reverses the Arbitrator's

14IWCC0817

Decision and finds that Petitioner suffered a permanent aggravation and acceleration of his preexisting degenerative cervical condition as a result of the accident in question.

In accordance with causal connection being found, Petitioner is entitled to additional temporary total disability (TTD) benefits. Due to his ongoing complaints after the accident, Petitioner was taken off of work on February 8, 2011. As of the date of Arbitration, no doctor had returned him to work. Accordingly, the Commission awards TTD benefits from February 8, 2011 through January 4, 2013 (the date of arbitration).

Lastly, pursuant to the Circuit Court Order, the Commission finds that the fusion surgery recommended by Dr. McNally is reasonable and necessary.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed January 31, 2013 is hereby reversed.

IT IS FURTHER ORDERED BY THE COMMISSION that Petitioner's current condition of ill-being is causally connected to the accident in question.

IT IS FURTHER ORDERED BY THE COMMISSION that Petitioner is entitled to additional temporary total disability benefits from February 8, 2011 through January 4, 2013.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall authorize and pay for the prospective fusion surgery recommended by Dr. McNally.

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 $25,000.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: SEP 2 3 2014

David L. Gore

Mario Basurto

Stephen Mathis

DLG/wde
O: 7/14/14
45

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Jeff Baker,

Petitioner,

14IWCC0818

vs.

NO: 09 WC 20490
10 WC 33530

Minova, U.S.A.,

Respondent.

DECISION AND ORDER ON REMAND FROM THE CIRCUIT COURT

This matter had previously been heard under §19(b) and the Decision of the Arbitrator had been filed September 6, 2011. The Arbitrator found that Petitioner sustained accidental injuries arising out of and in the course of his employment with Respondent; that Petitioner established a causal connection between these accidental work related injuries and his condition of ill-being; that Petitioner is entitled to an award of 74-3/7 weeks of temporary total disability benefits (4/30/09-10/4/10) at a rate of $486.29 per week under §8(b) of the Act ($36,193.87 total TTD); that Petitioner is entitled to an award of $1,444.00 for reasonable and necessary medical expenses under §8(a) of the Act. The Arbitrator found that on October 4, 2010, Dr. Ollinger opined Petitioner had reached MMI regarding the de Quervain's syndrome and that Petitioner did not have radial tunnel, although he was still symptomatic. The Arbitrator found Petitioner failed to prove he sustained repetitive trauma injuries as a result of his work duties with Respondent on 7/14/10 (10 WC 33530). The Commission affirmed and adopted the decision of the Arbitrator and Petitioner, thereafter, appealed to the Circuit Court. The Circuit Court thereafter heard the matter and remanded the matter back to the Commission. Petitioner's prior issues in their Petition for Review were causal connection, temporary total disability, medical expense benefits and prospective medical care.

- From the hearing before the Arbitrator, Petitioner testified that as of April 27, 2009 he had been working for Respondent for 6 years, making roof plates for the coal mines. He used a big press weighing between 3 and 5,000 pounds. He had to turn it to feed it up to

a machine which feeds it up to another machine which makes plates weighing between 800 and 850 pounds. The plates are stacked 5 to 10 on top of each other, they are then tied and stacked on a pallet. Petitioner did his own machine maintenance, dropping the top die, which weighs 2-300 pounds after the bolts are taken out. Petitioner works 5 days a week unless he is on mandatory overtime, in which case he works 6 days. He works 8 hour days. He performs these duties the entirety of his work day. He has breaks at 10:00, 12:00 and 2:00.

- Prior to the date in question, he had no symptoms in his left hand or arm. On April 27, 2009, Petitioner was blowing the die out of the machine, which requires him to go behind the machine and walk up three steps to a platform that is 2 or 3 feet off the ground. On top of the grate is a grease mat. When Petitioner stepped on it, he fell through the grease mat with his left leg and hit his elbow on the back of the press. A piece of angle iron hit his ankle as well when he fell. When he fell the first thing to hit the ground were his hands. Petitioner stated that the platform had been moved away from the machine, so the mat looked as if there was a floor underneath it.

- Initially Petitioner's ankle was hurting pretty badly. He informed the supervisor, who told him to complete an accident report. When he tried to walk, Petitioner's left foot was just flopping around. He had no control over it and knew he had broken it. Petitioner then reported it to the safety manager, who told the day shift manager, who told the plant manager. The plant manager came and asked Petitioner to take his shoe off. Petitioner was then denied the opportunity to complete an accident report. Petitioner was told he would be suspended three days. He then drove himself to Marion Memorial Hospital. An x-ray revealed his ankle was broken.

- Petitioner was referred to Southern Orthopedics and Dr. Morgan. On April 30, 2009 Petitioner was still complaining of ankle pain, but was also complaining of bilateral wrist pain. He was taken off work, placed in a walking boot and was referred for physical therapy. In June of 2009 Petitioner underwent MRI's for both wrists.

- Petitioner underwent an §12, independent medical examination (IME) with Dr. Ollinger on August 26, 2009. After the IME, Petitioner was approved for surgical treatment, which he underwent December 9, 2009 with Dr. Morgan. On February 24, 2010 Petitioner underwent left wrist surgery. At that time his left ankle was still in pain, but was improving. His right elbow had shooting pains from his wrist up through his forearm. Dr. Morgan prescribed an EMG, which he underwent May 4, 2010. On July 14, 2010 Petitioner underwent an IME by Dr. Browdy. Dr. Browdy stated that Petitioner's complaints were due to overuse.

- Petitioner underwent a functional capacity evaluation (FCE) on September 22, 2010. He then underwent another exam and EMG with a Dr. Phillips. He then underwent another IME with Dr. Ollinger. On December 21, 2010 Dr. Morgan referred Petitioner to Dr. Young, who diagnosed radial tunnel syndrome. In January and February of 2011, Dr. Young recommended surgical intervention.

- Petitioner was paid TTD through December 10, 2010. He was never notified of said termination or suspension of benefits. Petitioner has not had any medical treatment since seeing Dr. Young on February 25, 2011.

- At time of that hearing, Petitioner testified that he feels sharp wrist pains shooting up through his arms constantly. He feels pain while folding towels or pulling pins out of new shirts. The pain lasts between 2 hours and the rest of the night. His left ankle feels a lot better and he has no problems walking. He also does not have any elbow pain.

- On Review, the Commission affirmed and adopted the decision of the Arbitrator. Petitioner was found to be at maximum medical improvement (MMI) as of October 4, 2010 in regard to the de Quervain's and right radial tunnel syndrome per Dr. Ollinger, Respondent's examiner. Thereafter, temporary total disability benefits were terminated as was further medical treatment.

- On Review, Petitioner argued that there was no basis for the termination of his temporary total disability (TTD) benefits. From Petitioner's first appointment with Dr. Morgan on April 30, 2009 throughout, he was ordered off of work. Prior to October 4, 2010 Petitioner was seen by Dr. Morgan on August 10, 2010. Dr. Morgan noted that Petitioner was unable to perform any work duties until re-evaluated. Petitioner would need ongoing care. The functional capacity evaluation (FCE) report of September 17, 2010 also revealed that Petitioner was unable to perform his work duties at that time due to hand/wrist limitations. A follow-up report on November 23, 2010 stated that Petitioner was unable to return to work indefinitely. Dr. Morgan stated that Petitioner's complaints were caused by his radial tunnel syndrome. Dr. Morgan's associate, Dr. Young, opined that Petitioner's radial tunnel was causally connected to his accident.

- On October 4, 2010 Petitioner complained to Dr. Ollinger of bilateral symptoms, including shooting pains from his dorsal wrist to the mobile mass of the extensor muscles at the elbows. Dr. Ollinger had no opinion of what was causing said symptoms. Petitioner contends that this inability to provide an explanation of his symptoms is not synonymous with a finding that he had reached MMI. Moreover, Dr. Ollinger stated on November 30, 2010 that if Petitioner was able to choose a more symptomatic side, consideration could be given for a second MRI in the distal forearm to see if any objective evidence of the diagnosis is present. Petitioner states that if additional diagnostic testing is being recommended, MMI has not yet been reached. Accordingly, Petitioner argued that he had not reached MMI as of October 4, 2010. Thus his TTD benefits should have continued through the date of trial.

- Respondent argued that Dr. Ollinger was unable to explain Petitioner's symptoms because Petitioner was unable to specifically indicate where his pain was located. He stated that a patient with radial tunnel will usually have very selective areas of pain. Dr. Ollinger thus opined on October 4, 2010 that Petitioner's De Quervain's syndrome had reached MMI, and Petitioner did not have radial tunnel syndrome at all. Dr. Ollinger went on to state that a diagnosis of radial tunnel syndrome is not hard to make, and that it is more commonly associated with tennis elbow than with anything in the wrist area.

- Additionally, one of Petitioner's treating physician's, Dr. Young, admitted that if Petitioner had no forearm symptoms prior to December 2010 (*18 months after the initial accident and 5 months after a second alleged accident*), he would have a hard time believing that the work situation caused his radial tunnel syndrome. Petitioner's other physician, Dr. Morgan, agreed that Petitioner's records do not indicate any forearm pain until December 2010. Further, Dr. Young stated that he would expect radial tunnel to occur with a direct blow to the outside of the elbow, and there was no indication that Petitioner sustained a blow to either elbow following the April 2009 accident. Accordingly, arguably, the Arbitrator correctly found that Petitioner reached MMI as of October 4, 2010. It was unrebutted that Petitioner reached MMI with respect to his De Quervain's syndrome on said date. Further, Respondent argued that since Petitioner's alleged radial tunnel syndrome was not work related, he is not entitled to TTD benefits or prospective surgery for said condition. Lastly, there are several inconsistencies in Petitioner's argument. Petitioner claimed he was taken off work on April 30, 2009 and throughout his treatment with Drs. Morgan and Young. However, from the record it is clear from testimony that on January 14, 2010, Dr. Morgan returned Petitioner to light duty work. Additionally, Petitioner stated that he did not recall ever being released to light duty by Dr. Morgan, yet Dr. Morgan's records are clear that Petitioner called Dr. Morgan's office upset about the release.

- In regard to case 10 WC 33530, the Arbitrator denied Petitioner's repetitive trauma claim from July 14, 2010 and Petitioner made no argument in opposition of said denial in its Statement on Review.

- The Circuit Court's opinion was that the Commission decision affirming the Arbitrator's decision was against the manifest weight of the evidence. The Circuit court stated specifically the Arbitrator found the right radial tunnel condition was causally related but that Petitioner had reached MMI October 4, 2010 which was inconsistent and the MMI finding was contrary to the manifest weight of the totality of the continued medical testimony, including the treating doctors, Dr. Morgan and Dr. Young, and the examining doctor, Dr. Ollinger, who even though he opined MMI had been reached, was still recommending additional diagnostic testing. The Circuit Court further stated the manifest weight of the evidence demonstrated Petitioner's condition of ill-being has not stabilized. The Circuit Court further found the decision denying further prescribed medical treatment by the treating doctors for the condition was found to be causally connected was in error. The Circuit Court stated the findings of the Commission affirming the determination of MMI October 4, 2010 and denial of further medical treatment as recommended by the treating doctors are reversed and the case was remanded to the Commission with directions to reinstate TTD benefits and authorize further medical treatment as recommended by Dr. Morgan and Dr. Young.

The Commission finds no basis in the record, given the 18 month initial period with no radial tunnel symptoms, no evidence of a direct trauma to the elbow or of repetitive trauma to have caused the condition (as the treating doctors indicated) and evidence indicating Petitioner had

reached MMI as to the De Quervain's syndrome by October 4, 2010, to alter its Decision. However, pursuant to the order of the Circuit Court, the Commission reverses its prior decision to find an ongoing causal connection to Petitioner's current condition of ill-being. Further, with the Circuit Court's finding that Petitioner had not yet reached MMI, the Commission modifies its prior decision and orders Respondent to pay TTD benefits from October 4, 2010 through the date of the hearing, July 13, 2011 in addition to the TTD benefits originally awarded. The Commission further orders Respondent to authorize and pay for the prospective medical care per Dr. Morgan and Dr. Young per the order of the Circuit Court finding Petitioner had not yet reached MMI. The Commission affirms and adopts the decision denying penalties and attorney fees. The Commission therefore modifies in part and vacates in part its prior decision.

IT IS THEREFORE ORDERED BY THE COMMISSION that its prior decision on Review is, herein, modified in part and vacated in part to find that Petitioner has NOT yet reached MMI and entitled to further benefits.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay to the Petitioner the sum of $486.29 per week for a period of 114-5/7 weeks (4/30/09-7/13/11 [date of hearing before the Arbitrator]), 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, or reasonable and necessary medical expenses, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent authorize and pay for reasonable and necessary medical expenses related to the prospective medical treatment prescribed by the treating doctors and further to pay the reasonable and necessary medical expenses evidenced at the hearing before the Arbitrator, through the date if that hearing, as Petitioner has not yet reached MMI, 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.

14IWCC0818

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $52,500.00. 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: SEP 2 3 2014
o-7/31/14
DLG/jsf
045

David L. Gore

Stephen Mathis

Mario Basurto

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

Ronald Stevenson,

Petitioner,

14IWCC0819

vs.

NO: 12 WC 25820

Marathon Petroleum Company,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under Section 19(b) having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of medical expenses, prospective medical care, temporary total disability benefits, Section 8(j) credit, evidentiary rulings, and penalties and fees, and being advised of the facts and law, modifies the Decision of the Arbitrator as stated below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof. The Commission further remands this case to the Arbitrator for further proceedings for a determination of a further amount of temporary total compensation or of compensation for permanent disability, if any, pursuant to Thomas v. Industrial Commission, 78 Ill.2d 327, 399 N.E.2d 1322, 35 Ill.Dec. 794 (1980).

So that the record is clear, and there is no mistake as to the intentions or actions of 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 and after doing so, we find that the Arbitrator correctly found that Petitioner is entitled to prospective medical care, but find that the form of care Petitioner has proven entitlement to is a C3-4 anterior cervical discectomy and fusion and not a disc replacement as ordered by the Arbitrator.

The Commission notes that on November 2, 2012, Dr. Stephen Ritter, one of Petitioner's treating physician's, recommended a C3-4 ACDF procedure in order to eliminate the majority of

Petitioner's neck and right-sided complaints. (PX6) Dr. Ritter noted that the C5-6 level "is minimally implicated" and did not believe "that this level needs surgical treatment." Dr. Ritter noted that Petitioner indicated that he would be "fine with the intermittent symptoms he has into his radial sided right hand…on a more permanent basis as it does not contribute significantly to his complaints."

On December 20, 2012, Dr. Kelly Agnew issued a utilization review report at the request of Respondent in which he explained that "[b]ased on discussion with Dr. Ritter and consistent with evidence based medicine, [Petitioner] has failed conservative care, has neck pain and radicular pain in a dermatomal distribution despite appropriate conservative care greater than seven months….The C3-C4 anterior cervical discectomy and fusion would be recommended as medically necessary and is certified." (RX2)

On March 4, 2013, Dr. Matthew Gornet, who Petitioner saw twice, reviewed Petitioner's MRIs and, agreeing with Dr. Ritter that the C3-4 area should be treated, ordered a two-level Prestige disc replacement at C3-4 & C5-6. (PX10)

On July 2, 2013, Dr. S. Joshua Szabo, a board certified orthopedic surgeon licensed in Pennsylvania, issued a utilization report in which he noted that "a C3-4 and C5-6 Prestige was recommended" by Dr. Gornet. (RX3) Dr. Szabo explained that, based on ODG guidelines, "disc replacement is for patients with intractable symptomatic single-level cervical [degenerative disc disease]. Therefore, one can state with a degree of medical probability that the disc replacement surgery is not reasonable and necessary according to evidence-based medicine and is causally related to the work injury of 5/1/12 due to aggravation of the pre-existing conditions."

On August 6, 2013, Dr. Brett Weinzapfel, Respondent's Section 12 examiner, continued to opine that Petitioner has C3-4 retrolisthesis and superimposed herniated nucleus pulposus with right greater than left foraminal stenosis, neck pain and headache. (RX4) Dr. Weinzapfel indicated that Petitioner "had a chronic condition at this level that was possibly made worse by a work injury on May 1, 2012." Dr. Weinzapfel did not, however, agree with Dr. Gornet's recommendation for a two-level disc replacement and explained that "[c]urrent indications for a cervical disc replacement are for single level cervical degenerative disc disease. Disc replacement also requires intact facet joints. [Petitioner] does have retrolisthesis and facet arthropathy at C3-4, which I believe would be more appropriate for a fusion."

On August 26, 2013, Dr. Gornet examined Petitioner for the second time, as well as reviewed Dr. Weinzapfel's Section 12 report and Dr. Szabo's utilization report. (PX10) Dr. Gornet noted that Dr. Szabo, according to his website, has no experience in cervical disc replacement and has not performed any cervical spine surgeries. After reviewing the reports, Dr. Gornet again opined that disc replacement surgery was necessary and appropriate and explained that "all the practitioners who have evaluated [Petitioner] agree that his symptoms are causally connected to his work related injury. All agree that treatment is necessary and reasonable at C3-4. I believe it is also reasonable and necessary to cure the effects of his injury to treat C5-6."

The Commission agrees with Dr. Gornet that all the doctors who have evaluated Petitioner and/or reviewed his medical records and diagnostic exams agree that Petitioner

requires treatment at the C3-level. However, the Commission notes that Dr. Gornet is the only doctor who is recommending cervical disc replacement surgery. Dr. Ritter, Dr. Weinzapfel, and Dr. Agnew recommend fusion surgery at the C3-4 level.

The Commission notes that while Dr. Gornet dismisses the opinions of Dr. Szabo, he makes no mention of Dr. Agnew's utilization report which supports the findings and recommendations of Dr. Weinzapfel and Dr. Ritter. The Commission further notes that Dr. Ritter and Dr. Agnew actually discussed Petitioner's condition and their opinions regarding treatment. Also, Dr. Ritter explained that the C5-6 level "is minimally implicated" and did not believe it required surgical treatment.

Therefore, based on the totality of the evidence, the Commission finds that the appropriate form of treatment for Petitioner's cervical condition is a C3-4 discectomy and fusion and modifies the Arbitrator's Decision to reflect as such.

Next, the Commission notes that Respondent argued that the Arbitrator erred by awarding $23,939.54 in Section 8(j) credit instead of $38,942.41. In its Statement of Exceptions Respondent claims, and the Group STD/LTD & Salary continuation summary (RX9) and Petitioner's sick pay check stubs (PX15) show that Respondent paid Petitioner his accrued sick time and vacation time pay during the temporary total disability period of January 17, 2013 through September 9, 2013. The evidence does not show that Petitioner was paid temporary total disability benefits during that period. Petitioner used up his own accrued time during the stated temporary total disability period. Therefore, the Commission finds that Petitioner is entitled to temporary total disability benefits from January 17, 2013 through September 9, 2013, totaling $38,922.13, and that Respondent is not entitled to a credit under Section 8(j) of the Act.

Finally, one should not and cannot presume that we have failed to review any of the record made below. Though our view of the record may or may not be different than the arbitrator's, it should not be presumed that we have failed to consider any evidence taken below. Our review of this material is statutorily mandated and we assert that this has been completed.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Arbitrator's Decision is modified regarding prospective medical care and Section 8(j) credits as stated above, and is otherwise affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay to the Petitioner the sum of $1,154.47 per week for a period of 33-5/7 weeks, that being the period of temporary total incapacity for work under Section 8(b), and that as provided in Section 19(b) of the Act, this award in no instance shall be a bar to a further hearing and determination of a further amount of temporary total compensation or of compensation for permanent disability, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $4,052.26 for medical expenses under Sections 8(a) and 8.2 of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall authorize

and pay for prospective medical care in the form of a C3-4 discectomy and fusion as recommended by Dr. Ritter, Dr. Weinzapfel, and Dr. Agnew.

IT IS FURTHER ORDERED BY THE COMMISSION that Petitioner's Petition for Penalties and Fees is denied.

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

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

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

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $44,000.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: SEP 2 4 2014
MJB/ell
o-07/28/14
52

Michael J. Brennan

Thomas J. Tyrrell

Kevin W. Lamborn

NOTICE OF 19(b) DECISION OF ARBITRATOR

STEVENSON, RONALD E
Employee/Petitioner

Case# **12WC025820**

14IWCC0819

MARATHON PETROLEUM COMPANY
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:

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

2542 BRYCE DOWNEY & LENKOV LLC
JUSTIN T NESTOR
200 N LASALLE ST SUITE 2700
CHICAGO, IL 60601

14IWCC0819

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)

RONALD E. STEVENSON
Employee/Petitioner

v.

MARATHON PETROLEUM COMPANY
Employer/Respondent

Case # 12 WC 25820

An *Application for Adjustment 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 **September 9, 2013** and **December 6, 2013**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On the date of accident, **May 1, 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 **$90,048.92**; the average weekly wage was **$1,731.71**.

On the date of accident, Petitioner was **56** years of age, ***married*** with **1** dependent child.

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 **$23,939.54** for other benefits, for a total credit of **$23,939.54**.

Respondent is entitled to a credit of **$239.53** under Section 8(j) of the Act.

ORDER

Respondent shall pay Petitioner temporary total disability benefits of $1,154.47 per week for 33 5/7 weeks, commencing 01/17/2013 through 09/09/2013, as provided in Section 8(b) of the Act. Respondent shall be given credit in the amount of $23,939.54 for non-occupational benefits paid pursuant to Section 8(j) of the Act. (see above).

Respondent shall pay, after fee schedule application, credits and interest, reasonable and necessary medical services of $4,052.26, as provided in Sections 8(a) and 8.2 of the Act. Respondent shall be given credit of $239.53 for non-occupational medical benefits paid pursuant to Section 8(j) of the Act (see above).

Respondent shall authorize the cervical surgery recommended by Dr. Matthew Gornet.

Penalties and attorney's fees are not imposed upon Respondent.

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

01/22/2014
Date

ICArbDec19(b)

JAN 31 2014

STATE OF ILLINOIS)
) SS
COUNTY OF SANGAMON)

14IWCC0819

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

RONALD E. STEVENSON
Employee/Petitioner

v. Case # 12 WC 25820

MARATHON PETROLEUM CO.
Employer/Respondent

MEMORANDUM OF DECISION OF ARBITRATOR

FINDINGS OF FACT

On May 1, 2012, Petitioner, Ronald Stevenson, worked as a heavy equipment operator for Respondent, Marathon Petroleum Company. On that date, he struck the top of his head on a beam. (Petitioner's Exhibit (PX) 1). Petitioner experienced neck pain radiating down the right arm to his index finger, with a headache. He treated at Respondent's medical provider. He reported sharp, shooting moderate-to-severe neck pain radiating to the right shoulder. Petitioner was taking Prednisone and occasional pain medicine for his rheumatoid arthritis at this time. (PX 2, p. 1).

On May 3 and May 8, 2012, Petitioner saw his primary care physician, Dr. Scott Stine. Petitioner had decreased sensation into the right hand. (PX 3, p. 4). Dr. Stein ordered a cervical MRI that Petitioner underwent on May 14, 2012. The radiologist interpreted a C3-4 disc herniation with compression on the C4 nerve root, as well C4-5 and C5-6 disc herniations. He opined the findings could account for right C4 and C6 radiculopathies. (PX 4).

Respondent scheduled an examination with Dr. Brett Weinzapfel pursuant to Section 12 of the Illinois Workers' Compensation Act, 820 ILCS 305/1 *et seq*. (hereafter the "Act"). This examination occurred on June 25, 2012. Dr. Weinzapfel reviewed the MRI and diagnosed C3-4 and C5-6 disc herniations. He opined that the work accident could have made Petitioner's cervical condition worse. Dr. Weinzapfel recommended therapy, light duty, and, if therapy failed, consideration for a C3-4 fusion. (RX 1).

Petitioner underwent physical therapy from July 9 through August 23, 2012. The neck and right upper extremity symptoms worsened somewhat with traction treatment. (PX 5).

Petitioner saw Dr. Stine on July 19, 2012. There was decreased sensation in the right index finger and thumb noted. (PX 3, p. 15). Dr. Stein referred Petitioner to a surgeon, Dr. Stephen Ritter.

Petitioner saw Dr. Ritter on July 27, 2012. He reported neck pain, headaches and numbness and tingling in the thumb, index and middle fingers. He had a positive Spurling's test on the right in the C4 and C6 distributions. He had decreased biceps. (PX 6, p. 8). Dr. Ritter reviewed the MRI and saw evidence of a C3-4

disc herniation impinging the C4 nerve root and possible impingement at C6. He recommended an EMG with continued restrictions. (PX 6, p. 9). The August 8, 2012 EMG was negative for cervical radiculopathy and carpal tunnel syndrome. (PX 9).

Petitioner returned to Dr. Ritter on August 16 and 27, 2012. Petitioner had symptoms in the C4 and C6 distributions. Dr. Ritter recommended diagnostic injections. (PX 6, pp. 15, 18). On September 9, 2012, Dr. Anthony Sabatino performed a C4 nerve root block. It decreased Petitioner's pain from 7/10 to 1/10 and relieved the headaches. (PX 7, pp. 4-5). On October 5, 2012, Dr. Ritter recommended an epidural steroid injection at C4-5. If the symptoms did not improve, he recommended a selective nerve root block at C6 before considering surgery. (PX 6, p. 21). On October 31, 2012, Dr. Sabatino performed a C7-T1 epidural injection. (PX 7, p. 10).

Petitioner returned to Dr. Ritter on November 2, 2012. Dr. Ritter noted Petitioner had some relief from a C6 selective nerve root block. Dr. Sabatino did not perform that procedure. Dr. Ritter recommended that Petitioner attempt full duty work, and if the symptoms persisted, they could discuss permanent restrictions versus surgical intervention. If Petitioner opted for surgery, Dr. Ritter stated he could avoid C5-6 surgery because the radial sided hand symptoms were not significantly limiting. He causally connected the condition to the work accident. (PX 6, p. 24).

On November 12, 2012, Petitioner told Dr. Ritter his neck pain was 7/10. He had intermittent index and thumb numbness (C5-6). Dr. Ritter proposed a C3-4 fusion and placed restrictions. (PX 6, p. 27).

Respondent was no longer able to accommodate Petitioner's work restrictions as of January 17, 2013, but Petitioner was eligible for salary continuation and other lost time benefits through Respondent. (RX 8). Further, the evidence introduced at hearing revealed that Petitioner has received $38,942.41 in salary continuation and non-occupational disability benefits. (RX 9). Petitioner's Exhibit 15 contains payroll data for the period in question, and indicates that Petitioner has been paid a net amount of $22,233.18. Further, Respondent's Exhibit 9 indicates that two payments of long-term disability (LTD) payments were made totaling $1,706.36 ($1,388.77 + $317.59). (See RX 9, p. 2). Therefore, the total net amount paid Petitioner during the period in question totals $23,939.54 ($22,233.18 + $1,706.36).

On March 4, 2013, Petitioner came under the care of Dr. Matthew Gornet, a spine surgeon. Petitioner reported neck pain radiating to the right trapezius, shoulder, arm, scapula, and forearm into the thumb and index finger as well as headaches. Petitioner brought the records from Dr. Ritter and Dr. Stine. On physical examination, Petitioner had decreased biceps on the right of 4/5. Petitioner had decreased sensation in the C6 dermatome on the right. (PX 10, p. 7).

Dr. Gornet reviewed the May 14, 2012 MRI report and saw evidence of central and right C3-4 and C5-6 disc herniations. (PX 10, p. 8). He ordered a new MRI that revealed a large central disc herniation at C3-4 with smaller disc herniations at C4-5 and C5-6. (PX 12; PX 10, p. 8). Dr. Gornet proposed disc replacement surgery at C3-4 and C5-6. He opined that the chance of failed fusion with rheumatoid arthritis was as high as 40% at one or both levels. He causally connected the need for the surgery to the work accident. He kept Petitioner on light duty. (PX 10, p. 8).

Petitioner underwent a CT scan to the cervical spine. (PX 13). Petitioner then returned to Dr. Gornet on April 25, 2013. Dr. Gornet opined that there was no significant facet arthropathy and Petitioner was a candidate

for the C3-4 and C5-6 disc replacement surgery. The physical examination continued to show decreased right biceps of 4/5 with decreased sensation at C6 on the right. (PX 10, p. 10).

Respondent secured a utilization review on July 2, 2013 from Dr. Joshua Szabo. Dr. Szabo causally connected the current cervical condition to the work accident, but did not certify the two level disc replacement based upon the ODG Guidelines. (RX 3). Respondent also submitted a utilization review dated December 20, 2012 from Dr. Kelly Agnew, who opined a C3-4 fusion was medically necessary and appropriate. (RX 2).

Dr. Weinzafel prepared an addendum report dated August 6, 2013. He opined he would not support the two level disc replacement for three reasons: 1) he was not impressed with C6 radiculopathy at the time of his exam; 2) the current indications are for one level cervical disc replacement; and 3) Petitioner has facet arthropathy. (RX 4).

Petitioner returned to Dr. Gornet on August 26, 2013. Dr. Gornet opined that the two level disc replacement was reasonable and necessary based upon the imaging studies, Petitioners' symptoms and the physical examinations. (PX 10, pp. 12-13). Respondent objected to the admission of Dr. Gornet's August 26, 2013 note because it was not received within 48 hours prior to the hearing. The office note is admissible. Petitioner sent the note at 11:03 a.m. on September 7, 2013. The hearing did not begin until at least 11:05 a.m. on September 9, 2013. Moreover, Respondent did not claim prejudice or unfair surprise to the office note.

CONCLUSIONS OF LAW

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

Petitioner's current cervical condition is causally related to the work accident. All of the physicians, including Respondent's examining and UR physicians, opined at a minimum that the work accident aggravated or worsened Petitioner's cervical condition.

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

The medical bills listed in Petitioner's Exhibit 14 are reasonable, necessary and causally related to the work accident. Respondent shall pay the bills subject to the medical fee schedule, Section 8.2 of the Act. The following bills remain outstanding:

Providers	Charges	Fee Schedule	Balance
Dr. Anthony Sabatino	$3,745.00	$2,152.56	$2,152.56
Surgery Center of Carmel	$3,168.00	$1,888.92	$1,888.92
Dr. Matthew Gornet	$798.00	$485.17	$485.17
CT Partners	$2,109.36	$1,225.61	$1,225.61

The total balance due after the fee schedule adjustments and credits is $4,052.26. Respondent's group health plan made payments totaling $239.53, for which Respondent is entitled to a total credit pursuant to Section 8(j) of the Act.

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

Petitioner requests approval for a two level disc replacement at C3-4 and C5-6. All of the doctors agree surgery at C3-4 is reasonable. The evidence supports Petitioner's C5-6 level is symptomatic and surgery to address the level is reasonable and necessary.

Dr. Gornet's opinion is more persuasive than Dr. Weinzapfel's opinion. First, Dr. Gornet, unlike Dr. Weinzapfel, reviewed all the imaging studies, including the April 25, 2013 CT scan. Dr. Weinzafel opined one reason Petitioner is not a candidate for disc replacement is because he does not have intact facet joints. Dr. Gornet reviewed the CT scan and opined it did not show any significant facet arthropathy. Second, Dr. Gornet's impression of the MRI scans is consistent with the radiologist's interpretation. The May 2012 MRI report states Petitioner has a C5-6 central/right paracentral disc herniation that could account for right C6 radiculopathy. The March 2013 MRI also shows a C5-6 disc herniation. Third, Dr. Gornet has examined Petitioner three times between March and August 2013. Dr. Weinzapfel examined Petitioner one time on June 25, 2012. Dr. Gornet's physical examinations demonstrating decreased biceps on the right of 4/5 and decreased sensation of the C6 dermatome support the notion that both C3-4 and C5-6 are symptomatic.

The opinion of Dr. Szabo, the UR physician, is not persuasive. He is not a spine surgeon. Moreover, he never examined Petitioner or reviewed the actual MRI and CT scan films.

While Dr. Ritter ultimately offered a C3-4 fusion, his medical records support Petitioner's C5-6 level was symptomatic throughout treatment, even as of the final visit in November 2012. He did not offer surgery at C5-6 because at the time it was felt Petitioner could tolerate the symptoms. Petitioner testified that the C5-6 symptoms have worsened since that time (numbness in the thumb and index finger) and he did not want to fuse more than one level because it would restrict his motion, which would prevent him from returning to work full duty.

Issue (L): What temporary benefits are in dispute? (TTD); and

Issue (N): Is Respondent due any credit?

Petitioner is awarded temporary total disability (TTD) benefits from January 17, 2013 through September 9, 2013, a period of 33 5/7 weeks (or $38,922.13), because he has restrictions related to the accident that Respondent elected not to accommodate. Respondent introduced evidence of Petitioner's salary continuation and group non-occupational disability benefits received during that same period of time, which totaled $38,942.41. (RX 9). Respondent claims credit pursuant to Section 8(j) of the Act for the *gross* sick and vacation pay, as well as LTD pay made to Petitioner while he was off of work. Petitioner claims Respondent is entitled to credit for the *net* amounts paid.

In *Navistar International Transportation Corp. v. Industrial Comm'n*, 315 Ill.App. 3d 1197, 1208, 734 N.E.2d 900 (1st Dist. 2000), the Appellate Court held that the employer should not be entitled to credit for amounts not paid to the employee. Therefore, the Court affirmed the Commission Decision giving the employer credit for the net benefits paid.

Respondent paid Petitioner net benefits totaling $23,939.54, as noted *supra*. Therefore, Respondent owes Petitioner the difference of $14,982.59 ($38,922.13 – $23,939.54).

Issue (M): Should penalties or fees be imposed on Respondent?

Respondent's denial of the recommended two-level disc replacement is neither unreasonable nor vexatious. This finding is supported by the qualified medical opinions (Section 12 examination and utilization reviews) which do not support an award of that procedure.

The evidence introduced at hearing shows that Petitioner received salary continuation and non-occupational group disability benefits which total the amount of TTD benefits claimed. Pursuant to Section 19(k) of the Act, the Commission "shall consider whether an Arbitrator has determined that the claim is not compensable or whether the employer has made payments under Section 8(j)."

After reviewing all of the evidence, the Arbitrator finds that Respondent's denial of benefits was neither unreasonable nor vexatious, and declines to award penalties pursuant to Sections 19(k), 19(l), or attorney's fees pursuant to Section 16 of the Act.

STATE OF ILLINOIS)
) SS.
COUNTY OF MADISON)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

KIM BELL,

Petitioner,

14IWCC0820

vs.

NO: 12WC 19639

JOULE INDUSTRIAL CONTRACTORS,

Respondent,

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of medical expenses, causal connection, prospective medical, 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 November 13, 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.

14IWCC0820

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: SEP 24 2014
o072814
MJB/bm
052

Michael J. Brennan

Kevin W. Lamborn

Thomas J. Tyrrell

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

BELL, KIM
Employee/Petitioner

Case# **12WC019639**

JOULE INDUSTRIAL CONTRACTORS
Employer/Respondent

14IWCC0820

On 11/13/2013, 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:

0293 KATZ FRIEDMAN EAGLE ET AL
JON WALKER
77 W WASHINGTON ST 20TH FL
CHICAGO, IL 60602

5074 QUINTAIROS PRIETO WOOD & BOYER PA
MICHAEL J SCULLY
180 N STETSON AVE SUITE 4525
CHICAGO, IL 60601

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

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION 19(b)

14IWCC0820

Kim Bell
Employee/Petitioner

v.

Joule Industrial Contractors
Employer/Respondent

Case # **12** WC **19639**

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 **Gerald Granada**, Arbitrator of the Commission, in the city of **Collinsville**, on **September 24, 2013**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

14IWCC0820

FINDINGS OF FACT

This case proceeded to hearing pursuant to Sections 19(b) and 8(a) of the Act. Petitioner alleges an injury while working for the Respondent on May 1, 2012, resulting in injuries to his back. At the time of the alleged injury, Petitioner was 49 years old and worked for the Respondent as a millwright. Respondent is disputing this case and the issues in dispute are: 1) accident, 2) causation, 3) TTD and 4) prospective medical care.

Petitioner testified that on May 1, 2012, while employed as a millwright with the Respondent, he stepped on a wet step which caused him to fall and landed on his back. The accident occurred off site at an ethanol plant in Robinson, Illinois. Petitioner stated he reported it Don Hartaker who was a safety manager for Joule.

On May 3, 2012, Petitioner treated with his primary care physician Dr. Rohrer. (PX 1) Petitioner had a past medical history significant for lumbago and degenerative disc disease. (PX 2) His weight as of May 3, 2012 per Dr. Rohrer two days after the accident was 168 lbs. (PX 2) Petitioner testified to medications that he was on prior to May 1, 2012 were Naproxen and Loratab as well as Zanax. (PX 2)

On May 14, 2012 Petitioner had an MRI of the lumbar spine which showed mild multi level spondylosis and an L2-3 small peri-central disk bulge and three small central disc protrusions at L4-5. (PX 2)

On May 23, 2012, Petitioner presented to Pro-Rehab for initial therapeutic evaluation. The diagnoses were lumbago, lumbar sacral spondylosis and lumbar displacement. His past medical history was significant for back pain and arthritis in his hands. (PX 3) Petitioner continued with physical therapy at Pro Rehab on July 3, 9 and 11, 2012. (PX 3) As of July 17, 2012, Pro Rehab had Petitioner reported feeling better after thoracic manipulation. Petitioner reported some low back pain with exercises but was doing well. The plan was to continue stabilization with focus on back pain.

On June 27, 2012, Petitioner underwent an IME with Dr. Weidenbener. Petitioner's weight at the time of the exam was 166.4 lbs. (RX 1) Dr. Weidenbener had the impression that Petitioner had a lumbar contusion/strain and spasm with intermittent L3 radiculitis and a cervical strain. The doctor recommended physical therapy as well as a home exercise program. He was to continue with medications for the pain and was placed on light duty work, lifting up to 15 lbs with minimal bending, stooping and squatting. (RX 1) Petitioner returned to Dr. Weidenbener on August 22, 2012 for a second IME. (RX 2) The diagnosis was an improving right sided lumbar radiculitis, lumbar strain/spasm and improving cervical strain/spasm. Dr. Weidenbener continued physical therapy and a home exercise program. He also recommended a Medrol Dose Pack for the back pain and an epidural steroid injection. (RX 2) Petitioner was to continue working light duty.

On November 1, 2012, Petitioner sought treatment with Dr. Kovalsky. (PX 1) He complained of right back and buttock pain and denied any prior injuries. At the time of this visit, Petitioner weighed 165 lbs. (PX 1) Dr. Kovalsky also noted that Petitioner was a stocky male in no distress. (PX 1) The doctor's impression was an SI joint dysfunction vs. upper radiculopathy with possible disk herniation at L2-L3 on the right. Petitioner was continued on light duty, referred for physical therapy and was to have an SI injection performed. (PX 1) Petitioner returned to Dr. Kovalsky on January 3, 2013. He stated that he had relief from the SI injection performed. (PX 1) Dr. Kovalsky recommended an additional MRI scan, of the lumbar spine (PX 1). Petitioner was scheduled for a second injection on January 10, 2013. It was canceled for an unrelated medical condition (PX 1). On January 17, 2013, Petitioner returned to Dr. Kovalsky. Petitioner had an updated MRI that showed a disk herniation at L2-3 but did not have any severe compression of the nerve root. (PX 1) Dr. Kovalsky

FINDINGS

On the date of accident, **May 1, 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 **$38,933.32**; the average weekly wage was **$748.96**.

On the date of accident, Petitioner was **49** 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 **$36,295.74** for TTD, $ for TPD, $ for maintenance, and $ for other benefits, for a total credit of $.

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

ORDER

Respondent shall pay Petitioner temporary total disability benefits of $499.31/week for 42-6/7 weeks, commencing 5/2/12-6/18/12 and 1/16/13-9/24/13, as provided in Section 8(b) of the Act.

Respondent shall receive a credit for any and all amounts it has already paid toward TTD.

Respondent shall pay any and all outstanding, related, reasonable and necessary medical expenses, subject to the fee schedule and in accordance with Sections 8(a) and 8.2 of the Act; and shall authorize the prospective medical treatment recommended by Dr. Kovalsky.

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

11/6/13

Date

ICArbDec19(b)

NOV 13 2013

14IWCC0820

recommended a secondary therapeutic nerve root injection at L2-3 to determine whether or not the pain generator was at the SI joint. (PX 1)

On January 17, 2013, Petitioner followed up with Dr. Conrardy for pain management. (PX 1) It was noted his weight was 165 lbs. (PX 1) At this time, Dr. Conrardy performed a lumbar epidural sterile injection. Petitioner had an additional injection with Dr. Conrardy on May 13, 2013.

On May 23, 2013, Petitioner followed up with Dr. Kovalsky. Petitioner stated the injection provided short term relief and Dr. Kovalsky was of the opinion that SI joint was a pain generator and he recommended surgical intervention. This included a bone implant across the SI joint and Petitioner would be able to return to work four months from the surgery date without any restrictions. (PX 1)

On July 29, 2013, Petitioner saw Dr. Wayne for an IME. (RX 3) Dr. Wayne noted that Petitioner reported to be 5'6" tall and weighed 150 lbs (RX 3) Dr. Wayne was of the opinion that Petitioner did have an accident at work, however, Petitioner's current condition of back pain is not casually related to his claim of accident. (RX 3) He indicated that Petitioner was one year post accident for this type of back injury and should have recovered. He was not in need of any further treatment and not in need of any surgery. Petitioner was capable of working full duty without any restrictions. (RX 3) Petitioner testified that his current weight was 150 lbs at the time of trial on September 24, 2013.

Nurse Case Manager Libby Nevins testified to having over 20 years nurse case management experience. She was assigned to Mr. Bell's case on May 1, 2012 and has known Mr. Bell since that time. She attended appointments but was never present in the room. She also attended IME exams. She testified she only discussed Petitioner's medical condition while present with Petitioner and the treating doctor. However, they would talk with one another in general while waiting at appointments. Her duties were was to assess the medical condition status plan and to be a liaison for communication. Ms. Nevins attended the IME with Dr. Wayne on July 29, 2013. She testified she spoke to Petitioner prior to the exam. His brother in law was present but did not take part in the conversation. Ms. Nevins testified that she noticed Petitioner had lost a significant amount of weight since the last time she saw him in April 2013. Ms. Nevins testified that she asked Petitioner about how he lost weight and that Petitioner told her he lost all weight from walking.

CONCLUSIONS OF LAW

1. Petitioner sustained an accident on May 1, 2012. Petitioner's testimony regarding his slip and fall on that day while working for the Respondent was credible and Respondent offered no evidence to rebut this testimony.

2. Petitioner's current condition of ill-being is causally related to his accident from May 1, 2012. The Arbitrator finds persuasive the medical evidence from Petitioner's treating physicians, which clearly document Petitioner's continued complaints of pain throughout his medical treatment. Dr. Kovalsky's opinions are supported by the objective testing, including the MRI reports and SI injections. Although Respondent had the Petitioner examined by two different physicians who opined the Petitioner's current condition was not related because he should have already recovered from his diagnosed strain, it is apparent that the Petitioner has not yet recovered and that his condition is much more than a strain.

3. Based on the findings above, the Petitioner's medical care has been reasonable and necessary to treat his condition. As such, Petitioner is awarded all reasonable, related and outstanding medical expenses

14IWCC0820

incurred to date, subject to the fee schedule and in accordance with Sections 8(a) and 8.1 of the Act. Furthermore, Respondent is ordered to authorize the medical treatment recommended by Petitioner's treating physicians.

4. Petitioner is awarded TTD from May 2, 2012 through June 18, 2012, from January 16, 2013 through September 24, 2013 (the date of this hearing). This represents a period of 42-6/7 weeks. Respondent shall receive a credit of $36,295.74 of TTD already paid in this case.

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

Todd Vetkoetter,

Petitioner,

14IWCC0821

vs.

NO: 12 WC 26223

Auto Zone,

Respondent,

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed January 27, 2014, is hereby affirmed and adopted.

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

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

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

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $11,700.00. 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: SEP 24 2014

Michael J. Brennan

o072814
MJB/bm
052

Thomas J. Tyrrell

DISSENT

I respectfully dissent. The arbitrator's decision should be reversed, TTD and prospective medical should be denied.

Kevin W. Lamborn

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

VETKOETTER, TODD
Employee/Petitioner

Case# **12WC026223**

AUTO ZONE
Employer/Respondent

14IWCC0321

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

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

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

3650 MEINDERS LAW LLC
BLAKE MEINDERS
10 S JACKSON ST SUITE 300
BELLEVILLE, IL 62220

0710 SPRAQUE & URBAN
26 E WASHINGTON ST
BELLEVILLE, IL 62220

0358 QUINN JOHNSTON HENDERSON ET AL
CHRIS CRAWFORD
227 N E JEFFERSON ST
PEORIA, IL 61602

14IWCC0821

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)

Todd Vetkoetter
Employee/Petitioner

v.

Auto Zone
Employer/Respondent

Case # 12 WC 26223

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 10, 2013. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS 14IWCC0821

On the date of accident, June 14, 2012, Respondent was operating under and subject to the provisions of the Act.

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

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

Timely notice of this accident was given to Respondent.

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

In the year preceding the injury, Petitioner earned $13,915.72; the average weekly wage was $267.61.

On the date of accident, Petitioner was 34 years of age, single with 0 dependent child(ren).

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

Respondent shall be given a credit of $0.00 for TTD, $0.00 for TPD, $0.00 for maintenance, and $2,140.88 for other benefits (advance of permanent partial disability), for a total credit of $2,140.88.

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

ORDER

Respondent shall pay reasonable and necessary medical services as identified in Petitioner's Exhibit B, Exhibit C, Exhibit 6 and Exhibit 7 as provided in Sections 8(a) and 8.2 of the Act subject to the fee schedule.

Respondent shall authorize and make payment for the medical treatment recommended by Dr. Matthew Gornet including, but not limited to, cervical disc replacement surgery.

Respondent shall pay Petitioner temporary total disability benefits of $220.00 per week for 62 3/7 weeks commencing September 27, 2012, through December 10, 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)

January 21, 2014
Date

JAN 27 2014

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 June 14, 2012. According to the Application, Petitioner fell off of a ladder while at work and sustained injuries to the head, neck, left arm, left elbow and whole person. This case was tried in a 19(b) proceeding and Petitioner sought an order for payment of medical bills, temporary total disability benefits from September 27, 2012, to the date of trial as well as prospective medical treatment. Respondent disputed liability on the basis of accident and causal relationship.

Petitioner began working for Respondent as a part-time employee in October, 2011, and he worked as a stock person at Respondent's retail facility in Belleville. Petitioner also provided assistance to customers and would change batteries, install windshield wipers, etc. Petitioner testified that on June 14, 2012, he was standing on a ladder and while he was holding four or five quarts of oil with his left hand/arm, he started to climb down the ladder when he slipped and fell injuring his neck and back. Petitioner stated that shortly after the accident he reported it to an individual named "Jim" that he identified as the commercial manager but was informed that he would have to wait for Larry Purdue, the store manager to return. After approximately 15 to 20 minutes, Purdue return to the store and a written accident report was prepared. The description of the accident contained in the report was completed by Petitioner and was consistent with his description of it at trial (Petitioner's Exhibit A).

Subsequent to the accident Petitioner was seen in the ER of St. Elizabeth's Hospital. The ER record stated that Petitioner sustained a fall and had complaints to the head, low back and left elbow. X-rays were taken of these three anatomical areas which were negative. Because of the head injury, a CT scan of the brain was obtained which was also normal (Petitioner's Exhibit D).

On January 23, 2012, approximately five months prior to sustaining the accident at work, Petitioner sustained injuries as a result of a motor vehicle accident. The accident occured when the driver of another vehicle ran a red light and struck the truck that Petitioner was driving. On February 2, 2012, Petitioner sought treatment from Dr. Robert Meinders, a chiropractor. At that time, Petitioner complained of back and neck pain. Dr. Meinders provided chiropractic treatment to Petitioner on February 3, February 6, and February 8, 2012. At the time the Petitioner's visit of February 8, Petitioner was feeling better with the treatment that he had received; however, Dr. Meinders indicated in his records that Petitioner was to return in one week.

Petitioner testified that the injuries he sustained as result of the automobile accident totally resolved prior to the work-related accident of June 14, 2012. He also stated that he did not lose any time from work because of the injury sustained as a result of the automobile accident and that he did not return to Dr. Meinders for any further treatment regarding the motor vehicle accident following the visit of February 8, 2012.

At the direction of his attorney, Petitioner was examined by Dr. Matthew Gornet, an orthopedic surgeon, on July 30, 2012. Petitioner informed Dr. Gornet of the work-related accident of June 14, 2012, that he had been seen in the ER and that he had complaints of low back and neck pain. Dr. Gornet's record stated that Petitioner did not recall any prior neck or low back problems of

significance. Petitioner did not inform Dr. Gornet about the prior automobile accident. Dr. Gornet ordered MRIs of both the cervical and lumbar spine and referred Petitioner to Dr. Meinders (the same chiropractor that previously treated Petitioner) for chiropractic care (Petitioner's Exhibit B). Petitioner was seen in the ER of St. Elizabeth's Hospital on August 6, 2012, and the record erroneously stated that Petitioner sustained the work-related accident on July 14, 2012. It also noted that Petitioner had been seen by Dr. Gornet, an "orthopod" and that MRIs of the cervical and lumbar spine were scheduled for September 27, 2012. The clinical impression was a post-concussive headache and neck strain (Petitioner's Exhibit D).

Dr. Meinders saw Petitioner on August 17, 2012, and opined that Petitioner sustained injuries to the cervical, thoracic and lumbar spine. He recommended six weeks of conservative care of and that Petitioner should be re-evaluated after the MRIs were obtained (Petitioner's Exhibit E).

Petitioner had MRI scans of the cervical and lumbar spine performed on September 27, 2012. According to the radiologist, the MRI of the cervical spine revealed a disc bulge and left lateral disc herniation at C6-C7 and an annular tear and bulge at C5-C6. Again, according to the radiologist, the MRI of the lumbar spine revealed a disc bulge and herniation on the left side at L4-L5 and a central disc bulge at L5-S1. Dr. Gornet saw Petitioner that same day and he agreed with the radiologist's interpretation of the MRI of the cervical spine (he did not comment about the lumbar spine). Dr. Gornet authorized Petitioner to be off work and referred him to Dr. Kaylea Boutwell for some injections. He opined that Petitioner's condition was related to the accident of June 14, 2012, and that if Petitioner's condition did not improve that disc replacement surgery at C6-C7 and possibly C5-C6 might be indicated (Petitioner's Exhibit B).

Dr. Boutwell saw Petitioner on October 8, and October 22, 2012, and administered epidural steroid injections at the C5-C6 and C6-C7 levels on the left side (Petitioner's Exhibit C). Petitioner was seen again by Dr. Gornet on November 19, 2012, and he informed him that the injections did not result in any significant improvement of his symptoms. At that time, Dr. Gornet made the recommendation that Petitioner have disc replacement surgery at C6-C7. He did not believe that the annular tear at C5-C6 required any treatment. Petitioner still had some complaints of low back pain; however, Dr. Gornet stated that treatment for this condition could be placed on hold (Petitioner's Exhibit B).

At the direction of Respondent, Petitioner was examined by Dr. Michael Chabot, an orthopedic surgeon, on February 28, 2013. In connection with his examination of Petitioner, Dr. Chabot reviewed medical records provided to him by Respondent; however, he did not have the MRIs. Dr. Chabot opined that Petitioner sustained a strain/contusion to his neck and low back but that Petitioner's complaints of severe pain were inconsistent with his findings on examination and that there were positive signs of symptom magnification (Respondent's Exhibit 3).

Petitioner was seen again by Dr. Gornet on March 18, 2013, and, at that time, Dr. Gornet reviewed Dr. Chabot's medical report and he stated his disagreement with Dr. Chabot's opinion that there was symptom magnification on the part of the Petitioner and that the MRI clearly showed a disc herniation at C6-C7 consistent with Petitioner's continued symptoms. He restated his opinion that Petitioner's symptoms were related to the work-related accident and that additional treatment was required (Petitioner's Exhibit B).

Dr. Chabot was subsequently provided with the MRI and he prepared supplemental reports dated April 11, and April 12, 2013, in which he opined that there was evidence of mild disc bulging at C6-C7 but no evidence of neural compression or acute changes to indicate disc pathology. He opined that Petitioner was at MMI, that he could return to work and that cervical disc surgery was not appropriate (Respondent's Exhibits 4 and 5).

Dr. Meinders was deposed on August 14, 2013, by Respondent's counsel and his deposition testimony was received into evidence at trial. Dr. Meinders' testimony was consistent with his medical records. In regard to the injury sustained as a result of the automobile accident of January, 2012, Dr. Meinders testified that he diagnosed Petitioner with cervical, thoracic and lumbar strains/sprains, recommended two to four weeks conservative care and that after Petitioner's visit of February 8, 2012, that he did not return for any additional care. The next time Dr. Meinders saw Petitioner was on August 17, 2012, when he was referred there by Dr. Gornet. Dr. Meinders agreed with Dr. Gornet's treatment recommendations and that he did not note or observe any malingering on the part of the Petitioner (Petitioner's Exhibit 7).

Dr. Gornet was deposed on August 19, 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 opinions that Petitioner had a herniated disc at C6-C7, that disc replacement surgery at that level was indicated, and that the condition was related to the work accident of June 14, 2012. Further, Dr. Gornet opined that Petitioner showed no signs of malingering. He did agree that Petitioner did not initially inform him about the prior injury of January, 2012; however, Dr. Gornet observed that the medical records did not indicate any ongoing symptoms as a result of it (Petitioner's Exhibit 7).

Dr. Chabot was deposed on August 23, 2013, and his deposition testimony was received into evidence at trial. Dr. Chabot's testimony was consistent with his medical reports and he reaffirmed his opinions that Petitioner sustained neck and back strains, that Petitioner was magnifying his symptoms, that Petitioner was at MMI and that no further medical treatment, including disc replacement surgery at C6-C7, was indicated. Dr. Chabot stated his disagreement with both Dr. Gornet and the radiologist that the MRI revealed a disc herniation at C6-C7 (Respondent's Exhibit 10).

Petitioner testified that, subsequent to the accident, he continued to work for Respondent but that the hours he was scheduled to work were progressively reduced by Respondent. Petitioner agreed that he worked for another employer, Gas Mart, as a cashier during a portion of both August and September, 2012. Respondent disputed Petitioner's position that his work hours had been progressively reduced and two witnesses, Larry Purdue and Rebecca Peetz, testified at trial, primarily in regard to this issue.

Peetz testified that she was the Respondent's human resource manager and that Petitioner failed to come in to work or call in for three consecutive work days, August 27, August 29, and August 31, 2012, and pursuant to company policy, that this was a case of job abandonment and his employment was terminated. She also testified that Respondent will provide work that conforms to light duty restrictions; however, Petitioner failed to tender any sort of request for light duty

The Arbitrator concludes Petitioner is entitled to prospective medical treatment including, but not limited to, the cervical disc replacement surgery recommended by Dr. Matthew Gornet.

In support of this conclusion the Arbitrator notes the following:

Dr. Gornet examined Petitioner on multiple occasions, conservative treatment failed to resolve Petitioner's symptoms and Dr. Gornet has recommended disc replacement surgery at C6-C7. As previously stated, the Arbitrator found the opinions of Dr. Gornet to be more persuasive and credible than those of Respondent's Section 12 examiner, Dr. Chabot.

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 62 3/7 weeks commencing September 27, 2012, through December 10, 2013.

In support of this conclusion the Arbitrator notes the following:

As previously stated, the Arbitrator found the opinions of Dr. Gornet to be more persuasive and credible than those of Dr. Chabot. On September 27, 2012, Dr. Gornet reviewed the MRI scans taken that same day and authorized Petitioner to be off work.

At trial there was considerable testimony tendered by Respondent regarding Petitioner's alleged non-compliance with company attendance policies and whether Petitioner abandoned his job. The Arbitrator specifically declines to make any conclusions or findings in regard to whether Petitioner was in compliance with Respondent's attendance policy or whether he abandoned his job. This is a workers' compensation claim and given the fact that Petitioner did not claim entitlement for payment of any weekly compensation benefits until September 27, 2012, the Arbitrator finds the bulk of this testimony to be irrelevant to the issues in this case.

William R. Gallagher, Arbitrator

work. Purdue's testimony was consistent with Peetz' and he also testified that he observed Petitioner working at the gas station in September, 2012. He also testified that Petitioner had sought medical treatment two to three months after the automobile accident of January, 2012.

At trial Petitioner testified that he continues to have severe pain in his neck, that he has not been able to return to work and that he 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 June 14, 2012, and that his current condition of ill-being is causally related to same.

In support of this conclusion the Arbitrator notes the following:

Petitioner's testimony regarding the accident of June 14, 2012, was unrebutted by Respondent. Further, an accident report was prepared that same day and Petitioner sought medical treatment at the ER of St. Elizabeth's Hospital.

While Petitioner sustained an injury to his neck in January, 2012, as result of a motor vehicle accident, Petitioner testified that the symptoms attributable to that prior accident had resolved. Further, Petitioner did not seek any further medical treatment after February 8, 2012, approximately four months prior to the accident of June 14, 2012. The testimony of Respondent's witness, Purdue, that Petitioner had obtained medical treatment two to three months after the automobile accident is not supported by any medical records.

Petitioner was evaluated by Dr. Gornet who opined that Petitioner had a neck injury, in particular, a herniated disc at C6-C7. The radiologist who reviewed the MRI agreed with Dr. Gornet that the scan revealed a herniated disc at C6-C7. The Arbitrator finds the opinion of Dr. Gornet to be more persuasive and credible than that of Respondent's Section 12 examiner, Dr. Chabot.

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 B, C, 6 and 7, as provided in Sections 8(a) and 8.2 of the Act subject to the fee schedule.

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

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 Herring,
Petitioner,
vs.

Waste Management,
Respondent.

14IWCC0822

NO: 05 WC 55937

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed January 27, 2014 is hereby affirmed and adopted.

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: SEP 24 2014
KWL/vf
O-9/9/14
42

Kevin W. Lamborn

Thomas J. Tyrrell

Michael J. Brennan

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

14IWCC0822

HERRING, ROBERT
Employee/Petitioner

Case# **05WC055937**

WASTE MANAGEMENT
Employer/Respondent

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

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

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

4957 McNABOLA LAW GROUP PC
TERRANCE M NOFSINGER
55 W WACKER DR 9TH FL
CHICAGO, IL 60601

1109 GAROFALO SCHREIBER HART ET AL
STEVE R SCARLATI
55 W WACKER DR 10TH FL
CHICAGO, IL 60601

STATE OF ILLINOIS)
)
COUNTY OF COOK)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
DECISION

14IWCC0822

Case # 05 WC 55937

Robert Herring,
Employee/Petitioner

v.

Waste Management,
Employer/Respondent

This case came before me in Chicago, Illinois on Petitioner's Petition to Reinstate. Counsel for both parties appeared before me on Tuesday, January 21, 2014 to argue their respective positions. A record was made on said date. After considering the arguments, along with the Commission file, the various exhibits and the previously filed motions and responses, I hereby deny reinstatement for the reasons set forth below.

PROCEDURAL BACKGROUND

1. Petitioner, through his attorney, Kevin R. Gallagher, filed his Application for Adjustment of Claim on December 22, 2005, more than eight years ago. The Application alleges an injury of September 9, 2005 arising out of an exposure to leaking fuel. Arb Exh 1.

2. On February 10, 2010, Steven Scarlati of Garofalo, Schreiber, Hart & Storm filed an appearance on behalf of Respondent.

3. According to the Commission's main frame, this case was dismissed for want of prosecution by Arbitrator, now Commissioner, DeVriendt on June 14, 2011.

4. On August 11, 2011, attorney Gallagher filed a Petition to Reinstate alleging that no dismissal order was ever received, that Petitioner was still disabled, that the parties had not ruled out the possibility of settlement and that he had recently provided medical records to Respondent's attorney. PX 1, Exh H.

5. I was appointed to serve as an arbitrator in October 2011 and took over the call that had previously been assigned to Arbitrator DeVriendt. On October 25, 2011, I granted reinstatement, noting that Respondent did not object and that no dismissal notice appeared in the Commission file. PX 1, Exh H.

6. At Respondent's request, Dr. Larson, a neuropsychologist, examined Petitioner pursuant to Section 12 on May 22, 2012. In connection with this examination, Respondent issued a subpoena to the high school that Petitioner attended. On July 26, 2012, Respondent's counsel wrote to attorney Gallagher, indicating the high school would not release the requested records without a signed authorization and asking that Petitioner sign and return the authorization. PX 1, Exh C. Respondent's counsel subsequently provided attorney Gallagher with a short letter from Dr. Larson explaining the need for the academic records. PX 1, Exh C.

8. On January 30, 2013, attorney Terrance Nofsinger of the McNabola Law Group, a firm that maintains offices in the same building and on the same floor as the offices occupied by attorney Gallagher, sent an E-mail to me indicating he was going to file an appearance on behalf of Petitioner and requesting a continuance of the January 31st hearing per the agreement of both parties. PX 1, Exh A.

9. On April 12, 2013, attorney Nofsinger sent me an E-mail requesting that I again continue the case, which appeared on my 2:00 status call that day, citing Petitioner's upcoming neurology appointment. PX 1, Exh B.

10. On May 24, 2013, attorney Scarlati filed a Motion to Compel requesting that Petitioner sign the authorization referenced in paragraph 6 above so as to allow Dr. Larson to review Petitioner's high school records and finalize his opinions. I heard this motion on July 1, 2013. On said date, attorney Nofsinger and an associate from attorney Scarlati's firm appeared before me and argued their respective positions. No record was made. I denied the motion based on the parameters of Section 12 and for the reason that discovery is not allowed under the Act. Nevertheless, I told attorney Nofsinger (who I then believed to be of record) that, from a practical point of view and so as to allow the case to finally move forward, it would be prudent for him to have Petitioner sign the authorization. I entered an order indicating that the motion was denied. The order does not set forth any continuance date. PX 1.

11. At my status call of July 15, 2013, this case was set for hearing on July 31, 2013. Attorney Scarlati appeared before me at approximately 9:15 or 9:30 AM on July 31, 2013. No one appeared on behalf of Petitioner. My recollection is that I asked attorney Scarlati to come back in about fifteen or twenty minutes so as to allow time for Petitioner's counsel to appear. He returned as requested. I left my courtroom at about 10:30 AM, with Petitioner's counsel still having failed to appear. Later the same day, I issued a written order, reciting the events that had occurred that morning, noting the very advanced age of the case and dismissing the case for want of prosecution. Arb Exh 4.

12. In ruling, the Arbitrator takes into consideration the entire record, including the contents of the Commission file, in compliance with Conley v. Industrial Commission , 229 Ill.App.3d 929 (4th Dist. 1992). As of the January 21, 2014 hearing, the Commission file contained my typed dismissal order dated July 31, 2013 and two pre-printed Commission forms, with each entitled "Notice of Case Dismissal." One notice is directed to attorney Gallagher at 55 West Wacker Drive, 9th Floor, Chicago, IL, 60601. The second is addressed to Garofalo, Schreiber, Hart, et al., at 55 West Wacker Drive, 10th Floor, Chicago, IL, 60601. Both notices bear the date August 5, 2013. Both reflect that I dismissed this case on July 31, 2013. Both contain the standard language concerning the deadline for filing of a petition to reinstate. Arb Exh 2-3.

13. On September 27, 2013, attorney Nofsinger filed a lengthy Petition to Reinstate attesting, by way of affidavit, that it was his belief the case was continued to "October 2013" on July 1, 2013, that he received no notice from Respondent's counsel indicating the case had been set for July 31, 2013 off of my July 15, 2013 status call, that Respondent's counsel did not provide him with a copy of any order dated July 1, 2013, that he did not receive a notice of dismissal and that he learned of the dismissal on September 26, 2013, when he conducted a main frame search. Arb Exh 5.

14. On October 9, 2013, attorney Scarlati filed a Response to Petition to Reinstate citing the conflict over the high school records and alleging, inter alia, that Petitioner's counsel generally failed to move the case forward and specifically failed to appear on either July 15 or July 31, 2013, despite the case's "red line" status. RX 1.

15. On October 28, 2013, attorneys Nofsinger and Scarlati appeared before me on the Petition to Reinstate. Before they appeared, I checked both the main frame and the Commission file and found no indication that attorney Nofsinger had ever filed an appearance on behalf of Petitioner. I brought this situation to the attention of both attorneys. Attorney Nofsinger left my courtroom, called his office and determined that in fact he had never filed a Substitution of Attorneys or Additional Appearance. He returned to my courtroom and informed me and attorney Scarlati of this. Since he lacked standing, I marked my order to reflect that the Petition to Reinstate was withdrawn. No record was made on October 28, 2013. Arb Exh 5.

16. On October 30, 2013, attorney Gallagher filed a lengthy Petition to Reinstate essentially reiterating the statements made by attorney Nofsinger and incorporating a notarized affidavit signed by his legal assistant. The assistant attested that she has worked for Gallagher Law, P.C. for twelve years, that her responsibilities include opening and processing all of the mail that arrives at the firm, that she never received oral or written notice of the hearing date of July 31, 2013 from Respondent's counsel and that Gallagher Law, P.C. never received a notice of dismissal from the Commission. Arb Exh 6.

17. On November 5, 2013, Respondent filed a Response to attorney Gallagher's Petition to Reinstate, citing the previous dismissal in 2011, attorney Nofsinger's failure to file a formal appearance and Petitioner's failure to appear on July 15 or July 31, 2013. Attached to the Response are the Commission dismissal notices dated August 5, 2013 and my order of July 1, 2013. RX 2.

18. On November 13, 2013, attorney Nofsinger filed an Appearance as co-counsel for Petitioner (Arb Exh 7) and a supplemental brief in support of the Petition to Reinstate filed on September 27, 2013.

ARBITRATOR'S CONCLUSIONS OF LAW

Section 7020.60(b)(C) of the Rules Governing Practice Before the Illinois Workers' Compensation Commission provides that "in all cases which have been on file at the Commission for three years or more, the parties or their attorneys must be present at each status call on which the case appears." The same sub-section further provides that "the case will be set for trial unless a written request has been made to continue the case for good cause." Such a request must be received by the Arbitrator at least fifteen days in advance of the status call date. The instant case is clearly governed by this sub-section since it has been on file for more than eight years. The fact that attorney Nofsinger made two continuance requests in advance of scheduled status calls evidences his awareness of the requirements of the sub-section. Petitioner maintains he was relieved of the obligation of appearing at my July 15, 2013 status call because I allegedly continued the case to "October 2013" on July 1, 2013. My order of July 1, 2013 does not support this argument. Petitioner also maintains Respondent's counsel "hid" my July 1, 2013 order from his counsel. If counsel had any concerns along these lines, he could have returned to my courtroom to obtain the order from me or sent me and opposing counsel an E-mail.

Section 7020.90(a) provides, in relevant part, that "notices of dismissal shall be sent to the parties" and that a party has sixty days from the receipt of a dismissal order to file a petition for reinstatement. Section 7020.30(b) provides, in relevant part, that "an Appearance, on forms provided by the Commission, shall be filed by any attorney or law firm representing any party in any proceedings before the Commission." The same sub-section provides that "no attorney or law firm will be recognized in any case before the Commission unless he or they have duly entered their written Appearance."

Attorney Nofsinger failed to comply with sub-section 7020.30(b) in that he took action on behalf of Petitioner over a ten-month period without having filed an Appearance. The language of this sub-

section could not be clearer. The Arbitrator cannot recognize or give weight to the Petition to Reinstate that Nofsinger filed on September 27, 2013 because Nofsinger was not of record at that time. Nofsinger did not file his co-counsel Appearance until November 13, 2013.

Attorney Gallagher, who filed a second Petition to Reinstate on October 30, 2013, alleges, via his assistant's affidavit, that he never received any written notice of the July 31, 2013 dismissal. Gallagher agrees, however, that the Commission's Notice of Case Dismissal, dated August 5, 2013, bears the correct address of his law firm. Gallagher also agrees that he learned of the dismissal (from Nofsinger) on September 26, 2013.

Both Nofsinger and Gallagher argue that Respondent had the obligation of advising them of the July 31, 2013 dismissal for want of prosecution. The law imposes no such obligation. It is the Commission's obligation to provide notice. The Commission did in fact issue a properly addressed notice to Gallagher, Petitioner's attorney of record, five days after the dismissal and eighty-six days before Gallagher filed his Petition to Reinstate. The only other existing obligation, notice-wise, is the claimant's obligation to monitor his case. That obligation is heightened when the case is of very advanced age.

Section 7020.90(c) provides, in relevant part, that an arbitrator "shall apply standards of fairness and equity in ruling on the Petition to Reinstate and shall consider the grounds relied on by Petitioner, the objections of Respondent and the precedents set forth in Commission decisions." In endeavoring to comply with this sub-section, the Arbitrator notes a number of competing factors. The Arbitrator has to assume that the Commission's properly addressed notice failed to arrive at its destination in order to find Gallagher's Petition to Reinstate timely. It is only if the Arbitrator disregards the notice (a copy of which was in the Commission file) that she can find Gallagher filed the Petition to Reinstate within sixty days of learning of the dismissal from Nofsinger on September 26, 2013. Timeliness, however, is only one of the relevant factors. The Arbitrator must also give consideration to the age of the claim, the relative merits of the claim and whether Petitioner acted with due diligence in pursing the claim. See, e.g., Contreras v. Industrial Commission, 306 Ill.App.3d 1071, 1076 (1999). Petitioner alleges permanent total disability and has received no benefits to date yet the main frame reflects no filings of a request for hearing. It appears to the Arbitrator that the claim first became active in 2012 and only because Respondent filed a Motion to Compel in connection with its Section 12 examination. Between January of 2013 and the dismissal, the only activity engaged in by Petitioner was activity performed by an attorney who lacked standing.

Having considered all of the foregoing, the Arbitrator denies reinstatement.

Unless a *Petition for Review* is filed within 30 days from the date of receipt of this order, and a review perfected in accordance with the Act and the Rules, this order will be entered as the decision of the Workers' Compensation Commission.

Molly C Mass
Signature of arbitrator

1/27/14
Date

JAN 27 2014

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

14IWCC0823

Isabel Garcia,
Petitioner,
vs.

NO: 08 WC 25921

Bueno beef,
Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitione herein and notice given to all parties, the Commission, after considering the issue of petition to reinstateand being advised of the facts and law, affirms and adopts the Decision of the Arbitrator.

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

The party commencing the 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 24 2014
KWL/vf
O-9/9/14
42

Kevin W. Lamborn

Michael J. Brennan

Thomas J. Tyrrell

STATE OF ILLINOIS)
) SS.
COUNTY OF LASALLE)

☒ 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

LuAnn Pierard,
Petitioner,
vs.

14IWCC0824

NO: 03 WC 48570

State of Illinois Department of Human Services,
Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of accident, 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 June 3, 2013 is hereby affirmed and adopted.

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

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

DATED: SEP 24 2014
KWL/vf
O-9/9/14
42

Kevin W. Lamborn

Thomas J. Tyrrell

Michael J. Brennan

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

14IWCC0824

PIERARD, LuANN
Employee/Petitioner

Case# **03WC048570**

SOI DEPT OF HUMAN SERVICES
Employer/Respondent

On 6/3/2013, 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:

0190 LAW OFFICES OF PETER F FERRACUTI
JENNIFER KIESEWETTER
110 E MAIN ST PO BOX 859
OTTAWA, IL 61350

5048 ASSISTANT ATTORNEY GENERAL
MEGAN JANICKI
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

JUN 3 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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

14IWCC0824

LuAnn Pierard
Employee/Petitioner

v.

State of Illinois Department of Human Services
Employer/Respondent

Case # 03 WC 48570

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 and Ottawa**, on **4/9/2013 and 5/20/2013**. 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 _____

FINDINGS 14IWCC0824

On **7/30/2003**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

On this date, Petitioner ***did 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 **$53,855.88**; the average weekly wage was **$1,035.69**.

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 not*** paid all appropriate charges for all reasonable and necessary medical services because the claim is not compensable and no liability therefore exists

Respondent shall be given a credit of **$23,772.32** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$23,772.32**.

Respondent is entitled to a credit of **$5,493.82** under Section 8(j) of the Act.

ORDER

The Arbitrator finds as a matter of fact & as a conclusion of law the Petitioner's did not sustain an accident that arose out of and in the course of her employment under the Worker Compensation Act.

Respondent shall pay Petitioner temporary total disability benefits of $0/week for 0 weeks, commencing NA through NA, as provided in Section 8(b) of the Act.

Respondent shall pay reasonable and necessary medical services of $0, as provided in Sections 8(a) and 8.2 of the Act.

Respondent shall pay Petitioner permanent partial disability benefits of $0/week for NA weeks, because the Arbitrator finds no sustained permanency and therefore awards Petitioner no permanent partial disability benefits under the Act. The Arbitrator declines to award penalties or fees upon Respondent.

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

STATEMENT OF INTEREST RATE If the Commission reviews this award, interest at the rate set forth on the *Notice of Decision of Arbitrator* shall accrue from the date listed below to the day before the 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 30, 2013** Date

JUN -3 2013

STATEMENT OF FACTS 03 WC 48570

Luann Pierard ("Petitioner") filed a Workers' Compensation claim on October 1, 2003, alleging that her current mental status resulted from stress at her place of employment. (Respondent's Exhibit 3). On the date of alleged injury, Petitioner was a 52-year-old female employed at the Illinois Department of Human Services ("DHS") since 1976 in the LaSalle County office. Petitioner testified that in July 2003, she worked as a Local Office Administrator. Her job duties included oversight of the determination of welfare and Medicare and Medicaid benefits. She was secondarily employed as a real estate agent at Pride Realty, Inc. ("Pride Realty") by Pride Realty owner Virginia Sue Johnson. Petitioner testified, following her employment at Pride Realty, that she later became Virginia Sue Johnson's supervisor at DHS. Petitioner testified that she notified and had her Pride Realty job approved the State of Illinois, and was cautioned against any "dealings with [DHS] clients." Petitioner testified that she took a real estate salesperson class through Century21, and submitted her tuition to DHS for payment which was not approved. Petitioner testified that she allowed her real estate license to lapse in 2004 or 2005.

Petitioner testified that her supervisors instructed her to inform them of potential or known conflicts of interest between her secondary employment in real estate and her employment with DHS. (Respondent's Exhibit 5B, pp. 1-3). Allegations of improper use of state equipment, state time and conflicts of interest in certain real estate transactions were brought to the attention of DHS through anonymous reports sent to Petitioner's supervisors and the Bureau of Internal Affairs between approximately 1996 and 2003. (Respondent's Exhibit 9, Deposition of Barry Beckwith, 5/11/06; Respondent's Exhibit 10, Deposition of Terry A. Bruner; Respondent's Exhibit 11, Deposition of Derrick J. Moscardelli, 5/11/06).

The allegations in the anonymous reports were investigated appropriately and in a timely manner. (Respondent's Exhibit 5, A-D – Internal Investigation Reports; Respondent's Exhibit 9, 11; Respondent's Exhibit 9, Deposition of Barry Beckwith, 5/11/06; Respondent's Exhibit 10, Deposition of Terry A. Bruner; Respondent's Exhibit 11, Deposition of Derrick J. Moscardelli, 5/11/06). Petitioner reported to her psychologist that she was investigated fifteen times over the course of her employment (Petitioner's Exhibit 2 – Deposition Transcript of Dr. Michael Glavin, December 2, 2004, pp. 14-15). Petitioner testified that she was interviewed twice regarding these investigations: once in August 1999, and once in 2002. Petitioner testified that in March 2001, she started noticing vandalism to her car while it was parked at the DHS office.

Internal Affairs Investigator Derrick Moscardelli confirmed that Petitioner was interviewed twice (Respondent's Exhibit 11, Deposition of Derrick J. Moscardelli, 5/11/06, pp. 20-22), and Petitioner's supervisors during the time period – Terry Bruner and Barry Beckwith – testified that to their knowledge, Petitioner was investigated two or three times. (Respondent's Exhibit 9, Deposition of Barry Beckwith, 5/11/06, p. 11; Respondent's Exhibit 10, Deposition of Terry A. Bruner, p. 10). Only four investigations were ever fully initiated and completed, all

pertaining to alleged overlap or misconduct related to Petitioner's secondary real estate employment. No disciplinary action was ever taken against Petitioner. (Respondent's Exhibit 5, A-D – Internal Investigation Reports).

Petitioner claims that on July 30, 2003, she received a phone call from her supervisor at the time, Terry Bruner, asking what Petitioner's schedule would be for the week. Ms. Bruner later indicated that Internal Affairs contacted her to confirm Petitioner's schedule for the week. Petitioner testified that after she hung up the phone, she emotionally broke down. In August 2003, Petitioner testified that she went to see Dr. Mark McVay on August 1, 2003, with symptoms of fatigue and exhaustion. (Petitioner's Exhibit 6). Dr. McVay diagnosed Petitioner with acute situational anxiety, depression, and increased blood pressure. He took Petitioner off work, referred Petitioner to psychological Dr. Michael Glavin, and prescribed Effexor. (Petitioner's Exhibit 6).

Petitioner testified that she began treating with Dr. Glavin in August 2003. At his August 6, 2003 initial evaluation, he diagnosed Petitioner with major depression with anxiety and PTSD. (Petitioner's Exhibit 7). Dr. Glavin extended Petitioner's medical leave on August 27, 2003 (Petitioner's Exhibit 8), and completed subsequent FMLA certifications and Authorization for Disability Leave forms for Petitioner, keeping her off work for several months. (Petitioner's Exhibits 8, 9). In December 5, 2003 and January 2, 2004, Dr. Glavin indicated that due to Petitioner's anxiety and depression which were "aggravated by her present work environment/stress," he did not believe Petitioner would be able to return to her regular occupation. (Petitioner's Exhibit 9).

Petitioner attended a section twelve examination at Respondent's request on December 17, 2003 with Dr. Robert Reff. (Petitioner's Exhibit 54). Following his record review and interview, Dr. Reff opined that Petitioner had an adjustment disorder with anxiety and depressed mood, and that, by the date of his examination, Petitioner was "capable of performing the essential features of another job . . . manifested no observable evidence of cognitive impairment . . . [and] manifested no signs of Major Depression or other psychiatric conditions that would limit her capacity to function in her daily life." (Petitioner's Exhibit 54, p. 33). At his deposition, Dr. Reff opined that Petitioner "did not manifest any significant limitation in her day-to-day functioning as a consequence of a severely impairing psychiatric condition such that she would be incapable of functioning at any job. I felt that if – that based on her perceptions of the environment at her current job that it was unlikely that she would be capable of returning to that environment, but I did not believe that she was psychiatrically impaired and did not believe that she was incapable of functioning in a gainful way." (Petitioner's Exhibit 54, p. 32).

Petitioner never returned to work with DHS. Petitioner testified that she continued treating with Dr. Glavin through 2007. Petitioner received TTD benefits from December 4, 2003 through July 31, 2004. (Respondent's Exhibit 1).

Petitioner requested alternative employment accommodations which were granted, and Petitioner began working at LaSalle County Veteran's Affairs Office as an adjunct on September 18, 2007. She testified that her job is to process paperwork and determine eligibility of Veterans' benefits.

Petitioner testified that at present, she is angry, and that she feels that she is not an easy person with whom to get along or work. She stated that she does not put up with things as she used to, and is no longer active in the community.

CONCLUSIONS OF LAW

The Arbitrator adopts the above findings of material facts in support of the following 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?

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

K. What TTD benefits are in dispute?

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

M. Should penalties or fees be imposed upon Respondent?

Petitioner alleges that she suffers from a mental disability incurred from mental stressors related to Internal Affairs investigations into alleged misuse of State time and property in relation to Petitioner's secondary employment.

The Arbitrator finds as a matter of law and fact the Petitioner did not sustain an injury that arose out of or in the course of her employment in the case at bar under the Act.

Petitioner's claim is a" mental/mental claim"because she did not experience or witness a trauma. Petitioner claims that her alleged mental disorders resulted from stressful work incidents, but these do not amount to "trauma":

> "Mental disorders not resulting from trauma must arise from a situation of greater dimensions than the day-to-day emotional strain and tension which all employees must experience . . . the worker must prove that employment conditions, when compared with nonemployment conditions, were the 'major contributory cause' of the mental disorder."

Chic. Bd. of Educ. v. Indust. Cmmn., 169 Ill.App.3d 452, 268 (1st Dist. 1988).

The Court noted that job stress, of itself, is not a disease, and further noted that events and conditions capable of producing stress exist in every employment environment. Disorders not resulting from trauma must arise from a situation of greater dimensions than the day-to-day emotional strain and tension that all employees must exercise. *Chic. Bd. of Educ. v. Indust. Cmmn.*, 169 Ill.App.3d at 468.

The Arbitrator takes notice of *Pathfinder Co. v. Indust. Cmmn.*, 62 Ill.2d 556 (1976), which first determined that mental injuries, without physical trauma, are compensable. The Supreme Court held that a Petitioner who "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, although no physical trauma or injury was sustained." *Id.* at 563. "Recovery for non-traumatically inducted mental disease is limited to those employees who can establish that: (1) the mental disorder arose in a situation of greater dimensions than the day-to-day emotional strain and tension which all employees must experience; (2) the conditions exist in reality, from an objective standpoint; and (3) the employment conditions, when compared with the nonemployment conditions, were the major contributing cause of the mental disorder. *Northwest Suburban Special Educ. Org. v. Indust. Cmmn.*, 312 Ill.App.3d 783, 787-788 (1st Dist. 2000) (citing *Runion v. Indust. Cmmn.*, 245 Ill.App.3d 470, 473 (5th Dist. 1993)). "Illinois courts have consistently held that conflicts with co-workers and/or supervisors, disciplinary action taken by employers, verbal abuse, and various other types of non-physical confrontations occurring at or related to work are simply a normal part of the employment environment and, in so finding, deny compensation for claims of mental disability arising out of such situations." *Gathright v. Comprehensive Mental Health*, 02 ILWC 28522, 10 IWCC 0880, 2010 WL 2094236 (2010) (citing *Pathfinder v. Indust. Cmmn.*, 62 Ill.2d 556 (1976)); *see also Northwest Suburban*, 312 Ill.App.3d at 788 (internal citations omitted).

In *City of Springfield v. Indust. Cmmn*, the petitioner – a fire inspector – claimed he was subjected to stress due to excessive workload, political considerations within his department, misinterpretation of rules and discrimination by his supervisors. *City of Springfield v. Indust. Cmmn*, 214 Ill.App.3d 301, 309 (4th Dist. 1991). The petitioner claimed that for the final four years of his employment, he expressed stress-related problems while on the job and sought help for a psychiatrist. The Fourth Appellate District found that a compensable accident did not take place since the petitioner failed to show he was exposed to emotional strain and tension greater than that which all employees experience. The court noted that the conditions producing the disability must be "extraordinary," and they must, from an objective standpoint, exist in reality. *City of Springfield v. Indust. Cmmn*, 214 Ill.App.3d at 308. It is not sufficient that the employee believes, although mistakenly, that the conditions exist.

Petitioner claimed that she was "singled out" and that there was a conspiracy against her at DHS. (Respondent's Exhibit 5, A-D – Internal Investigation Reports). She told her doctor that anonymous reports to the Bureau of Internal Affairs – although the origin of the reports was never determined – constituted harassment which caused her stress. (Petitioner's Exhibit 2 –

Deposition Transcript of Dr. Michael Glavin, December 2, 2004). However, the reports alleged that other additional DHS employees were using state time and equipment improperly and that conflicts of interest existed with their secondary employment. Petitioner testified that she was aware that some other individuals involved in secondary real estate had also been investigated. These employees were interviewed, investigated and on occasion, individually disciplined. (Respondent's Exhibit 5, A-D – Internal Investigation Reports).

Petitioner also slanted the details of her investigation to Dr. Michael Glavin by informing him, in August 2003, that she had been investigated over fifteen times. (Petitioner's Exhibit 2 – Deposition Transcript of Dr. Michael Glavin, December 2, 2004, pp. 14-15). In fact, as attested to by Petitioner, she was only interviewed by Internal Affairs on two separate occasions and only four investigations were actually initiated. (Respondent's Exhibit 5, A-D – Internal Investigation Reports; Respondent's Exhibit 11, pp. 20-22). Furthermore, legitimate potential conflicts of interest existed with Petitioner and her DHS employment: an employee supervised by Petitioner – Virginia Sue Johnson – was Petitioner's supervisor at Pride Realty, and allegations were made that Petitioner and Virginia Sue Johnson conducted real estate transactions with Public Aid recipients. It is not "extraordinary" for an employer to look into allegations of misconduct in the workplace.

In addition, Petitioner's work stressors did not amount to "trauma." Traumatic events listed in the DSM-IV under the diagnostic features of Post-Traumatic Stress Disorder include, but are not limited to, "military combat, violent personal assault (sexual assault, physical attack, robbery, mugging), being kidnapped, being taken hostage, terrorist attack, torture, incarceration as a prisoner of war or in a concentration camp, natural or manmade disasters, severe automobile accidents, or being diagnosed with a life-threatening illness. Witnessed events include, but are not limited to, observing the serious injury or unnatural death of another person due to violent assault, accident, war, or disaster or unexpectedly witnessing a dead body or body parts." (Respondent's Exhibit 7 – Diagnostic and Statistical Manual of Mental Disorders, American Psychiatric Association, Washington, DC, 1999).

Although Petitioner attempts to link her PTSD diagnosis to the incident of July 30, 2003, there was no harassment experienced by Petitioner on that date. Petitioner testified that on July 30, 2003, her supervisor asked what Petitioner's schedule was for that week.

The Arbitrator declines to discuss the details of the investigations, but is persuaded that the investigations described by the Petitioner and the witnesses objectively did not cause stress in greater dimensions than that endured by all, or most of, the State of Illinois' managerial employees. *See generally, City of Springfield v. Indust. Cmmn*, 214 Ill.App.3d 301; *see also Johnson v. Dept. of Human Serv.*, 08 IWCC 0014 (Jan. 3, 2008).

Petitioner failed to meet her burden to prove that her injury arose out of the course of her employment and that her four investigations were "extraordinary" from an objective standpoint.

Petitioner assertions of the number of investigations, the length of the investigations, and the scope of the investigations in that other employees were being investigated does not comport to the evidence in the record. Petitioner was not "singled out," as she portrayed to her doctor. Petitioner's belief that there was a conspiracy against her did not exist in reality and it is not sufficient that an employee mistakenly believes that such conditions exist. Any increase in work load, fear of losing her job or apprehension regarding investigations surrounding Petitioner's voluntary secondary employment do not arise from a situation of greater dimensions than the day-to-day emotional strain and tension all employees must experience.

Morever, the Arbitrator finds as fact that there was 1) no selective law enforcement in the actions of the State and or Inspectors General. The State personnel performed the assignments they are directed to do via the Illinois Revised Statutes.

CONCLUSION

The Arbitrator concludes as a matter of law, based upon the material facts, that the Petitioner did not sustain an accident as contemplated by the Workers' Compensation Act. In support of the Arbitrator's decision, he looks to the standard set forth by the Illinois Supreme Court in *Pathfinder* and upheld by the First District Court in *General Motors*. Petitioner did not allege, nor did she sustain a sudden, severe emotional shock traceable to a definite time, place and cause. Rather, she had an onset of anxiety resulting from cumulative stress that she attributes to investigations which took place sporadically over seven years during Petitioner's employment with Respondent.

Given that the Arbitrator concludes that there was no accident under Illinois law within the meaning of the Workers' Compensation Act, no further determinations on other issues in dispute are necessary. Nevertheless, the Arbitrator finds that the record does not contain evidence that the Respondent acted unreasonable or vexatiously such that would rise to the level of an award of penalties and/or attorney fees.

The Arbitrator has reviewed and taken into consideration all evidence and testimony in this case in issuing this Decision. Based on all of the above, the undersigned Arbitrator denies Petitioner's entitlement to workers compensation benefits under the Act.

STATE OF ILLINOIS)
) SS.
COUNTY OF KANE)

☐ 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

MICHAEL KING,

Petitioner,

14IWCC0825

vs.

NO: 10 WC 44712

TURNER INDUSTRIES GROUP,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of medical expenses, temporary total disability 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. 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).

A review of the record reflects that the parties stipulated that Respondent was entitled to a credit for any payments made by Respondent or any write-offs identified in the medical bills and the group carrier payments identified in PX9. (T54). Accordingly, the Commission modifies the Arbitrator's medical award from $83,198.23 to $ 66,912.00, subject to the medical fee schedule, Section 8.2.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed January 31, 2014, is hereby modified as stated herein and otherwise affirmed and adopted.

14IWCC0825

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay to the Petitioner the sum of $1,243.00 per week for a period of 88-2/7 weeks, for the periods of October 12, 2010 through July 25, 2011, February 13, 2012 through April 26, 2012, and March 04, 2013 through November 15, 2013, that being the periods 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 $66,912.00 for medical expenses under §8(a) and subject to §8.2 of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall authorize and pay for the prospective medical treatment prescribed by Dr. Freedberg.

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: SEP 24 2014
KWL/kmt
O-09/09/14
42

Kevin W. Lamborn

Thomas J. Tyrrell

Michael J. Brennan

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

14IWCC0825

KING, MICHAEL
Employee/Petitioner

Case# **10WC044712**

TURNER INDUSTRIES GROUP
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:

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

1872 SPIEGEL & CAHILL PC
KATERINA D KYROS
15 SPINNING WHEEL RD SUITE 107
HINSDALE, IL 60521

STATE OF ILLINOIS)
)SS.
COUNTY OF Kane)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

14IWCC0825

Michael King
Employee/Petitioner

v.

Turner Industries Group
Employer/Respondent

Case # 10 WC 44712

Consolidated cases: n/a

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Gregory Dollison**, Arbitrator of the Commission, in the city of **Geneva, Illinois**, on **11/15/13**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **10/11/10**, 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 **$14,758.30**; the average weekly wage was **$3,689.58**.

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

Respondent shall be given a credit of **$50,963.00** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$50,963.00**.

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

ORDER

Respondent shall pay Petitioner temporary total disability benefits of $1,243.00/week for 88-2/7 weeks, commencing 10/12/10 through 7/25/11, 2/13/12 through 4/26/12, and 3/4/13 through 11/15/13, as provided in Section 8(b) of the Act.

Respondent shall pay Petitioner the temporary total disability benefits that have accrued from 10/11/10 through the present, and shall pay the remainder of the award, if any, in weekly payments.

Respondent shall pay reasonable and necessary medical services of $83,198.23, as provided in Section 8(a) of the Act, subject to the fee schedule. Respondent is entitled to a credit for all medical bills paid.

Respondent shall authorize and pay for the treatment prescribed by Dr. Freeberg.

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

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

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

Signature of Arbitrator — Date: 1/30/14

JAN 31 2014

Statement of Facts:

Petitioner, a small equipment operator, Local 151, testified he sustained a work related injury to his right shoulder while employed by Turner Industries Group, on October 11, 2010. Petitioner provided that he was coming down from fueling a generator and lost footing on the ladder. Petitioner stated he grabbed the ladder with right hand and was hanging by his right arm. He felt a pulling sensation in the right arm.

Petitioner presented to the emergency room at Adventist Bolingbrook Hospital with a chief complaint of right shoulder pain and injury. Petitioner provided a history that he sustained an injury where his right shoulder was injured while catching himself while in the process of falling. He stated that pain was quite significant and was requesting pain medicine due to the severity of the pain. An exam of the right shoulder was tender. There was decreased range of motion due to severity of pain. X-ray of right shoulder showed mild acromioclavicular osteoarthritis. The bones of the shoulder otherwise were normally developed. No definite acute fracture, dislocation, or subluxation was seen. The glenohumeral joint was intact. Petitioner was diagnosed with right shoulder injury, probable strain, rule out internal joint derangement. Petitioner was prescribed Vicodin and advised to follow-up with Dr. Jonathan Wigderson in 1-2 days. (PX 1)

On October 12, 2010, Petitioner presented to Physician's Immediate Care where he saw by Dr. Ronald Gregus. Petitioner provided a history that while at work on October 11, 2010, he was coming down a ladder when his foot slipped off the rung of the ladder stretching his right shoulder as he attempted to hold on. He noted severe pain in the anterior and lateral part of his shoulder. Petitioner stated that he did not experience any paresthesias or numbness into the right arm and had no pain radiating to the neck. He denied any non-work related incident or event correlating with the development of this condition. He rated his pain level at 8/10, constant worse at times and sharp in quality. An examination of the right shoulder revealed marked tenderness both anteriorly just lateral to the bicipital groove and laterally in the shoulder. There was some mild swelling. His range of motion was markedly limited. He had 80 degrees in lateral abduction with significant pain. He was unable to internally or externally rotate and he adducted with limited movement. Internal rotation caused him significant pain. Petitioner was assessed with right shoulder sprain/strain. A MRI of the right shoulder was recommended and he was to continue wearing the arm sling and his prescribed medication. Petitioner was returned to restricted work, left hand duty only. (PX 3)

Petitioner next began treating with Dr. Timothy S. Petsche at at Fox Valley Orthopaedic Associates. On October 14, 2010, Petitioner presented with a consistent history. An examination of the right shoulder revealed positive abduction weakness, 2/5 strength, external rotation strength was 2/5. Internal rotation strength was 3/5. It was noted that the shoulder had diffuse tenderness to palpation of the soft tissues surrounding the glenohumeral joint. There was no focal AC joint tenderness, but there was diffuse tenderness. There was also some mild diffuse edema surrounding the shoulder. The doctor noted that he could not perform a good instability exam or range of motion exam secondary to the severity of his symptoms and guarding. Petitioner was assessed with right shoulder acute traumatic traction injury at work from falling off a ladder. A MRI with arthrogram of the shoulder was recommended to rule out cuff tear or labrum tear. Petitioner was also taken off work. (PX 2)

On October 26, 2010, Petitioner underwent an arthrogram of right shoulder at Fox Valley Orthopaedic Associates, S.C. by Dr. Joseph M. Persak. Neutral, external and internal rotation films were taken which showed a small amount of contrast leaking in the subacromial-Subdeltoid bursal space consistent with a small full-thickness rotator cuff tear.

Petitioner also underwent the MRI of right shoulder post arthrogram on October 26, 2010. The findings were as follows:

> "The acromion process reveals moderate degenerative arthrosis and undersurface spurring indenting the supraspinatus muscle tendon belly junction. There was lateral downward sloping of the acromion process. The acromion process was type II in nature. The superior glenohumeral ligament and coracohumeral ligament were not well identified on the study but appeared to be intact as well as the biceps sling. The biceps tendon

was within the biceps groove. The middle glenohumeral ligament appeared cohgenitally absent. The anterior band, posterior band and axillary recess of the inferior glenohumeral ligament appeared normal. There was contrast leakage into the subacromial Subdeltoid bursal space via a small full-thickness tear of the extreme anterior aspect of the supraspinatus tendon. There was marked tendinosis of the subscapularis tendon with evidence for a partial intrasubstance tear of the superior aspect with slight subluxation of the biceps tendon into the tendon itself. The infraspinatus tendon and teres minor tendon appeared normal. There was no evidence for atrophy-or edema of rotator cuff muscle bellies. The patient could not undergo the Abduction external rotation (ABER) position but there was suggestion of an inferior labral tear. There was some distortion of the superior labrum either consistent with diffuse degeneration or possible Superior Labral Anterior Posterior (SLAP) II-C tear." (PX 2)

Petitioner follow-up with Dr. Petsche on October 28, 2010. The MRI of right shoulder was reviewed and Dr. Petsche assessed: 1.) Right shoulder full thickness acute traumatic rotator cuff tear due to work injury; 2.) Type 2 acromion; 3.) SLAP tear, possibly acute traumatic, possibly degenerative; 4.) Biceps tendon slight subluxation; and 5.) possible inferior labrum tear. Dr. Petsche recommended a right shoulder arthroscopy for the primary purpose of repairing his rotator cuff tendon. Dr. Petsche noted that at the time of surgery he would evaluate the biceps tendon for significant subluxation. If it was subluxed he would perform a tenodesis. He would evaluate the labrum both superiorly and inferiorly which he indicated might require a labrum repair or debridement. (PX 2)

On January 14, 2011, Dr. Petsche performed 1.) right shoulder arthroscopy with rotator cuff repair; 2.) biceps tenodesis; 3.) subacromial decompression; 4.) debridement of SLAP tear; 5.) partial synovectomy; 6.) chondroplasty of glenoid (removal of chondral flap); and 7.) debridement of subscapularis tendon. The postoperative diagnosis was 1.) right shoulder acute, traumatic, full thickness rotator cuff tear; 2.) type 2 acromion; 3.) type I SLAP tear; 4.) biceps tendon subluxation; 5.) cartilaginous anterior inferior labrum tear; 6.) glenohumeral synovitis; 7.) chondral flap on the glenoid posteriorly; and 8.) partial tear of the subscapularis tendon. (PX 2)

Post surgery, Petitioner continued with Dr. Petsche. On February 28, 2011, the doctor noted Petitioner had been doing well. Risk of re-tear and overdoing it were discussed. Physical therapy was initiated on March 7, 2011. On April 11, 2011, Dr. Petsche noted that Petitioner reported that his pain was tolerable. His biggest complaint was a feeling of spasming and cramping over the greater tuberosity region. He didn't feel this in the biceps region. An examination revealed his strength was 3+/5 with abduction external rotation, 4-/5 with internal rotation. Physical therapy was continued. (PX 2)

On May 9, 2011, Dr. Petsche noted Petitioner was feeling very good, had no pain, just weakness. Petitioner informed the doctor that he tried to do some activity around the house. He tried to help his daughter till a garden and it was much too painful for him to tolerate. With routine activities of daily living he was doing great, but with any actual vigorous physical activity he had pain. An examination showed right shoulder weakness. He was at 3/5 strength to external rotation and abduction. Internal rotation strength was 4/5. Dr. Petsche felt Petitioner was doing well status post right shoulder arthroscopic rotator cuff repair with biceps tenodesis, decompression, debridement of SLAP. However, he noted Petitioner had significant residual weakness. The doctor indicated that it would be necessary to recover prior to returning to his work as a heavy equipment operator. Physical therapy was continued and he was to be reevaluated at monthly intervals. (PX 2)

On June 9, 2011, Dr. Petsche noted Petitioner was feeling good and physical therapy was very effective. The doctor stated, "[he] just does not have the strength or endurance to return to his full duty job." An examination revealed the right shoulder had excellent restoration of mobility. In all planes, he had good motion, but also in all planes, he had weakness. The plan was to continue with physical therapy to work on strengthening and endurance. The doctor also planned on releasing Petitioner to full duty work after July 14, 2011. (PX 2)

On July 21, 2011, Petitioner was discharged from physical therapy. At that time, the therapist noted Petitioner reported that he felt much better overall and felt he was ready for discharge. (PX 2)

Petitioner returned to Dr. Petsche on July 25, 2011. Petitioner reported that he was feeling good and was pleased that he had the shoulder fixed. He felt that he had a normal enough strength to return to work without any restrictions. On examination, the right shoulder had excellent restoration of mobility and strength in all planes. Dr. Petsche felt

Petitioner had reached maximal medical improvement and released him to return to work. (PX 2)

Petitioner testified that upon his release, he was placed on the "wait list" through the Union.

On January 26, 2012, Petitioner returned to Dr. Petsche with right shoulder complaints. Dr. Petsche noted that Petitioner provided that the "...right shoulder was doing excellent from when I sent him to work in the midsummer up until about 2-3 months ago. He states pretty much when it got cold out. He was driving a truck with stick shift and his symptoms at work have recurred. Now that his pain is back, it seems the same as it was preoperatively. He has weakness and locking in the shoulder with sharp, at times dull pain that will wake him up at night and occasionally give him numbness and tingling. He has been taking Advil and using icy hot. He is very frustrated with his inability to sleep." An examination showed positive abduction weakness 4/5. X-ray of the right shoulder show changes consistent with a previous decompression but no acute bony pathology was noted. Also, a lucent area was noted in the humerus proximally from a biceps tenodesis screw and cuff repair screw in the greater tuberosity. The doctor assessed status post right shoulder arthroscopy, cuff repair decompression and biceps tenodesis with recurrent pain and weakness, rule out recurrent tear. A MRI scan with arthrogram was ordered. (PX 2)

Petitioner underwent an arthrogram and MRI of the right shoulder on February 8, 2012. Dr. Sharmi Jayachandran who performed the MRI noted the following:

> "Please note that there is no extravasation of contrast into the subacromial-sub-deltoid bursa even in the ABER position. There is, however, noted irregularity along the articular surface fibers of the anterior aspect of the supraspinatus tendon with some retraction of the partially torn articular surface fibers by approximately 14 mm from the site of insertion, best .seen on coronal image #10, parasagittal image #14-16 and well demonstrated on the ABER position images #5-13. The recurrent tear appears high grade. This is along the anterior rotator cuff interval. The remainder of the rotator cuff tendons are intact. The two anchors from the prior cuff repair are seen in the anterosuperior aspect of the greater tuberosity. There is also an anchor from the tenodesis of the biceps tendon noted. There is debridement of the superior glenoid labrum seen, which appears somewhat amputated; however, there is no clear undermining of the glenoid labrum seen on the current exam. There is some synovial debris suggested in the inferior axillary pouch region best visualized on coronal sequence 10-15. This may be synovial frond. There is some thinning of the cartilage lining the glenoid posteriorly. No full-thickness cartilage defect is seen. The acromion is type II."

On February 13, 2012, Petitioner followed-up with Dr. Petsche to discuss the MRI of right shoulder. Dr. Petsche felt the MRI was consistent with a well-healed biceps tenodesis, a well performed subacromial decompression, and the appearance of a synvial fold, or frond, inferiorly. The doctor noted that in the area of the rotator cuff tendon repair, there appeared some undersurface partial tearing, or residual tear, that did not completely heal at the repair site. The doctor assessed 1.) right shoulder pain 1 year status post arthroscopic rotator cuff repair with incomplete healing on the articular side of the rotator cuff repair site; 2.) well-performed decompression and biceps tenodesis; and 3.) inferior synovial frond seen by MR arthrogram. Physical therapy was recommended. The doctor noted that he was not recommending surgical intervention, indicating that if Petitioner did not get better with the rest and therapy, he would consider Toradol injection. (PX 2) Physical therapy was initiated at ATI Physical Therapy on February 27, 2012.

On April 2, 2012, Petitioner returned to Dr. Petsche. The doctor recommended proceeding with a Toradol injection. Petitioner was kept off work. (PX 2)

On April 26, 2012, Petitioner followed with Dr. Petsche. The doctor noted that Petitioner indicated that the Toradol injection worked wonderfully. It took a while to kick in, but his symptoms gradually improved to the point where he had no residual symptoms. Petitioner reported he felt very well and was confident he would be able to return to work. Dr. Petsche provided that Petitioner could resume work and activities as tolerated, with no restrictions. The doctor also warned him that recurrence does occasionally occur, and if it did he was welcome to come back for a repeat Toradol injection. (PX 2)

On April 30, 2012, Dr. Petsche authored an addendum to his January 26, 2012 office note. Dr. Petsche wrote, "It

should be noted that when patient told me that his shoulder pain has reoccurred, he meant that he was having such pain that he had putting his truck in gear, not that he was driving a stick shift truck at work. This was not the intent of my note and just to clarify, he called to clarify the situation. He was simply having pain putting the truck in gear, not that he was driving a stick shift truck." (PX 2)

Petitioner returned to work for his union without restrictions and was employed by a different employer as a machine operator.

On December 17, 2012, Petitioner returned to Dr. Petsche with complaints of persistent symptoms in his right shoulder. Dr. Petsche noted Petitioner had total relief of his symptoms after Toradol injection. Petitioner reported this lasted 3 months and then all of his symptoms recurred. Petitioner had pain in his shoulder diffusely. He pointed at the AC joint also as the source of his symptoms. The doctor stated that the Toradol injection was wonderful, but was very temporary. Petitioner wanted permanent relief indicating the pain was waking him up every night. Routine activities of daily living were quite painful. He was able to tolerate regular work, but not without serious discomfort by the end of the day. An examination revealed he had full range of motion with a painful arc. He had a positive AC joint tenderness and positive cross-arm test. He had good strength in all planes, but discomfort to strength testing. Dr. Petsche assessed right shoulder pain almost 2 years status post arthroscopic decompression; 2.) biceps tenodesis and rotator cuff repair; 3.) AC joint degenerative joint disease, possible osteolysis clinically that did not show up substantially on previous X-rays or MRI scan a year ago. Dr. Petsche recommended a second-look arthroscopy, noting that Petitioner had failed to respond to all other methods of conservative treatment. Dr. Petsche also provided that he also offered him alternatives including, repeat injection, more therapy, living with it, oral pain medication. Petitioner indicated that he wanted the surgery. (PX 2)

At Respondent's request, Petitioner underwent a Section 12 examination with Dr. Verma on February 18, 2013. Upon examination, Dr. Verma reported Petitioner had diffused nonanatomic pain with palpation over the shoulder including anterior, lateral and posterior aspects. There was no specific pain with palpation over the AC or SC joint. Petitioner also had full range of motion actively including forward elevation of 160 degrees, external rotation at the side to 60 degrees and behind the back rotation to L4. Strength testing of the right shoulder graded at 5/5 with abduction in the scapular plane and external rotation at the side. Petitioner had subjective complaints of pain throughout the range of motion, which the doctor felt was out of proportion to the objective findings. Petitioner had pain with an O'Brien maneuver. The doctor noted Petitioner had diffuse weakness in the right upper extremity that appeared to have mediated. After conducting a physical examination and reviewing Petitioner's medical records, Dr. Verma's diagnosis was atypical right shoulder pain status post right shoulder rotator cuff repair. The doctor opined that Petitioner current subjective complaints were atypical and do not correlate with the objective findings. The doctor also provided that because his symptoms occurred 4-5 months after being released at full duty, Petitioner's complaints did not relate to the work accident. He noted that the nature of Petitioner's ongoing complaints were unclear. The doctor opined that no further medical treatment was required that was specifically related to the work injury. Lastly, the doctor opined that Petitioner had reached maximal medical improvement on July 25, 2011. The doctor also wanted to review the actual arthrogram images from February 8, 2012. (RX 2)

On March 4, 2013, Dr. Petsche reiterated his recommendation. The doctor also imposed light duty work restrictions. (PX 2) Petitioner testified that his Union did have light duty positions available.

On April 25, 2013, Petitioner began treating with Dr. Howard Freedberg at Suburban Orthopaedics. Records submitted show Petitioner was referred by his primary care physician, Dr. Reena Shah. Petitioner had complaints of right shoulder pain from work related injury. His symptoms included numbness in the right shoulder joint. Pain in the front of the shoulder, in the center of the joint. ROM limited by pain. He had stiffness in the morning. He got shooting pains and popping, scraping-like bone on bone. Petitioner provided that the shooting pains come randomly, and go all the way down the right arm. If he is holding something, he had to sit it down or he would drop it. He switched to using his left hand for most things. An examination of the AC joint demonstrated tenderness bilaterally; cross arm adduction test was positive at right. He also positive Neer impingement sign and Hawkin's impingement at right. At the rotator cuff he had greater tuberosity and positive tenderness at right. Biceps tendon /SLAP Testing was positive tenderness at right with palpation. His Speed test and O'Brien's test were positive. Dr. Freedberg's impression was right shoulder rotator cuff tear. Shoulder bicipital tenosynovitis- status post tenodesis with rupture of

the repair. Dr. Freeberg stated, "It is my opinion that he is functioning as a FTRCT and the MRI-Arthrogram shows the partial articular side tear which is making his cuff not functioning. At over one year post onset of the symptoms which I believe emenate from the original injury. I feel he needs to have a rotator cuff repair (RCR) which the repair is medialized and take the tension off." Dr. Freeberg issued a Work Duty Status of medically unable to work. (PX 6)

Petitioner underwent right shoulder arthroscopy at St. Alexius Medical Center by Dr. Freedberg on August 2, 2013. The procedures performed were right shoulder arthroscopy, debridement of the labrum and a re-do subacromial decompression, distal clavicle resection, rotator cuff repair. The postoperative diagnosis was right shoulder status post rotator cuff repair with a recurrent rotator cuff tear partially, status post biceps tenodesis with an anterior labral tear and acromioclavicular degenerative joint disease. (PX 6) Post-operatively, Petitioner began a course of physical therapy.

On October 2, 2013, Dr. Verma issued an addendum report. The doctor reviewed additional medical records including the February 2012 MR arthrogram report and the MRI images as well as the August 2, 2013 surgical report. Dr. Verma stated that his opinion remained the same in that Petitioner was at maximum medical improvement at the time of his initial IME. He noted that the MRI scan did not detect any full-thickness tear of the rotator cuff that required surgery which he felt was confirmed at the time of surgery. (RX 3)

Petitioner continued treating with Dr. Freeberg. On October 10, 2013, Petitioner reported that he was getting his mobility back, but strength and coordination and endurance still needed some work. He felt some numbness in the area of the top of the shoulder, and some spasms, which seem to be more at night. X-ray were taken showing maintained augment distal clavicle resection (DCR) with excellent spacing. On November 4, 2013, Petitioner reported that he was doing better. He still experienced a little soreness if he "pushes it." His range of motion was almost complete and his everyday activities were getting easier. Physical therapy and his off work status was continued. (PX 6)

Petitioner testified that his second surgery was successful. He stated that after the surgery he had a lot more mobility. He still has not gained full strength.

With respect to issue (F.) Is Petitioner's current condition of ill-being causally related to the injury, the Arbitrator finds the following:

There is no issue as to accident or initial causation. The present dispute is whether benefits should terminate on July 25, 2011, the date on which Dr. Petsche noted that Mr. King "feels that he has a normal enough strength to return to work without any restrictions." He was returned to work as tolerated. There was then a gap in treatment of about 6 months. Petitioner next saw Dr. Petsche on a follow up visit for right shoulder pain on January 26, 2012. The issue then is whether the shoulder pain on Janaury 26, 2012 through the trial date was still causally connected to the accident of October 11, 2010.

Initially, the Arbitrator notes there is no evidence of an intervening superseding accident. Both counsels questioned Mr. King about a notation by Dr. Petsche in his January 26, 2012 note that Mr. King had been driving a truck for work when his symptoms worsened. Mr. King however clarified that in fact he had been trying to get his old pickup truck into gear and this was when he felt pain. It was not a new incident, but rather the same pain that other activities of daily living and work had brought on since the accident. Dr. Petsche himself notes this in his April 30, 2012 note.

Respondent's IME doctor, Dr. Verma, opined that the accident at work caused an acute rotator cuff tear, but that he should have reached maximum medical improvement as of July 25, 2011. This opinion is in part based on the fact that there had been a release to full duty, his opinion of an atypical nature of the complaints, the lack of an anatomic localizing factor with regard to the pain complaints and the essentially pain free interval for four to five months after discharge with release to full duty work. The doctor also felt that the subsequent MRI scan was otherwise normal and the August 2, 2013 operative report confirmed that there was no full thickness defect of the rotator cuff.

By contrast, treating doctor and surgeon Dr. Freedberg testified that the condition of ill being continued to be related to the work accident. When posed as to a medical explanation for the gap in treatment. Dr. Freeberg replied, "The explanation is that he never healed his primary rotator cuff repair that was performed on January 13 of 2011. It is a very

well-known phenomenon that patients that undergo surgery don't heal from a repaired rotator cuff tear, and therefore, the reason that you have this what appears to be a six-month gap is that he was then active and doing work or activities, and the shoulder then became more painful and problematic to him because the cuff had not healed, which I was able to identify in my surgical procedure that I performed." Dr. Freedberg attributed the need for treatment to the work accident.

There was no evidence of any shoulder condition before this work accident. After this work accident Respondent's Section 12 examiner provides causation, but finds MMI as of the first attempt to return to work. By contrast, the treating surgeon who performed the second surgery found that the rotator cuff had not healed from the first surgery and needed additional treatment. Dr. Verma finds no objective findings in his exam, which is in conflict with the medical evidence in this case.

The Arbitrator notes that Dr. Petsche also felt that a second procedure, "a second-look arthroscopy," would be appropriate. The following sequence lead to said decision. On February 13, 2012, Petitioner followed-up with Dr. Petsche to discuss the most recent MRI of right shoulder. Dr. Petsche felt that in the area of the rotator cuff tendon repair, there appeared some undersurface partial tearing, or residual tear, that did not completely heal at the repair site. The doctor assessed among other findings right shoulder pain 1 year status post arthroscopic rotator cuff repair with incomplete healing on the articular side of the rotator cuff repair site. Initially, the doctor did not recommend surgery but offered consideration for a Toradol injection which was carried out. On April 26, 2012, Dr. Petsche noted the Toradol injection worked "wonderfully." Dr. Petsche provided that Petitioner could resume work and activities as tolerated, with no restrictions. The doctor also warned that recurrence does occasionally occur. On December 17, 2012, Petitioner returned to Dr. Petsche with complaints of persistent symptoms in his right shoulder. Dr. Petsche noted that the Toradol injection was wonderful, but was very temporary. Petitioner reported he was able to tolerate regular work, but not without serious discomfort by the end of the day. Dr. Petsche recommended a second-look arthroscopy, noting that Petitioner had failed to respond to all other methods of conservative treatment.

Based upon the medical records and testimony the Arbitrator finds that Petitioner's current condition of ill being continues to relate to his work accident. There is no intervening cause, there was no shoulder condition prior to this accident, and it is the very same diagnosis the first surgery sought to treat that had to be addressed by the second surgery. Petitioner continues to treat for this injury and all treatment is causally related, reasonable and necessary.

With respect to issue (J.) Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all necessary medical services, the Arbitrator finds the following:

With exception of medical charges from Dryer Medical Clinic in the amount of $1,741.00, the Arbitrator finds that Respondent is liable under Section 8(a) for all medical bills incurred as stated in Petitioner's exhibit 9, subject to the fee schedule. Petitioner has requested payment for the following bills:

Provider	Beginning	Ending	Total	WC Pd.	Balance
ATI	2/27/2012	4/4/2012	$4,881.59	$0.00	$4,881.59
Dryer Medical Clinic	11/26/2012	7/18/2013	$1,741.00	$0.00	$1,741.00
Fox Valley Orthopaedic Assoc.	10/14/2010	3/4/2013	$45,426.00	$21,290.77	$24,135.23
Prescription Partners	4/25/2013	4/25/2013	$2,656.41	$0.00	$2,656.41
St. Alexius Medical Center	8/2/2013	8/2/2013	$19,930.00	$0.00	$19,930.00
Suburban Orthopaedics	4/25/2013	11/4/2013	$31,595.00	$0.00	$31,595.00

Total	-	-	-	-	$106,230.00	$21,290.77	$84,939.23

With respect to the medical bills claimed from Dreyer Medical Clinic, said bills appear to be for unrelated conditions including but not limited to skin sensation disturbance, hypertension, anxiety state, dizziness, airway obstruction, insomnia, vaccines, tobacco disorder, vitamin D deficiency, restless leg syndrome and stroke.

The Arbitrator adopts Dr. Freedberg's opinion, and further finds based upon the treatment records that all treatment, with exception of medical charges from Dryer Medical Clinic, was reasonable and necessary to cure Petitioner of his condition of ill being. (PX11). As such, Respondent shall pay reasonable and necessary medical services of $83,198.23 under Section 8(a) of the Act, subject to the medical fee schedule. Respondent is entitled to a credit for all medical bills paid. Respondent shall further authorize the treatment as prescribed by Dr. Freeberg.

With respect to issue (K.) What temporary benefits (TTD) are due, the Arbitrator finds the following:

A review of the medical records indicates Petitioner was kept off work from the periods below.

Respondent shall pay Petitioner temporary total disability benefits of $1,243.00/week for 88-2/7 weeks, commencing 10/12/10 through 7/25/11, 2/13/12 through 4/26/12, and 3/4/13 through 11/15/13, as provided in Section 8(b) of the Act. Respondent shall pay Petitioner the temporary total disability benefits that have accrued from 10/11/10 through the present, and shall pay the remainder of the award, if any, in weekly payments.

With respect to issue (M.) Should penalties or fees be imposed upon Respondent, the Arbitrator finds the following:

The Arbitrator finds that a legitimate dispute existed regarding Petitioner's current condition of ill-being. Respondent's reliance on the opinions of Dr. Verma was not unreasonable. As such, Petitioner's request for penalties is hereby denied.

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

Ricco Dixon,

Petitioner,

14IWCC0826

vs.

NO: 12 WC 22725

City Link,

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed December 23, 2013 is hereby affirmed and adopted.

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

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

14IWCC0826

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $31,800.00. 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: SEP 24 2014
KWL/vf
O-7/28/14
42

Kevin W. Lamborn

Thomas J. Tyrrell

Michael J. Brennan

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

14IWCC0826

DIXON, RICCO
Employee/Petitioner

Case# **12WC022725**

CITYLINK
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:

0980 HASSELBERG GREBE SNODGRASS
KENNETH M SNODGRASS
124 S W ADAMS ST SUITE 360
PEORIA, IL 61602

1248 WILLIAM C WOMBACHER
416 MAIN ST
SUITE 700
PEORIA, IL 61602

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

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

14IWCC0826

RICCO DIXON
Employee/Petitioner

v.

CITYLINK
Employer/Respondent

Case # **12 WC 22725**

An *Application for Adjustment 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 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. [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?
[x] 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 **June 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 current condition of ill-being *is* causally related to the accident.

In the year preceding the injury, Petitioner earned $*48,657.57*; the average weekly wage was $*935.72*.

On the date of accident, Petitioner was *38* years of age, ***single*** with *3* dependent children.

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

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

To date, all TTD benefits *have not* been paid by the respondent on account of this injury

In support of the Arbitrator's Decision relating to ***(C) Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent? (F) Is Petitioner's current condition of ill-being causally related to the injury?, (J) Were the 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?, and (L) What is the nature and extent of the injury?,*** *the Arbitrator finds as follows:*

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

Petitioner testified that on June 7, 2012 he was a bus driver employed by the Respondent, CityLink. On that date at approximately 5:30 a.m., the Petitioner was assigned his bus for the day. He did a safety walk around the bus. He boarded the bus and adjusted the seat for the day's drive. While adjusting the seat, the Petitioner noticed the seat in sliding forward got stuck and he felt a pop in his left knee. He worked the remainder of the day. The following day, Petitioner reported to Christy, the morning dispatcher, that his knee was swollen and he was having difficulty walking. He worked his normal shift that day. At the end of the day, Petitioner reported to Patty Taylor, a CityLink supervisor, that he had injured his left knee the day before while adjusting the seat. After getting off work on June 8, 2012, Mr. Dixon went to the St. Francis emergency room for treatment.

Petitioner's Exhibit 9 is the Form 45 incident report that was prepared by Rick Tieken, former Assistant General Manager at CityLink. The report details that the Petitioner reported the bus seat was stuck and would not move. The report further reflects the Petitioner sustained a left knee injury. The incident report further notes that the Petitioner told Patty Taylor at the end of the shift on June 8 about the accident. The date of the Form 45 incident report is June 13, 2012. No evidence was presented to refute Mr. Dixon's testimony regarding his reporting how the incident occurred and the fact he reported the incident on June 8. (PX-9).

The June 8, 2012 OSF St. Francis Medical Center record reflects Petitioner giving a history of injuring his left knee while seated with his feet planted and trying to pull his seat up. The records note he felt a pop in the left knee on the medial side. (PX-6). On June 12, 2012, the Petitioner was seen by the company physician, Dr. Homer Pena. He gave a history of having to push on a button on the right side of the seat to release the chair and

while attempting to pull the seat forward with the toes of his feet a pop was noted to the left knee. (PX-5). On August 8, 2012, Mr. Dixon was seen by his family physician, Dr. Gregory Moskop. He gives a history on June 7, 2012 of attempting to adjust his seat and hearing a pop in the left knee. (PX-2).

The Arbitrator was shown a video at arbitration, which is Respondent's Exhibit 1. Mr. John L. Anderson, the current Assistant General Manager at CityLink, testified regarding the video. Mr. Anderson testified that the video does not reflect the seat being stuck as testified to by Mr. Dixon. Mr. Anderson further testified that there is no standard operating procedure as to how the bus driver is to adjust the seat. Mr. Anderson is a former mechanic for CityLink as well as Director of Fleet Maintenance. There were instances where they had to work on the seats in regards to their ability to go back and forth. Mr. Anderson confirmed that the Form 45 was signed by Rick Tieken, former Assistant General Manager at CityLink. Mr. Anderson acknowledged that the Form 45 indicates Mr. Dixon reported the seat being stuck and Mr. Anderson could not dispute Mr. Dixon's characterization of the seat being stuck on June 7, 2012.

The Arbitrator finds that based upon the testimony, the medical and the Form 45, the Petitioner sustained an accident which arose out of and in the course of his employment. The Petitioner reported his accident right away and described his knee being injured while attempting to adjust the seat. Petitioner's testimony is further supported by the history provided to the medical providers as well as to his employer.

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

The Petitioner was seen by the company physician, Dr. Pena, on June 12, 2012. The Petitioner gave a history of injuring his left knee while adjusting the bus seat. Dr. Pena in a note of June 22, 2012 found "it is conceivable that the injury can occur with the mechanism described." Dr. Pena went on to note that the need for surgery for the meniscal tear was obvious. (PX-5).

Dr. Moskop, the Petitioner's family doctor, was deposed on July 9, 2013. Dr. Moskop testified that as far as he knew, the Petitioner had no previous left knee problems prior to the event of June 7, 2012. (PX-3, p. 8). Dr. Moskop noted he had the OSF emergency room records of June 8, 2012 which provided a history consistent which was provided by Mr. Dixon to him on August 8, 2012. (PX-3, p. 9). Dr. Moskop believed Mr. Dixon sustained a left knee meniscal tear and described it as acute. (PX-3, p. 11). Dr. Moskop believed that the patient's history of injury was consistent with causing a meniscal tear (PX-3, p. 12).

Dr. Lawrence Li's deposition was taken on July 22, 2013. Dr. Li is the IME doctor for the Respondent. Dr. Li testified that he could find no evidence that the Petitioner had treated for any left knee problem prior to the June 7, 2012 event. (RX-7, p. 15). Dr. Li felt it appropriate that Mr. Dixon undergo left knee surgery regarding the torn meniscus. (RX-7, p. 16). Dr. Li notes that the only history Mr. Dixon gave of injuring his left knee was while he was attempting to move the bus seat on June 7, 2012. (RX-7, p. 18). Dr. Li found nothing in the medical records which would be inconsistent in his opinion from what was reported in Illinois Form 45 as to how the accident occurred. (RX-7, p. 20). Dr. Li acknowledged that Dr. Pena in his note of June 22, 2012 found that it was conceivable that the injury can occur with the mechanism described. (RX-7, p. 22). Dr. Li testified that the video shown to him of the bus seat demonstration does not reflect the seat being stuck. (RX-7, p. 26). Dr. Li testified that if the video does not show the seat as being stuck, it would not accurately depict what Mr. Dixon did on June 7, 2012. (RX-7, p. 27). Dr. Li further noted that Petitioner's reporting his knee popped when he was adjusting the seat can be an indication of a meniscus tear in the right circumstance. (RX-7, p. 29).

On June 18, 2012, Mr. Dixon was seen by Dr. Brent Johnson at Midwest Orthopaedic Center. He gives a history of injuring his knee at work on Friday morning while adjusting his seat when it jammed and jarred his knee. (PX-4).

14IWCC0826

- The Respondent shall pay the Petitioner the sum of $ ***125.42***/week for a further period of ***4*** weeks, from ***November 19, 2012*** through ***December 24, 2012*** which is the period of temporary partial disability payments for which compensation is payable.

- The Respondent shall pay the Petitioner the sum of $ ***561.43***/week for a further period of ***43*** weeks, as provided in Section **8(e)(12)** of the Act, because the injuries sustained caused ***permanent partial disability to the extent of 20% of the left leg.***

- The Respondent shall pay the Petitioner compensation that has accrued from ***December 24, 2012*** through ***September 26, 2013*** and shall pay the remainder of the award, if any, in weekly payments.

- The Respondent shall pay $ ***1,096.84*** for medical services, as provided in Section 8(a) of the Act.

- The Respondent shall pay $ **N/A** in penalties, as provided in Section 19(k) of the Act.

- The Respondent shall pay $ **N/A** in penalties, as provided in Section 19(l) of the Act.

- The Respondent shall pay $ **N/A** in attorneys' fees, as provided in Section 16 of the Act.

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

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

S J Mathis

Signature of Arbitrator

12-13-13

Date

DEC 23 2013

The Arbitrator finds based upon the foregoing, that Petitioner's condition of ill-being is causally related to the incident at work. The Arbitrator specifically notes there is no previous incident of left knee treatment prior to June 7, 2012. Dr. Moskop has opined that the incident could have caused the meniscus tear in the left knee. Dr. Homer Pena, the Respondent's company physician, further states in his notes that Mr. Dixon's left knee injury could have been caused as a result of the mechanism of injury described to him which occurred on June 7, 2012.

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

Based upon the findings as set forth in (C) and (F), the Arbitrator finds that the outstanding medical bills of $1,096.84 is the responsibility of the Respondent and the Respondent, since it is self-insured, is to be given credit for any bills that have been paid under group.

(K) What temporary benefits are in dispute?

Based on the findings as set forth in (C) and (F), the Arbitrator finds that the Petitioner is entitled to TTD and TPD. The records reflect that Mr. Dixon was off work from September 13, 2012, the date of his surgery, through November 19, 2012. This represents 9 3/7 weeks of TTD. Additionally, the parties have stipulated that from November 19, 2012 through December 24, 2012, the Petitioner worked four hours per day or 20 hours per week. For that period of time, the Petitioner would have earned $498.40 per week for the 20 hours worked. His TTD rate for that period of time would have been $623.81 based on the stipulated average weekly wage of $935.72. Therefore, for that four week period of time, there would be a difference of $125.42 per week or a total of $501.68 in TPD owed in addition to the 9 3/7 weeks of TTD at the rate of $623.81.

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

On September 13, 2012, Petitioner underwent a left knee arthroscopy with a partial medial meniscectomy with chondroplasty of the patella and trochlea. (RX-4). Petitioner returned to work on or about December 24, 2012 and has continued to work as a bus driver. However, he has been seen by Dr. Moskop for ongoing left knee complaints. (PX-2; PX-3). He further noted he was having swelling in both knees, the left more than the right. The Petitioner testified that he noted his gait had changed in order to compensate for his left leg injury. He treated at Midwest Orthopaedic Center on January 21, 2013 regarding the ongoing left knee, along with the right knee pain. (PX-4).

He eventually was seen at Great Plains Orthopaedic by Dr. Below and was diagnosed with left knee tricompartmental degenerative joint disease. He received a cortisone injection to his left knee on July 25, 2013 and was prescribed physical therapy. (PX-1).

Petitioner testifies he continues to have occasional swelling of the left knee and notices stiffness after driving a bus all day. He notices left knee stiffness in the morning. He still experiences pain and is on prescribed medication.

Based on the foregoing, the Arbitrator deems that the Petitioner has sustained loss of use of the left leg of 20% representing 43 weeks at a permanent partial disability rate of $561.43.

ORDER

- The Respondent shall pay the Petitioner the sum of ***$623.81/week*** for ***9 and 3/7*** weeks, from ***September 13, 2012*** through ***November 19, 2012***, which is the period of temporary total disability for which compensation is payable.

STATE OF ILLINOIS)
) SS.
COUNTY OF MADISON)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Tommy Johnson,

Petitioner,

vs.

NO: 12 WC 36194

14IWCC0827

Ameren IP,

Respondent.

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed October 29, 2013, is hereby affirmed and adopted.

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

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

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

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $11,000.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: SEP 2 5 2014
TJT:yl
o 7/28/14
51

Thomas J. Tyrrell

Michael J. Brennan

Kevin W. Lamborn

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

JOHNSON, TOMMY
Employee/Petitioner

Case# **12WC036194**

AMEREN IP
Employer/Respondent

14IWCC0827

On 10/29/2013, 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 0.08% 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:

1775 HUSTAVA, JOHN H
ANDREW NALEFSKI
101 ST LOUIS RD PO BOX 707
COLLINSVILLE, IL 62234

1241 LEMP & ANTHONY PC
WILLIAM LEMP
10805 SUNSET OFFICE DR #203
ST LOUIS, MO 63127

14IWCC0827

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)

Tommy Johnson
Employee/Petitioner

v.

Ameren IP
Employer/Respondent

Case # **12** WC **36194**

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 **Joshua Luskin**, Arbitrator of the Commission, in the city of **Collinsville**, on **8/28/13**. 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. ☒ 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, **10/9/12**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**73,163.26**; the average weekly wage was $**1,406.96**.

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

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

ORDER

See Attached Decision

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

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

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

OCT 29 2013

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

TOMMY JOHNSON,	)	
	)	
Petitioner,	)	
	)	
vs.	)	No. 12 WC 36194
	)	
AMEREN IP.,	)	
	)	
Respondent.	)	

ADDENDUM TO ARBITRATION DECISION

This matter was heard pursuant to Sections 8(a) and 19(b) of the Act. Prior to hearing, the parties stipulated that the petitioner was not asserting a causal connection between the petitioner's accident and his cervical spine condition.

STATEMENT OF FACTS

The petitioner has worked for the respondent for 14 years as a union gas journeyman. On October 9, 2012, while exiting the basement of a customer's house, he struck his forehead on the doorjamb. He said he knocked his hard hat off, and felt numbness in the neck, shoulders, and down his arms and back. He stated he stumbled to his knees but did not fall to the ground. The petitioner acknowledged a significant prior neck condition, including prior fusion surgeries in 2005 and 2008; he was, at the time of this injury, under treatment with Dr. Gornet for a failed cervical fusion, and had a pending surgical recommendation.

The petitioner reported his injury that day. Ron Hamilton, his supervisor, testified that the petitioner complained of neck and shoulder pain only on the accident date.

The petitioner was seen at Memorial Hospital E.R. that day. RX3. The records that day note complaints to the head and neck with cervical radicular symptoms. A CT scan of the head was normal and the CT of the C-spine showed no damage to the hardware. He was prescribed off work for two days, given medication and instructed to follow-up with his physician. RX3.

On October 18, 2012, he presented to his spine surgeon, Dr. Gornet. The petitioner reported striking his head and described hyperextension of his low back. He described increased neck pain into both shoulders as well as low back pain. Dr. Gornet prescribed the petitioner off work and ordered new MRI scans. On November 19, 2012, Dr. Gornet reviewed the MRIs on November 19, 2012; the cervical MRI demonstrated no

significant change from the prior MRI, and Dr. Gornet opined that the cervical spine condition was not related to the October 9, 2012 accident date. Dr. Gornet noted the lumbar MRI revealed a disk herniation at L5-S1, which he opined was related to this incident. He ordered lumbar injections. PX1.

The injections were thereafter performed. In a follow-up on January 7, 2013, Dr. Gornet noted mild improvement with the injections. He released the petitioner to light duty and recommended a CT discogram. The respondent has accommodated the petitioner's light duty restrictions.

On May 7, 2013, a lumbar discogram was performed. A post discogram CT showed annular tearing and disk bulging at L5-S1. On May 16, 2013, Dr. Gornet recommended L5-S1 fusion surgery and casually related the condition and need for surgery to the work incident of October 9, 2012.

The respondent commissioned a records review and Section 12 examination by Dr. Kitchens, a neurosurgeon. Dr. Kitchens noted several inconsistencies in the petitioner's account history, and opined that the petitioner's low back condition was degenerative in nature and nontraumatic. RX2.

On cross-examination, the petitioner was asked about prior low back treatment, which he denied. The respondent submitted medical records demonstrating a diagnosis of lumbar spondylosis in 2007 and a prescription for a lumbar spine bone scan in 2009, which included radiating back pain into the legs. RX1.

The petitioner testified that he desires to proceed with the low back fusion surgery recommended by Dr. Gornet. The petitioner, through counsel, submits the initial expenses related to the neck, the E.R. and the MRI, and did not request further treatment to the neck given the pre-existing condition and Dr. Gornet's opinions.

OPINION AND ORDER

Causal Connection to the Injury

The parties stipulated that the petitioner's cervical spine condition is not causally connected to the October 9, 2012 accident. Relative to the lumbar spine, the respondent is likely correct in its assertion that the petitioner's low back condition is primarily degenerative in nature. Moreover, the petitioner's denial of prior low back treatment is somewhat disingenuous given lumbar diagnoses that predated the injury by five years. However, the respondent did not demonstrate any active treatment or recommendations for such in the three years prior to the work accident of October 9, 2012, and there was no indication that the petitioner had ever been recommended surgical intervention to the lumbar spine. Given these factors, the Arbitrator is more persuaded by Dr. Gornet's causal assessment relative to the low back than Dr. Kitchens'.

Medical Care (Past and Prospective)

Given the above findings relative to causation, the Arbitrator finds the respondent liable for the submitted expenses, subject to the limits of medical fee schedule, as these expenses appear reasonably related to cure or relieve the petitioner's medical condition pursuant to Section 8(a) of the Act. However, if any of the submitted expenses relate to the petitioner's cervical spine after November 19, 2012, those are denied subject to the above causal connection findings. The respondent is provided credit for any amounts previously paid and shall hold the petitioner harmless for credit claimed.

The respondent shall further authorize and pay for the L5-S1 fusion surgery recommended by Dr. Gornet, as it appears reasonably related to treat the injury incurred. Future medical expenses regarding the cervical spine are denied, due to the lack of a causal relationship.

Temporary Total Disability

The petitioner submits TTD benefits are due and owing from October 10 through 13, 2012, and from October 18 through January 7, 2013. The Arbitrator does not find sufficient evidence to substantiate October 12 and 13 off work based on the exhibits, and therefore the first period of lost time does not surpass the three-day waiting period set forth in Section 8(b). The Arbitrator awards the period October 18, 2012 through January 17, 2013, inclusive, a period of 11 & 5/7 weeks, in accordance with the above findings as to causal connection. The respondent shall pay TTD at the appropriate rate of $937.97 per week for this period.

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

JAMES SALE,

Petitioner,

vs.

NO: 03 WC 01135
consolidated with 03 WC 11872

TOWN & COUNTRY DISPOSAL,

14IWCC0828

Respondent.

DECISION AND OPINION ON REVIEW

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

The Arbitrator's decision states only that there is a causal connection between the Petitioner's current condition of ill-being and his work injury on August 29, 2002. The Commission clarifies that the award in this case is limited to the right ulnar nerve transposition surgery, as prescribed by Dr. Bindra, for the diagnosis of cubital tunnel syndrome. The Commission's finding of causation relative to this current 19(b) determination is limited to the right cubital tunnel condition only, and does not include the diagnoses made by Dr. Bindra of Guyon's canal or epidermoid cyst. The Commission notes that Respondent's Section 12 examining physician, Dr. Weiss, opined that the right Guyon's canal and carpal tunnel conditions were unrelated to the August 29, 2002 accident. The only opposing opinion is from Dr. Bindra.

14IWCC0828

However, when asked how he would relate the carpal tunnel syndrome condition at the wrist to the accident since Petitioner did not complain of such symptoms until January 2008, Dr. Bindra stated that "it's very difficult to tell when a patient can start to experience symptoms or when they first notice symptoms", and that patients can give different answers at different times. This explanation of his opinion leads the Commission to conclude that it is speculative. As such, greater weight is given to the opinion of Dr. Weiss with regard to Petitioner's right Guyon's canal and carpal tunnel syndromes. All doctors in this case have agreed that the epidermoid cyst is not related to Petitioner's job duties.

Because there is currently no monetary award due and owing, there is no bond.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed November 13, 2013 is hereby affirmed and adopted, with the clarification of the award noted above.

IT IS FURTHER ORDERED BY THE COMMISSION that the Respondent shall authorize the right ulnar transposition surgery prescribed by Dr. Bindra.

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: SEP 25 2014
TJT: pvc
o 07/28/14
51

Thomas J. Tyrrell

Michael J. Brennan

Kevin W. Lamborn

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

SALE, JAMES
Employee/Petitioner

Case# **03WC001135**
03WC011872

TOWN & COUNTRY DISPOSAL INC
Employer/Respondent

14IWCC0828

On 11/13/2013, 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:

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

1872 SPIEGEL & CAHILL PC
MILES P CAHILL
15 SPINNING WHEEL RD SUITE 107
HINSDALE, IL 60521

STATE OF ILLINOIS)
)SS.
COUNTY OF LASALLE) 14IWCC0828

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

JAMES SALE,
Employee/Petitioner

v.

TOWN & COUNTRY DISPOSAL, INC.,
Employer/Respondent

Case # **03** WC **1135**

Consolidated cases: **03-WC-11872**

An *Application for Adjustment 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**, on **July 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 **Prospective Medical Care**

FINDINGS

On **August 29, 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.

Petitioner's current condition of ill-being ***is*** causally related as it relates to the petitioner's epicondylitis condition, persistent pain, cubital tunnel syndrome and ulnar nerve entrapment.

In the year preceding the injury, Petitioner earned **$31,026.32**, the average weekly wage was **$596.66** .

On the date of accident, Petitioner was **40** years of age, ***married*** with 0 dependent children.

ORDER

Pursuant to Section 8(a) of the Act, Respondent shall authorize the surgical procedure as prescribed by Dr. Randy Bindra.

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

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

11/12/13
Date

NOV 13 2013

14IWCC0828

STATEMENT OF FACTS:

Petitioner testified that he worked for employer, Town & Country Disposal, Inc., from 1998 through 2005. He worked as a truck driver and would also throw garbage that weighed between 50 to 75 pounds into the truck.

On January 14, 2002, while at work, Petitioner tore his right bicep tendon when he grabbed onto a handrail in an attempt to break his fall. On January 29, 2002, orthopedic surgeon, Dr. Robert Mitchell, surgically repaired Petitioner's right distal biceps tendon. Dr. Mitchell released him back to full duty work on July 1, 2002. Petitioner testified that he performed his usual duties between July 1, 2002 and August 29, 2002.

On August 29, 2002, Petitioner presented to Dr. Robert Mitchell complaining of pain over his right biceps tendon after working significant amount of overtime and throwing garbage bags in the truck. On examination, Dr. Mitchell found pain over his bicipital tendon with resistance to elbow flexion and supination. Dr. Mitchell diagnosed right elbow bicipital tendinitis. (PX 1)

Petitioner returned to Dr. Mitchell on October 11, 2002, complaining of pain over the lateral aspect of his right elbow. He stated that he was working full time and the pain was becoming worse. Dr. Mitchell's impression was right lateral epicondylitis. Dr. Mitchell prescribed mediction, Vioxx and noted that if Petitioner didn't experience significant relief, a corticosteroid would be indicated. (PX 1)

Petitioner followed up with Dr. Mitchell on November 8, 2002, complaining that the prescription medicine was giving him minimal pain relief. At that time the doctor administered a corticosteroid injection over the right lateral epicondylar region. (PX 1)

Petitioner testified that on January 20, 2003, he was performing his duties as a garbage man and experienced increased pain in his right arm. He reported this incident to the owner of Town & Country Disposal, Inc.

On January 31, 2003, Dr. Mitchell stated in a letter, his opinion on causal relationship. Dr. Mitchell wrote:

> "I have recently seen James Sale, Sr., for lateral epicondylitis. I do not believe that this is related to his prior distal biceps tendon repair since this complaint developed after he returned back to work in July. I saw him on August 29, 2002 and he was complaining of lateral epicondylar pain consistent with right elbow bicipital tendinitis. I believe that this is a new work injury, which is attributable to his job."

Petitioner returned to Dr. Mitchell on February 4, 2003. Petitioner provided that the previous cortisone injection provided significant relief but only last 6-8 weeks. Petitioner informed the doctor that his pain had

returned noting he was throwing heavy garbage bags and containers. Dr. Mitchell assessed persistent right lateral epicondylitis and admistered a repeat cortisone injection. (PX 1)

On September 16, 2003, Petitioner began treating with orthopedic surgeon, Dr. Paul Perona, for his continuing right elbow pain. He reported to Dr. Perona that his regular work activities exacerbated his elbow pain. Dr. Perona injected the elbow with cortisone and gave him a counter tension strap. On follow-up visits, Petitioner reported having only temporary relief of his symptoms. Dr. Perona believed that if Petitioner's symptoms persisted, he would ultimately require a lateral epicondylar debridement. (PX 2)

On September 14, 2004, Dr. Paul Perona stated in a letter, his opinion on causal relationship. Dr. Perona wrote:

> "It is my feeling that if the patient's symptoms persist that he may ultimately require a lateral epicondylar debridement. I feel that his condition of ill being is related to his repetitive throwing of garbage. I do feel that he will most likely continue to have pain and symptoms from his lateral epicondylitis as long as he continues working as a garbage man. I do feel that he is ultimately going to require surgical intervention."

Dr. Perona was deposed on March 29, 2005. Dr. Perona stated at his evidence deposition that Petitioner right elbow condition of lateral epicondylitis was causally related to his job duties as a garbage man, where he was required to throw garbage repetitively. (PX 4)

On June 10, 2005, Dr. Perona performed right lateral epicondylar debridement surgery. During surgery, Dr. Perona debrided the elbow including the lateral epicondyle. Dr. Perona also used a suture anchor to secure the lateral epicondyle. (PX 2)

Post-operatively, Petitioner's right arm was placed in a posterior mold splint of the elbow with the elbow flexed at 90 degrees. He was restricted from work and was placed in physical therapy. After several months with continued complaints of right elbow pain, Dr. Perona referred Petitioner for further care to Dr. Guido Marra of Loyola University Medical Center. (PX 2)

On December 13, 2005, Dr. Guido Marra began treating Petitioner for his continuing right elbow pain. On examination, Petitioner had point tenderness over the lateral epicondyle and pain with resisted wrist extension. He also had pain with hyperflexion and extension. Dr. Marra's impression was persistent pain following a lateral epicondylar release and mild evidence of osteoarthritis. Treatment options included elbow arthroscopy with debridement versus continued observation and medications. The doctor noted Petitioner was exquisitely tender over the sutures which were palpable in the subcutaneous tissues over the lateral elbow. (PX 3)

On August 24, 2006, Dr. Marra stated in a letter, the following medical opinion:

> "It is my opinion that the pain present in the sutures is related to his lateral epicondylitis" and that "[p]ersistent pain following epicondylar release is a known complication of this surgery."

Dr. Guido Marra testified via evidence deposition on May 25, 2007. At his deposition, Dr. Marra testified that Petitioner's pain was from the lateral epicondylar release, commonly referred to as tennis elbow surgery, noting that the location of his pain was over the outer aspect of the arm. Dr. Marra recommended an arthroscopic surgery to remove any tendon that would be potentially degenerated and removal of the suture that was used in the first surgery. (PX 5)

On September 17, 2007, Dr. Guido Marra performed arthroscopic debridement of the elbow and open removal of sutures. Post surgery, Dr. Guido Marra prescribed a course of physical therapy. (PX 3)

On September 25, 2007, Petitioner presented to City Center Physical Therapy for an initial evaluation. He complained of constant right elbow pain and rated it as 7-8 out of 10. The functional goals of therapy was to improve range of motion of the right elbow through exercise and to reduce pain and swelling of the right elbow. (PX 7)

On October 4, 2007, which was the fifth physical therapy session, Petitioner complained of numbness in his second through fifth fingers when his elbow was extended. The physical therapist's note states, "c/o numbness 2^{nd} - 5^{th} finger with elbow extension." On October 5, 2007, the physical therapist's progress note states, "c/o numbness in 2^{nd} + 5^{th} digit with full ext + flexion range." (PX 7)

On January 11, 2008, Petitioner complained that he had numbness in hand and fingers this past week when arm was resting on his lap. On January 14, 2008, he complained that he continued to have constant numbness in fourth and fifth fingers. On January 16, 2008, Petitioner complained that his fourth and fifth fingers now tingled all the time. On January 18, 2008, he indicated that his fourth and fifth fingers still tingled.

On January 24, 2008, which was the forty-ninth physical therapy session, the therapist recorded the following:

> "Patient stated he had numbness ever since surgery, but did not mention it because he thought it was part of the process. Numbness worsened three weeks ago. He is unable to feel what he is holding."

On January 22, 2008, Petitioner had a follow-up visit with Dr. Marra and complained that over the past three to four weeks, he developed increasing numbness in his little finger and ring finger. He felt the numbness was becoming progressively worse over time. Dr. Marra examined Petitioner's right elbow and found a positive Tinel over the course of the ulnar nerve. Dr. Marra ordered an EMG and referred Petitioner to Dr. Bindra for evaluation of his ulnar neuritis. (PX 3)

On February 18, 2008, Petitioner underwent the prescribed EMG. Petitioner provided a history to the neurologist, Dr. Gregory Gruener, that he began having right hand numbness a few weeks after an uneventful

elbow arthroscopy in September 2007. The EMG findings were consistent with a right ulnar neuropathy, whose site of involvement was at the condylar groove. (PX 3)

On February 18, 2008, Petitioner began treating with hand surgeon, Dr. Randy Bindra, for numbness in his right hand. Petitioner provided a history of numbness on the side of his right hand towards the small finger, which started in September 2007. Dr. Bindra diagnosed osteoarthritis of the right elbow, cubital tunnel syndrome on the right elbow, meaning a compression of the ulnar nerve at the elbow level. He also found Guyon's canal syndrome, meaning compression of the ulnar nerve at the level of the wrist.

On March 4, 2008, Petitioner saw Dr. Guido Marra, who made the following notation in his records:

> "James returns today, he is being follow up for an arthroscopic debridement of OA. Postoperatively he has developed symptoms of ulnar neuritis. We sent him to see Dr. Bindra. Her is currently treating him with a nocturnal extensor splint but he continues to experience numbness. His therapy does appear to be aggravating his ulnar neuropathy."

On April 3, 2008, Dr. Bindra wrote a letter seeking treatment approval. Dr. Bindra wrote:

> "To Whom it May Concern,
> We are seeking approval for a right ulnar nerve transposition at elbow, right Guyon's canal release, and excision of cyst right hypothenar area to be done for a diagnosis of cubital tunnel syndrome and ulnar nerve entrapment to be done under workman's compensation on an outpatient basis ..."

On June 12, 2008, Dr. Randy Bindra stated in a letter, the following medical opinion:

> "1. Taking into account the symptoms, physical findings and the nerve studies, diagnosed compression of the ulnar nerve at the right elbow (Cubital tunnel syndrome). I also felt the nerve was compressed at the wrist (Guyons canal syndrome). In addition he had an epidermoid cyst in the palm.
>
> 2. The ulnar nerve runs close to the elbow joint. Dysfunction of the nerve can be caused or aggravated by occupations that require working with the elbow in a bent posture or previous surgery around the elbow.
>
> 3. It is my opinion it is possible that Mr. Sale's job as a "thrower" on a garbage truck can have contributed to development of ulnar nerve dysfunction or at least caused an aggravation of symptoms from cubital tunnel syndrome. As the previous surgeries did not involved excessive dissection around the medial aspect of the elbow, they are less likely to have contributed to the ulnar nerve symptoms."

On February 5, 2009, Dr. Randy Bindra testified at his evidence deposition, as follows:

"Q. In your opinion, based on a reasonable degree of medical and surgical certainty, do you have an opinion as to whether or not Mr. Sale's position as a garbage thrower could or might have been the cause of his ulnar nerve dysfunction that you diagnosed?

A. Yes, I believe that it would certainly contribute to either the onset or if not the onset certainly the aggravation of symptoms from a cubital tunnel syndrome."
(Bindra deposition, p. 19-20)

Dr. Randy Bindra further testified as follows:

"Q. I see. In Dr. Marra's records from January of 2008, he reports that the patient was having increased numbness in his hand with undergoing physical therapy. Do you have an opinion as to whether or not physical therapy on the right elbow could or might aggravate an underlying condition of ulnar dysfunction?

A. I think if you have an ulnar nerve that is pinched and irritated at the elbow and you initiate a program of repetitive elbow movement, you will constantly stretch and relax an irritated nerve and probably you could provoke symptoms."
(Bindra deposition, p. 22)

At Respondent's request, Petitioner was examined by Dr. Stephen Weiss on January 12, 2005, March 6, 2006 and July 25, 2006. Petitioner provided that he developed pain in the epicondylar region after repetitively lifting 75-100 pound garbage cans. Dr. Weiss rendered a diagnosis of 1.) status post repair, bicipital tendon repair, January 2002; and 2.) lateral epicondylitis, September or October of 2002. Dr. Weiss opined that Petitioner's job activity could cause or aggravate extensor tendinitis or lateral epicondylitis. The doctor agreed with the need for surgery. (RX 7,8, and 9)

On March 13, 2008, Dr. Stephen Weiss re-examined Petitioner. Dr. Weiss noted Petitioner had undergone the arthroscopic debridement of the elbow in 2007 and was left with diminished sensation in the ulnar nerve distribution. Specifically, Petitioner complained of diminished sensation in the small finger and the ulnar half of the ring finger. Dr. Weiss indicated that the records he reviewed confirm an ulnar nerve compression at the elbow. Dr. Weiss felt Petitioner had essentially reached MMI regarding his lateral epicondylitis and for the arthroscopic procedure and debridement of the elbow. With respect to the ulnar nerve compression, the doctor felt Dr. Marra's recommendation for continued observation was appropriate. Dr. Weiss also felt that if there was no improvement, surgical exploration was appropriate. (RX 10)

At Respondent's request, Dr. Weiss reviewed Dr. Bindra's records from March 31, 2008 and his depositional testimony. On July 17, 2009, Dr. Weiss authored a report indicating he disagreed with Dr. Bindra's attributing Petitioner's cubital tunnel syndrome in part to arthritis in the elbow joint. He opined that there is no relationship between arthritis in the elbow and the work injury. The doctor noted that the lateral epicondylar surgery should not have produced arthritis in the joint as same is extra-articular and do not involve damage to the joint surfaces. Dr. Weiss also added that he disagreed that repetitive motion causes the condition. He noted that repetitive forceful elbow flexion and extension similar to biceps curls could produce a cubital tunnel syndrome. He noted that the electrical studies not only showed cubital tunnel syndrome, but also showed

abnormalities at Guyon's canal. He indicated that repetitive elbow flexion and extension would not produce a Guyon's canal syndrome as the anatomic structure is in the heel of the hand. He summed indicating the ulnar nerve problems are not specifically related to the elbow as they were systemic in nature. (RX 11)

Dr. Stephen Weiss testified via deposition on October 9, 2009. The following are excerpts from that testimony:

> "Q. Is that still one of your impressions, is that his ulnar nerve compression did develop post arthroscopic surgery?
>
> A.Are you talking temporally, chronologically, or are you talking cause/effect?
>
> Q. Cause/effect.

> A.I don't know. Ulnar nerve compression is a known complication of elbow arthroscopy and so at first blush if somebody has an arthroscopy of the elbow and then says, gee, within a week or two, I had ulnar nerve compression and people would say as I guess Dr. Bindra did it was scar tissue from the surgery and I would say it was a complication. On the other hand, that doesn't explain the Guyon's canal and it doesn't explain the carpal tunnel so I would have to say I don't know. It's something to consider as a possibility but I can't say to a medical degree of probability."
>
> (Dr. Weiss deposition, p. 24)

Dr. Weiss further testfied as follows:

> "Q. Can physical therapy aggravate a pre-existing ulnar neuropathy condition?
>
> A.I know that I noted after I examined him, I think, that was in the records.
>
> Q. Page 4, Dr. Marra's chart note, March 4th of '08.
>
> A.Yeah, unfortunately, I didn't have that in time to discuss that record with him. I have believed and do believe that performing biceps curls or activities like that on a repetitive basis because it is forceful and repetitive can produce medial epicondylitis and ulnar nerve compression so I would have to know what he was doing in physical therapy, I would have to know if he was doing weight work in physical therapy, was he doing - - what kind of weight work, but forceful elbow flexion and extension I believe can cause or aggravate cubital tunnel syndrome. If he was doing that and if he was doing it in sufficient volume, then I would say it was related. I just don't have that information."
>
> (Dr. Weiss deposition, p. 25-26)

Petitioner testified that he desires to have surgery to correct the numbness in his right hand.

With respect to (F.)IS PETITIONER'S CURRENT CONDITION OF ILL-BEING CAUSALLY RELATED TO THE INJURY, the Arbitrator finds as follows:

Petitioner testified that he never before had numbness in his right hand. There were no medical records presented at Arbitration to contradict his testimony concerning this issue. Petitioner testified that he had a prior right arm injury on January 14, 2002, when he tore his right bicep . On July 1, 2002, he was released back to full time work where he drove a garbage truck and threw garbage onto the truck.

On August 29, 2002, Petitioner saw Dr. Robert Mitchell for pain over his right bicep tendon after working significant overtime and throwing garbage. Dr. Mitchell diagnosed right elbow bicipital tendinitis. Dr. Mitchell wrote a medical report stating that this was a new work injury and that the right elbow bicipital tendinitis was attributable to his job.

Petitioner came under the care of Dr. Paul Perona, who wrote a medical report stating that Petitioner's condition of ill being is related to his repetitive throwing of garbage. On June 10, 2005, Dr. Perona performed a right lateral epicondylar debridement procedure on Petitioner's right elbow. Following surgery, Petitioner continued to experience persistent pain and was referred to Dr. Guido Marra for a second opinion.

Dr. Guido Marra wrote a medical report stating that Petitioner's persistent pain is related to his right lateral epicondylitis surgery since it is a known complication. On September 17, 2007, Dr. Marra performed an arthroscopic debridement of the elbow and open removal of sutures. Shortly after surgery, Petitioner was referred for physical therapy to increase the range of motion in his right elbow.

On October 4, 2007, which was the fifth physical therapy session, Petitioner for the first time complained of numbness in his second through fifth fingers when his right elbow was extended. Petitioner continued to complain of numbness in the fingers on his right hand to his therapists.

On January 22, 2008, Dr. Marra examined Petitioner and diagnosed him with right ulnar neuritis. An EMG confirmed that there was a right ulnar neuropathy at the condylar groove.

On March 4, 2008, Dr. Marra documents in his records that Petitioner post operatively developed symptoms of ulnar neuritis. Dr. Marra further noted that his therapy did appear to aggravate his ulnar neuropathy. Dr. Marra then referred Petitioner to hand surgeon, Dr. Randy Bindra, for further care.

On June 12, 2008, Dr. Randy Bindra stated in a medical report that dysfunction of the nerve can be caused or aggravated by occupations that require working with the elbow in a bent position on previous surgeries around the elbow. Dr. Bindra stated at his evidence deposition that Petitioner's position as a garbage thrower, would certainly contribute to either the onset or aggravate the symptoms of cubital tunnel syndrome. Dr. Bindra also testified that undergoing physical therapy program of repetitive elbow movement would irritate the nerve and would provoke symptoms.

Respondent's Section 12 examiner, Dr. Stephen Weiss agreed that it was a possibility that the ulnar nerve compression was a complication from the elbow arthroscopy. Dr. Weiss also agreed that physical therapy involving forceful elbow flexion and extension could cause or aggravate cubital tunnel syndrome.

The Arbitrator, after careful consideration of the evidence, finds that there is a causal connection between Petitioner's current condition of ill-being and his work injury on August 29, 2002.

With respect to (O.) IS PETITIONER ENTITLED TO ANY PROSPECT MEDICAL CARE FOR THE INJURY, the Arbitrator finds as follows:

Petitioner is requesting prospective medical care to relieve his right hand numbness. Dr. Randy Bindra testified that a right ulnar nerve transposition at the elbow be done for a diagnosis of cubital tunnel syndrome and ulnar nerve entrapment.

The Arbitrator accepts the opinion of Dr. Randy Bindra, including his recommendation on the type of surgical procedure to relieve his right hand numbness. Having found the requisite causal relationship, the Arbitrator finds that Petitioner is entitled to prospective medical care as prescribed by Dr. Randy Bindra.

STATE OF ILLINOIS)
) SS.
COUNTY OF WILLIAMSON)

☐ Affirm and adopt	☐ Injured Workers' Benefit Fund (§4(d))
☐ Affirm with changes	☐ Rate Adjustment Fund (§8(g))
☒ Reverse Accident	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☐ Modify	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

ROLLIN RAUGUST,

Petitioner,

14IWCC0829

vs.

NO: 10 WC 42634

SOI/TAMMS CORRECTIONAL CENTER,

Respondent.

DECISION AND OPINION ON REVIEW UNDER 19(B)

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, notice and medical expenses and being advised of the facts and law, reverses the Decision of Arbitrator as stated below. Given the Commission decision, this case is not remanded to the Arbitrator for further proceedings pursuant to Thomas v. Industrial Commission, 78 Ill.2d 327, 399 N.E.2d 1322, 35 Ill.Dec. 794 (1980).

On January 22, 2014, Arbitrator Gallagher caused to be filled with the Illinois Workers' Compensation Commission a 19(b) Decision of Arbitrator, one in which he found Petitioner successfully demonstrated that his claimed bilateral cubital tunnel syndrome symptoms arose out of and in the course of his employment with Respondent. Accordingly, Arbitrator Gallagher awarded the prospective bilateral cubital tunnel surgeries Petitioner sought as well as compensation for the medical expenses incurred while treating these symptoms. The Commission relying, in part, on *Sisbro v. Industrial Commission,* 207 Ill.2d 193, 797 N.E.2d 665, 278 Ill.Dec. 70 (2003), concludes Petitioner failed to prove he suffered compensable injuries to either elbow and, consequently, reverses the abovementioned 19(b) Decision of Arbitrator.

"The Commission must decide whether there was an accidental injury which arose out of employment . . . However, the Commission's decision must be supported by the record and not based on mere speculation or conjecture." *Sisbro,* 207 Ill.2d at 215. The Commission, upon reviewing both the arbitration testimonies of Petitioner and Lieutenant Daniel Monti and the medical records, finds Petitioner engaged in pattern of overly-general statements and misrepresentations with respect to his job activities as to find Petitioner not credible. And in so finding Petitioner to be not credible, the opinion of Petitioner's examining physician, Dr. David Brown, is considered to be tainted to such a degree by the misrepresentations Petitioner made to him that it cannot be relied upon.

Notice is taken of Petitioner both qualifying nearly every duty he performs as well as omitting certain aspects of those duties, aspects that might belie the actual physical aspects of those duties. Petitioner testified, "If you're upstairs . . . you have five trays in one hand." Petitioner's qualified indicates that he might not be upstairs delivering food on trays while using one hand but might be on the lower level moving the trays from cell to cell on the food cart as was shown in Respondent's video of aspects of a CO's job duties. Petitioner's testimony also presumes that all of the cells in the upper level are occupied. Both Petitioner and Lieutenant Monti indicated that Tamms Correctional Center was not at full capacity.

Petitioner stated, in a self-penned job description, that delivering food to the inmates requires the chuckholes to opened and closed 120 times. This frequency presumes the facility to be at full capacity and, also, to Petitioner working alone. Per the correctional officer interviewed in the video produced by CorVel, two correctional officers are assigned to deliver food. This being so, the number of food trays carried, key turns necessary to unlock and lock the chuckhole locks and the number of times the chuckholes are opened and closed when delivering food would be halved. Also per the video, inmates are given 20-25 minutes to finish their meals, meaning Petitioner would have had respite before having to use his arms, elbows and wrists again.

Petitioner testified that the chuckholes that were in use for ten years did not open easily due to a lack of maintenance. He did not state how frequently he encountered these ten-year-old chuckholes that were difficult to open. In the above-referenced job description, Petitioner stated that the chuckholes were heavy and didn't pull down easily, but he failed to attribute the difficulty in pulling the chuckholes down to anything in particular. The above-referenced video, demonstrated a single chuckhole, age unknown, being opened with one finger and then, with additional force being applied by the rest of the hand, it was placed into an open position. A presumption can be made that those chuckholes that were not ten-years-old opened easily.

Similarly, Petitioner testified that not all Folger Adams keys turned easily. What number or percentage of these keys was difficult to turn is unknown because Petitioner did not offer any figure. Nor did he testify to how often he encountered a Folger Adams key that was difficult to turn. He testified that there were times when it would take both hands to turn the key but, he contradicted himself when testified that he did not use his left hand to operate keys.

Petitioner testified that, on occasion, inmates resisted being placed in cuffs and, when an inmate pulls away, he has to pull the inmate back towards himself. "On occasion" and "when"

are used by Petitioner, but he, again, did not provide any context to the frequency of these happenings that would allow one to know if this was an hourly, daily, weekly, monthly or less frequent occurrence.

Petitioner's job description provides further examples of his job duties, examples that are, again, often qualified. Those job duties that are not qualified, however, are either rebutted or given a more nuanced explanation of what those duties entailed by Daniel Monti, Petitioner's supervisor and witness, or by Major Markel, the day shift commander at the facility.

Petitioner wrote that laundry was performed once a week, but uses the pronoun "we" to state who performs the duties involved in the process. "'We" pull the bags through these chuckholes and push them through when returning the laundry." The use of "we" indicates Petitioner did not perform these tasks alone. Moreover, Lieutenant Monti testified that Petitioner's shift was responsible only for delivering clean laundry to the inmates as the earlier shift was responsible for picking up the soiled laundry. Consideration must also be given that the amount of laundry to be returned would be in proportion to the population of inmates in the pods Petitioner was responsible for.

Again, Petitioner used the pronoun "we" when stating who opens the chuckholes to pass items to the inmates. This, again, implies Petitioner did not do this alone. Furthermore, no testimony or claim was made as to the number of times the chuckholes had to opened and closed for such purposes. According to Lieutenant Monti, Petitioner's shift was responsible for delivering mail six days a week and generally did not deliver books from the library. While the number of days the mail was delivered is known, the number of times a chuckhole was opened and closed is not. The number would depend on the number of inmates who received mail and how often they received mail over the course of the week.

Petitioner, again, uses "we" to describe who performs shakedowns. In describing the frequency of the shakedowns in the job description, Petitioner stated that inmates are shaken down during every shift, and, in doing so, must be cuffed and uncuffed. Petitioner's testimony indicates shakedowns are less frequent than as stated in the job description, testifying that all non-high risk inmates were shaken down once a month and only that all high-risk inmates were shaken down more frequently. When pressed for the number of shakedowns that occur on a given day, Petitioner indicated he was unaware of that number.

Petitioner's job description indicates that the staff must do all the cleaning. CorVel's report indicated that correctional officers clean the wings three or four times a day, not per shift. The frequency of cleaning as stated in the report was corroborated by a Major Markel. Lieutenant Monti hinted that the cleaning schedule is not strictly adhered to, that an area would have to be cleaned if it wasn't messy. He testified further of cleaning not occuring every day unless a supervisor orders it. He also hinted that it not always be the case that the staff does all the cleaning, indicating that an inmate might.

The Commission takes particular notice of the claim made in Petitioner's self-penned job description of his performing the job activities referenced in the job description daily for 12½ years, particularly when Respondent provided Petitioner's staff assignment history from April

19, 2009, and April 15, 2011, which indicated Petitioner's assignments rotated every few months. It showed Petitioner was assigned, on two occasions, to be the kitchen officer and roving patrol officer. An assumption is made that Petitioner was not performing wing checks or cleaning hallways or delivering mail or food or laundry when he as the kitchen officer. Similarly, Petitioner was, on four occasions, assigned to be a control officer when he was not a wing officer. It was repeatedly stated that the control officer stayed in the control booth and pressed buttons that opened and closed doors.

Petitioner's testimony and submitted evidence requires the Commission to engage in speculation and conjecture, the exact behavior *Sisbro* prohibits it from doing. Rather than straightforwardly explaining what his actual job activities were, Petitioner, instead, either increased the number of the individuals who actually performed the activities as evidenced by the use of the pronoun "we" or repeatedly qualified what activities were performed or problems encountered. "If" one worked on the second tier, they had to carry trays of food up a flight of stairs. "Some" of the chuckholes that were ten years old were difficult to open. "Not all" Folger Adams keys worked well. These are examples of Petitioner's qualified answers to questions asked of him during his arbitration testimony. The end result of the manner in which Petitioner testified and presented his evidence makes it uncertain what activities Petitioner actually performed and, if he performed them, how often. Without knowing these facts, the Commission cannot find Petitioner proved that his accidental injuries arose out of and in the course of his employment with Respondent.

The Commission conducted oral arguments on July 29, 2014. Though both parties were given an opportunity to argue, only Respondent argued. The Commission recognizes, however, Respondent failed to file a Statement of Exceptions in support of its Petition for Review of Arbitration Decision and, *sua sponte*, vacates and disregards any argument presented to the Panel on said date. In arriving at its decision, the Commission relied solely on the evidentiary record contained within the authenticated Transcript of Proceedings on Arbitration filed with the Illinois Workers' Compensation Commission on April 24, 2014.

IT IS THEREFORE ORDERED BY THE COMMISSION that the January 22, 2014, 19(b) Decision of Arbitrator is reversed and all benefits awarded vacated.

DATED: SEP 25 2014
KWL/mav
O: 07/29/14
42

Kevin W. Lamborn

Thomas J. Tyrrell

Michael J. Brennan

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

14IWCC0829

RAUGUST, ROLLIN
Employee/Petitioner

Case# **10WC042634**

SOI/TAMMS CORRECTIONAL CENTER
Employer/Respondent

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:

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

4948 ASSISTANT ATTORNEY GENERAL
WILLIAM H PHILLIPS
201 W POINTE DR SUITE 7
SWANSEA, IL 62226

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

JAN 22 2014

KIMBERLY B. JANAS Secretary
Illinois Workers' Compensation Commission

STATE OF ILLINOIS)
)SS.
COUNTY OF JEFFERSON)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

14IWCC0829

Rollin Raugust
Employee/Petitioner

Case # 10 WC 42634

v.

Consolidated cases: _____

State of Illinois/Tamms 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 Mt. Vernon, on November 8, 2013. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

14IWCC0829

FINDINGS

On October 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 $57,055.44; the average weekly wage was $1,097.22.

On the date of accident, Petitioner was 42 years of age, married with 1 dependent child(ren).

Petitioner has not received all reasonable and necessary medical services.

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

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

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

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 authorize and pay for the medical treatment recommended by Dr. David Brown including, but not limited to, bilateral cubital tunnel surgeries.

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)

January 13, 2014
Date

JAN 22 2014

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 October 27, 2010, and that Petitioner sustained repetitive trauma to the right and left hands and arms/elbows. This case was tried in a 19(b) proceeding and Petitioner sought an order for payment of medical bills and prospective medical treatment. Respondent disputed liability on the basis of accident, notice and causal relationship.

Petitioner began working for Respondent as a Correctional Officer in January, 1998, and was employed in that capacity at the Tamms Correctional Center until the time it closed approximately three years ago. At that time, Petitioner was transferred to the Vienna Correctional Center where he has continued to work as a Correctional Officer.

Tamms Correctional Center was a maximum security facility (also described as a "Supermax" facility). The housing units at Tamms contained pods each of which had a maximum capacity of 60 inmates.

Petitioner testified that a significant amount of the contact he had with the inmates was through chuckholes. The chuckholes were used for passing items such as mail, books, laundry, meals, etc. and for cuffing/uncuffing them. The chuckholes were locked/unlocked with a Folger-Adams key. Petitioner testified that locking/unlocking the chuckholes was difficult, the keys would get stuck and sometimes require the forceful use of both hands to operate. On occasion, opening a chuckhole would require Petitioner to use his knee and both hands to turn the key and force the lock. Cuffing and uncuffing of the inmates had to be performed in the confined space of the chuckhole which required force and dexterity. Further, Petitioner testified that there were occasions when inmates would become uncooperative during cuffing/uncuffing which resulted in Petitioner engaging in a "tug of war" with the inmate.

Petitioner was also required to perform wing checks, restrain uncooperative inmates, perform shakedowns and perform various other cleaning/maintenance tasks. When Petitioner performed a wing check, he would forcefully pull on the doors to make certain that they were secured. Petitioner estimated that he was required to perform these various hand intensive tasks thousands of times during his years at Tamms. Because Tamms was a "Supermax" facility, there were no inmate workers to assist with cleaning, sweeping/mopping, picking up trash, etc.

At the request of Respondent, Melanie Welch of Corvel Corporation, prepared a Job Site Analysis of a Tamms Correctional Officer. Welch was deposed on September 9, 2011, in regard to another case involving a Correctional Officer and the transcript of her deposition testimony was tendered into evidence at trial by Petitioner's counsel. In connection with her preparation of this analysis, Welch toured the Tamms facility and recorded a video that was approximately 10 minutes long. For security reasons, Welch was not permitted to film Correctional Officers while they were performing their job duties.

Welch testified that she did not have specific information as to the amount of keying and cuffing/uncuffing performed by the Correctional Officers. She did not know if the chuckhole doors were heavy or whether they opened easily. She was unaware of how the Correctional Officers performed shakedowns of inmates. While she was aware of the fact that Correctional Officers did sweeping and mopping, she did not know who emptied trash receptacles or who cleaned showers, toilets, furniture and ducts.

Major Daniel Monti was present on behalf of the Respondent but was called to testify on behalf of the Petitioner. He was Petitioner's supervisor while at Tamms and agreed that Petitioner was a good employee. He was present during Petitioner's testimony and did not dispute any portion of it. Monte agreed that Petitioner used his arms/hands while working as a Correctional Officer at Tamms.

Concurrent with the time Petitioner was performing his job duties at Tamms, he began to notice symptoms of numbness and pain in his hands. At that time, Petitioner did not associate these symptoms with his employment duties. Petitioner sought medical treatment sometime in 2006 and had nerve conduction studies performed which revealed he had bilateral cubital tunnel syndrome. The medical records of this prior treatment were not tendered into evidence at trial. Petitioner received some conservative treatment including splints but did not report this as being a work-related condition.

At the direction of his attorney, Petitioner was examined by Dr. David Brown, an orthopedic surgeon, on October 27, 2010. At that time Petitioner complained of a four year history of progressive pain/numbness in the little and ring fingers of both hands and aching in both elbows. Petitioner informed Dr. Brown that he had worked as a Correctional Officer since 1998 and that his job required him to turn keys, pull doors, pick up trays, pass laundry, pull bags, cuff/uncuff inmates and open/close doors. Dr. Brown referred Petitioner to Dr. Dan Phillips who performed nerve conduction studies which were positive for bilateral cubital tunnel syndrome. Dr. Brown opined Petitioner had chronic bilateral cubital tunnel syndrome and, given the fact that he had failed conservative treatment, he recommended that Petitioner have surgery. In regard to causality, Dr. Brown opined that Petitioner's duties as a Correctional Officer was an aggravating factor for the development of cubital tunnel syndrome (Petitioner's Exhibits 3 and 4).

Petitioner testified that, subsequent to his examination by Dr. Brown, was when he became aware that his job duties were causing his arm/hand symptoms. On November 1, 2010, Petitioner reported the condition to Respondent as being a work-related condition and he completed an accident report at that time.

At the direction of Respondent, Dr. Anthony Sudekum, a hand surgeon, performed a records review on February 10, 2012. Dr. Sudekum reviewed medical records of Dr. Brown and Dr. Phillips, the Job Site Analysis prepared by Melanie Welch, the Accident and Supervisor's Reports and a Department of Corrections Memorandum regarding repetitive trauma and door buttons and keying. Dr. Sudekum agreed with the diagnosis of cubital tunnel syndrome; however, he opined that the condition was not caused or aggravated by Petitioner's work duties at Tamms.

Dr. Sudekum was deposed on February 16, 2012, and his deposition testimony was received into evidence at trial. Dr. Sudekum's deposition testimony was consistent with his medical report and he reaffirmed his opinion that Petitioner's cubital tunnel syndrome was neither caused nor aggravated by his job duties at Tamms. On cross-examination, Dr. Sudekum agreed that he was not aware of the force and frequency that Petitioner used Folger-Adams keys when opening/closing chuckholes and he believed that the Correctional Officers at Tamms typically performed relatively light, intermittent normal activities in a relaxed and unhurried fashion. In spite of the fact that there were no inmate workers at Tamms, Dr. Sudekum believed that kitchen work and other duties were performed by the inmates (Respondent's Exhibit 1).

During the aforementioned deposition, more specifically, when Dr. Sudekum was cross-examined about whether he would "cut and paste" from one report to another, he denied same. (Respondent's Exhibit 1). At the request of Petitioner's counsel, Zachary Weiss, a college student, reviewed a number of Dr. Sudekum's reports. Weiss made no medical conclusions in connection with his review of these reports but was merely looking for similarities. Weiss was deposed on March 15, 2013, in connection with another case and he testified that typically numerous pages in Dr. Sudekum's reports were virtually identical in each case (Petitioner's Exhibit 7).

Dr. Brown was deposed on September 24, 2013, and his deposition testimony was received into evidence at trial. Dr. Brown's testimony was consistent with his medical records and he reaffirmed his opinion that there was a causal relationship between Petitioner's work activities at Tamms and the bilateral cubital tunnel syndrome condition he diagnosed as well as the need for surgery. Dr. Brown testified that the occupational risk factors for cubital tunnel syndrome involved repeated elbow flexion, twisting type motions, supination/pronation type activities and repetitive arm motions. Based on Petitioner's arm intensive activities such as opening/closing chuckholes, as well as others, and the lack of other contributing factors, such as diabetes, hypothyroidism or arthritis, Dr. Brown opined that Petitioner's job activities were a contributing factor in the development of the cubital tunnel syndrome condition. Given the failure of conservative treatment, Dr. Brown renewed his recommendation that Petitioner have bilateral cubital tunnel surgeries performed.

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 a repetitive trauma injury arising out of and in the course of his employment for Respondent and that Petitioner's current condition of ill-being is causally related to same.

In support of this conclusion the Arbitrator notes the following:

Petitioner credibly testified that his job duties as a Correctional Officer at the Tamms Correctional Center required the repetitive use of his arms/hands, in particular, using Folger-Adams keys, opening/closing chuckholes, cuffing/uncuffing inmates, performing wing checks, performing shakedowns and restraining uncooperative inmates. This testimony was unrebutted.

The Arbitrator finds the opinion of Dr. Brown to be more persuasive and credible than that of Dr. Sudekum. Dr. Brown had knowledge of Petitioner's arm/hand intensive activities required by Petitioner's job and Dr. Brown's opinion that there was a causal relationship between those activities and the bilateral cubital tunnel syndrome was well-founded.

While Dr. Sudekum denied cutting and pasting sections of on one report to another, the deposition testimony of Zachary Weiss indicates otherwise.

In regard to disputed issues (D) and (E) the Arbitrator makes the following conclusion of law:

The Arbitrator concludes that Petitioner's condition manifested itself on October 27, 2010, and that Petitioner gave notice to Respondent within the time prescribed by the Act.

In support of this conclusion the Arbitrator notes the following:

While Petitioner had previously sought treatment for and been diagnosed with bilateral cubital tunnel syndrome, he testified that October 27, 2010 (the date of his evaluation with Dr. Brown), was when he first became aware of the relationship between his arm/hand symptoms and his work-related activities.

Petitioner gave notice to Respondent and prepared an Accident Report on November 1, 2010, which is within the time limit for giving notice as 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 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.

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 bilateral cubital tunnel surgeries recommended by Dr. Brown.

William R. Gallagher, Arbitrator

STATE OF ILLINOIS)
) SS.
COUNTY OF KANE)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Emmanuel Diaz,

Petitioner,

vs.

Optimum Nutrition,

Respondent.

14IWCC0830

NO: 10 WC 15712

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 the reasonableness and necessity of prospective medical treatment and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof. We agree with the Arbitrator's finding that Petitioner is entitled to a trial of a spinal cord stimulator as recommended by Dr. Lorenz. 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 30, 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

14IWCC0830

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: SEP 30 2014
RWW/plv
o-8/5/14
46

Ruth W. White

Charles J. DeVriendt

Daniel R. Donohoo

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

DIAZ, EMMANUEL
Employee/Petitioner

Case# **10WC015712**

14IWCC0830

OPTIMUM NUTRITION
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:

0190 LAW OFFICES OF PETER F FERRAUTI
JENNIFER KIESEWETTER
110 E MAIN ST
OTTAWA, IL 61350

2284 LAW OFFICE OF LAWRENCE COZZI
ASHLEY VONAH
27201 BELLA VISTA PKWY #410
WARRENVILLE, IL 60555

STATE OF ILLINOIS)
)SS.
COUNTY OF Kane)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION 19(b)

14IWCC0830

Emmanuel Diaz
Employee/Petitioner

v.

Optimum Nutrition
Employer/Respondent

Case # 10 WC 15712

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 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 _____

FINDINGS

On the date of accident, **2/11/10**, 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 **$30,060.16**; the average weekly wage was **$578.08**.

On the date of accident, Petitioner was **24** years of age, ***married*** with **0** dependent children.

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

Respondent shall be given a credit of **$0** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$0 The parties stipulated that all temporary benefits were paid through 1/31/13.**

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 $385.39/week for 13 5/7 weeks, commencing 2/1/13 through 5/7/13, as provided in Section 8(b) of the Act.

Respondent shall pay reasonable and necessary medical services of $40,144.18, as provided in Sections 8(a) and 8.2 of the Act.

Respondent shall pay for prospective medical treatment in the form of trial spinal cord stimulator as recommended by Dr. Jain, treating pain management physician.

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

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

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

Signature of Arbitrator

8/29/13
Date

ICArbDec19(b)

AUG 30 2013

14IWCC0830

FINDINGS OF FACT

This matter was previously heard pursuant to Section 19(b) of the Act on September 10, 2010, by Arbitrator Jacqueline Kinnaman. These findings include relevant facts incorporated from that record.

Petitioner Emmanuel Diaz first began working for Respondent Optimum Nutrition approximately two years prior to his accident. Petitioner testified that he was a warehouse worker, and his duties included moving and breaking down pallets, as well as operating the forklift.

In February of 2009, Emmanuel was diagnosed with a lumbar strain, including a disc herniation at L5-S1. (PX5, 19(b) hearing exhibits). He was referred to Dr. John B. Mazur, a neurosurgeon, and on March 6, 2009. Emmanuel underwent a bilateral L5-S1 microhemilaminectomy, partial facetectomy, foraminotomy, and bilateral L5-S1 diskectomy to repair the herniated disc. The surgery was successful, and Emmanuel was allowed to return to work with restrictions.

Emmanuel returned to Dr. Mazur's office on April 23, 2009 for a postoperative check-up, at which point Emmanuel was completely negative for any pain, discomfort or numbness. (PX5, 19(b) hearing exhibits). The records indicate that Emmanuel told Dr. Mazur that "everything I had before surgery is gone". Thus, Emmanuel was returned to work without restrictions on April 23, 2009. Emmanuel testified that from April 23, 2009 until February 10, 2010, he worked with no restrictions for Optimum Nutrition. Emmanuel further testified that his back remained completely pain-free with no discomfort or numbness whatsoever from the date he returned to work without restrictions until his accident on February 10, 2010.

It is undisputed that Petitioner suffered an accidental injury that arose out of and in the course of his employment on February 10, 2010. Emmanuel testified that the accident occurred as he was retrieving some pallets at work when he slipped on an accumulation of ice on the loading dock and fell to the ground with great force and violence. Emmanuel testified that he landed on his right elbow and back. Emmanuel testified that he immediately reported this accident to his supervisor, Francisco. The Respondent stipulated that Petitioner gave proper notice of his accident later that same day to his supervisor, Juan Vega. Emmanuel testified that in the time immediately following his accident, he tried to cope with his pain and continue to work. However, Emmanuel testified that as the day went on, he began to experience more pain in his "mid back". Emmanuel testified that ultimately, his supervisor sent him home for the day, and then approved him for medical treatment the following day.

On February 12, 2010, Emmanuel reported to Concentra Medical Center, where the records indicate that his injury originally occurred when he slipped on ice on the loading dock and injured his lower right back, right arm and leg. (PX3, 19(b) hearing exhibits). His primary complaints were of middle and lower back pain. An x-ray was administered, but Emmanuel did not receive an MRI. He was diagnosed with a lumbar strain, a thoracic strain and an abrasion on his lower leg. He was instructed to return to Concentra in four days for a follow-up.

Emmanuel returned to Concentra on February 16, 2010 indicating that his symptoms had not improved. (PX3, 19(b) hearing exhibits). He complained of stiffness in his back, including pain in his mid and lower back area. He was prescribed a regimen of pain medication and physical therapy. Thereafter, Emmanuel continued to work full duty.

Emmanuel testified that working caused an increase in pain in his mid back and lower back, especially operating the forklift. On February 22, 2010 Emmanuel reported to Concentra as a walk-in due to increased

pain in his mid back. (PX3, 19(b) hearing exhibits). After follow-up visits on March 1, 2010 and March 8, 2010, Emmanuel reported to Concentra on March 15, 2010 indicating that he continued to experience significant pain in his mid back. His activity status was modified to lighter duty with no forklift driving. He was referred to Physiatrist Dr. Heller at the earliest convenient time, but this referral was denied by the Respondent and Petitioner was returned to full duty at work.

Thereafter, Emmanuel visited Concentra on March 25, 2010 and April 8, 2010 complaining that the pain in his mid back persisted. (PX3, 19(b) hearing exhibits). Additionally, Emmanuel testified that he complained to his physician at Concentra that his lower back pain had worsened, and he was experiencing tingling and numbness in his lower extremities.

On April 10, 2010, Emmanuel's back hurt so severely that he reported to the emergency room at Rush Copley Medical Center. (PX2, 19(b) hearing exhibits). He was prescribed pain medication and told to follow up with his primary doctor. On April 26, 2010, Emmanuel followed-up with Dr. Mazur to address his ongoing back pain, as well as tingling in his lower extremities. (PX5, 19(b) hearing exhibits). Dr. Mazur did not perform an MRI and suggested that Emmanuel let his pain improve on its own. Emmanuel testified that Dr. Mazur only spent between ten and twenty minutes examining him, and he suggested that Emmanuel's back pain was likely due to obesity.

When asked at the 19(b) hearing to describe where his back pain was located at this time, he pointed to the area of his back directly above his waist line. He testified that the pain then became even worse in his lower back.

Petitioner testified that he continued to work light duty but that he noticed his pain worsening.

On May 6, 2010, Emmanuel returned to Concentra complaining that his symptoms were no better. (PX3, 19(b) hearing exhibits). Specifically, Emmanuel complained of pain in his lower back. That same day, Emmanuel went to see Dr. Mark Lorenz complaining of thoracolumbar and lumbar pain and bilateral leg pain. (PX10 at 17). Dr. Lorenz ordered that Emmanuel be kept off work and ordered an MRI, which was administered on May 12, 2010. (Px4, 19(b) hearing exhibits).

On May 13, 2010, Emmanuel returned to Concentra indicating that his back pain had showed no improvement, specifically mentioning his lower back. (Px3, 19(b) hearing exhibits). The pain medications were not helping, and the pain was radiating to his lower extremities. Once again, Concentra referred Emmanuel to Physiatrist Dr. Heller as soon as possible, which was once again denied by the Respondent.

On June 9, 2010, Emmanuel followed-up with Dr. Lorenz to discuss his MRI results, which showed L3-4, L4-5 annular tears with disc herniations and bilateral radiculopathy. (PX10 at 15). Dr. Lorenz recommended Emmanuel receive bilateral L4 and L5 transforaminal epidural steroid injections. Subsequently, the Respondent's insurance company denied the injections, and instead approved Emmanuel for additional physical therapy. (PX6, 19(b) hearing exhibits).

On June 16, 2010, Petitioner was seen by Dr. Gary Koehn for a pain management consultation. (PX8 at 15). He was diagnosed with L3-L4, L4-L5 disc herniation with annular tears and foraminal stenosis and L5-S1 instability. It was also indicated that he had chronic progressive multifactorial bilateral back pain and bilateral lumbar radiculopathy following his work injury of February 11, 2010, and that he has been unresponsive to time and conservative treatments and it is disruptive to his activity, lifestyle, and sleep. (PX8 at 16). Arrangements were made for Petitioner to have bilateral L4 and L5 transforaminal epidural steroid injections. (PX8 at 17).

On September 2, 2010, Petitioner was examined by Dr. Babak Lami at the request of Respondent's workers' compensation carrier for an IME. (RX1). Dr. Lami opined that Petitioner's treatment of physical therapy, x-rays, and MRI were reasonable, necessary, and related to the injury. He further opined that he did not think that this current condition was related because he had multiple degenerative changes which he states were present prior to the fall.

At the 19(b) hearing, Petitioner testified that he had not been approved for any medical treatment since July 2010. He testified that he is not able to leave his house often. He states that he feels better if he is lying down and has difficulty walking. He has experienced a worsening of pain since the accident. He stated that the pain goes from his lower back up to his mid back up into his neck. He also notices pain down into his legs and thighs.

Petitioner testified at the 19(b) hearing that it was his wish to continue medical treatment as prescribed by Dr. Lorenz.

Arbitrator Kinnaman issued a 19(b) Decision on October 12, 2010, which awarded temporary total disability benefits, medical expenses, and awarded prospective medical care as prescribed by Dr. Lorenz, specifically the epidural steroid injections and physical therapy.

Petitioner was seen by Dr. Douglas Dorman at Dreyer Medical Clinic on October 7, 2010. (PX5 at 87). Dr. Dorman indicated he would follow-up pending obtaining Workers' Compensation status and MRI reports/orthopaedic notes.

Petitioner returned to Dr. Koehn on November 3, 2010. His pain in both back and legs had worsened since his last visit. It was indicated that the bilateral transforaminal L4-L5 epidural steroid injections had just recently been approved. (PX8 at 9). Petitioner received the injections on November 4, 2010. (PX8 at 7).

Petitioner was seen at Hinsdale Orthopaedics on December 20, 2010. (PX10 at 14). He was diagnosed with a thoracic strain, L5-S1 spondylosis with axial back pain, and L3-4, L4-5 annular tears with disc herniation and bilateral radiculopathy. The plan was for him to return to Dr. Koehn for a lumbar discography.

Petitioner returned to Dr. Koehn on December 29, 2010, who noted that he had no short or long-term gain from the bilateral transforaminal L4, L5 steroid injections. (PX8 at 5). Diagnostic provocation discography was discussed in order to identify internal disc disruption and discogenic pain and future treatment options. This would examine four levels L2-S1, left approach. (PX8 at 6).

On September 2, 2010, Petitioner was examined by Dr. Edward Goldberg at the request of Respondent's workers' compensation carrier for an IME. (RX2). Dr. Goldberg diagnosed Petitioner with lumbar and thoracic strains and opined that the February 11, 2010 accident did cause these diagnoses. He also opined that Petitioner's treatment has been reasonable, necessary, and related to the injury. He recommended an FCE and a follow-up discography to ascertain whether the degenerative disk disease seen on the MRI is truly the source of pain.

A diagnostic lumbar discography at L2-3, L3-4, L4-5, and L5-S1 was done on March 22, 2011 by Dr. Neeraj Jain. (PX3 at 6, PX16). Petitioner had discogenic pain at L4-5 and L5-S1, and although there was an annular tear at L3-4, this level was negative. (PX3 at 8). Petitioner was kept off work, and it was recommended that he continue with current medications and continue with physical therapy as tolerated. (PX3 at 10). A CT scan was also performed on March 22, 2011, showing disc herniations at L2-L3, L3-L4, L4-L5, and L5-S1. (PX4 at 4).

Petitioner saw Dr. Lorenz on March 31, 2011. (PX10 at 12). He reviewed the discography and recommended that Petitioner undergo an L3-4, L4-5 decompression and an L3-S1 posterior spinal fusion, along with a possible discectomy at L5-S1. He kept Petitioner off work.

Petitioner was seen by Dr. Lorenz on May 18, 2011. (PX10 at 10). He complained of back pain, rated at an 8/10 and bilateral leg pain, going down the backs of both legs and also down the insides of both legs, along with numbness in the bottoms of both feet. He rated his leg pain at a 6/10 when sitting and a 10/10 when walking. Dr. Lorenz indicated Petitioner was being admitted to Hinsdale Hospital for an L3-S1 posterior spinal fusion and decompression.

On May 24, 2011, Dr. Lorenz performed lumbar fusion surgery at L3, L4, L5, and S1, along with a decompressive lumbar laminectomy at L3, L4, and L5. (PX2 at 117). Petitioner's preoperative and postoperative diagnoses were lumbar spinal stenosis at L3-L4 and L4-L5 with resulting L4-L5 lumbar radiculopathy and axial instability and discogenic back pain at L3, L4, L5, and S1. Petitioner completed inpatient physical therapy while at Hinsdale Adventist Hospital. (PX2 at 287). Petitioner was discharged from the hospital on May 28, 2011. (PX2 at 84).

Petitioner had post-operative follow-up visits with Dr. Lorenz. On June 20, 2011, Petitioner was asked to continue wearing his brace until he was reevaluated for rehab or physical therapy. (PX12 at 10).

Petitioner was evaluated for a follow-up independent medical evaluation by Dr. Goldberg on July 6, 2011. (RX3). He opined that based on the discogram, he felt the patient was having pain from multilevels. He recommended Petitioner start formal therapy for the next three months. He indicated if the fusion is healed, he could have a functional capacity evaluation. If not, he would benefit from work hardening. He opined that Petitioner is capable only of sedentary work.

Dr. Mark Lorenz, treating orthopedic surgeon, testified via evidence deposition on July 13, 2011. (PX12). Dr. Lorenz testified that Petitioner's current condition of ill-being was causally related to the accident of February 10, 2010. (PX12 at 11). Dr. Lorenz testified:

> "Basis for that opinion is . . . the patient was in good physical condition and was unrestricted at working his normal fashion without dysfunction or pain. After the fall, which is a competent cause for creating this type of injury, the patient experienced pain in his lower back, and upon work-up it was revealed that the patient had a torn disk at 3-4 along with a herniation and torn disk at 4-5 and an aggravation of previously degenerative area that he didn't know about that ultimately led to surgery." (PX12 at 11).

Dr. Edward Goldberg, Respondent's IME, testified via evidence deposition on July 18, 2011. (RX4). He testified that the need for the fusion was related to the work injury. (RX4 at 10).

Petitioner had a follow-up visit with Dr. Lorenz on July 18, 2011. (PX11). Treatment recommendations included a bone stimulator and use of cane. Petitioner had additional follow-up visits with Dr. Lorenz on August 22, 2011 and October 5, 2011, during which physical therapy was recommended. (PX11).

Petitioner began a course of physical therapy at ATI Physical Therapy on August 26, 2011. (PX18). He underwent 39 sessions of therapy.

Petitioner returned to Dr. Lorenz on November 30, 2011. (PX11). He stated his back pain is still the same, rated at a 7-8. Petitioner indicated that while he is in pool therapy it helps, but after the fact he has more pain. He still complains of bilateral leg pain. The recommendation was to discontinue pool therapy, send him

for a CT scan of the lumbar spine to insure the fusion is maturing well, do a Functional Capacity Assessment, and keep him off work.

On December 6, 2011, a CT scan of the lumbar spine was done, showing no significant interval change. (PX6 at 10).

A Functional Capacity Evaluation was done on December 7, 2011. (PX18).

Petitioner returned to Dr. Lorenz on January 4, 2012. (PX11). He indicated that the CT scan demonstrates his hardware to be in good position. He also commented on Petitioner's FCE:

> "The FCE demonstrates him to be lifting at a maximal occasional level of 22 pounds between 23 overhead, bilateral and desk to chair 19. The patient furthermore is restricted to pushing and pulling at 37 pounds each and carrying of 22 on left and right hand. Furthermore, the patient is restricted to infrequent bending. No stooping, no climbing and limited walking."

Dr. Lorenz indicated that these restrictions were permanent and prescribed vocational rehabilitation. (PX11).

Dr. Lorenz wrote a referral on January 31, 2012 for Petitioner to be evaluated and treated for pain management. (PX11).

Petitioner was seen by Dr. Christopher Morgan at Chicago Pain & Orthopedic Institute on February 14, 2012. (PX9 at 13). He complained of persistent pain in his lower back and both legs and reports numbness and weakness in his legs as well. Dr. Morgan's diagnoses were lumbar discogenic pain, lumbar facet syndrome, lumbosacral radiculopathy, sacroiliac pain, lumbar spondylosis, and post laminectomy syndrome. (PX9 at 14). Dr. Morgan's recommendations were as follows:

> "MMI is undeterminable at this time. We will refill the patient's Norco and start him on a Durgaesic patch at 25 mcg. He will also be started on gabapentin. We will obtain a urine and drug screen today. Patient will be recommended for bilateral S1, S2, and S3 lateral branch blocks, and dorsal root of L5 medial branch block for his sacroiliac pain. Depending on his response to the nerve blocks, we may consider doing facet injections in the future above the level of the fusion. The possibility of a spinal cord stimulator trial was also discussed with the patient. His work status will remain as per Dr. Lorenz."

On February 17, 2012, Dr. Jain performed a bilateral dorsal root of L5 medial branch nerve block, and S1, S2, S3 lateral branch nerve blocks. (PX9 at 7, PX14). Dr. Jain testified that Petitioner had a concordant response to this nerve block, meaning he had greater than 50% improvement in his buttock pain. (PX15 at 6).

Petitioner returned to Dr. Morgan on February 28, 2012. (PX9 at 18). Petitioner did note significant improvement with decrease in his pain and increase in his walking tolerance for several hours after the medial branch blocks, but then his back and leg pain resumed. He continues to experience low back, bilateral buttocks, and bilateral leg pain and paresthesias. Dr. Morgan's plan was to begin the use of bilateral Cool-tipped S-I rhizotomies starting on the right side and then 2 weeks later on the left, as he did show concordant pain relief with the lateral branch blocks.

Petitioner's next visit with Dr. Morgan was on March 13, 2012. (PX9 at 22). The bilateral Cool-tip S-I rhizotomies recommended at the last visit had not been performed. Dr. Morgan continued to recommend the S-I rhizotomies and defer to Dr. Lorenz's off work status. (PX9 at 23).

At Respondent's request, Petitioner was evaluated for a follow-up independent medical examination with Dr. Goldberg on March 19, 2012. (RX7). Dr. Goldberg indicated that he would review the CT scan to ensure the fusion is healed. If healed, he would recommend only oral medications but no further injections. He also opined if the fusion had healed, Petitioner would be at maximum medical improvement.

On March 29, 2012, Dr. Goldberg drafted an addendum to his IME report after reviewing Petitioner's CT scan. (RX8). He opined that the fusion had not fully healed. He recommended that Petitioner return to work per the FCE restrictions and follow up with Dr. Lorenz every six weeks to ensure the fusion heals. He indicated Petitioner would be at MMI when the fusion heals.

On the next visit with Dr. Morgan on April 24, 2012, the recommended treatment still had not been approved. (PX9 at 26). Dr. Morgan recommended bilateral Cool-tipped sacroiliac rhizotomoies and referred Petitioner for a spinal cord stimulator trial.

On May 2, 2012, a utilization review report indicated that the recommended lumbar spinal cord stimulator trial and bilateral cool-tipped SI joint rhizotomies were not medically necessary. (RX9).

Petitioner returned to Dr. Lorenz on May 14, 2012. (PX11). It was indicated that he should continue at the same working restrictions with a 22 pound weight limitation, limited walking, and no bending. He indicated that Petitioner was at MMI, but may not return to his previous job. Petitioner was to continue ongoing pain management with Dr. Morgan, and Dr. Lorenz indicates that a spinal cord stimulator trial is a reasonable approach to pain control.

On May 22, 2012, Dr. Morgan indicated that both the Cool-tipped S-I rhizotomies and spinal cord stimulator trial had been denied. (PX9 at 30). The recommendations were as follows:

> "The plan is to gradually stop the gabapentin, using 1 less tablet every 3-4 days until he discontinues it. He is to continue with his current medication regiment with use of the Duragesic and Flexeril. He is again referred for bilateral Cool-tipped sacroiliac rhizotomies and also for a spinal cord stimulator trial. He is to continue with the same permanent work restrictions as per Dr. Lorenz. Maximum medical improvement is undeterminable."

After an appeal, a second utilization review report issued on May 30, 2012, continued to deny the recommended treatment as medically necessary. (RX10).

On June 19, 2012, Petitioner returned to Dr. Morgan. (PX9 at 34). Dr. Morgan's recommended treatment had still not been approved. He referred Petitioner to pain psychologist Dr. Brown for a spinal cord stimulator trial, indicating that Petitioner has failed to show significant improvement with physical therapy and use of multiple different medications. Petitioner next saw Dr. Morgan on July 17, 2012. (PX9 at 38). His medications were changed due to nausea, vomiting, and cold sweats. The prior treatment recommendations still had not been approved by his insurance carrier.

Dr. Neeraj Jain, board certified in anesthesiology and pain management, testified via evidence deposition on August 7, 2012. (PX15). Dr. Jain testified that as a result of the diagnostic nerve block, it was recommended by both Dr. Morgan and himself that an ablative procedure be done, a more permanent procedure for the SI joints. (PX15 at 7). Dr. Jain explained that the cool-topped SI ablation addresses the innervation for the SI joints. (PX15 at 21). He explained that the SI joints become a very common pain generator after a multi-level fusion because there is a shift in the load bearing in the body from the spine onto those joints themselves. (PX15 at 21-22). He elaborated that the cool-tipped SI or radiofrequency ablation is just ablating the nerves, the

small sensory nerves that innervate that joint, and presumably would take that component of the pain away. (PX15 at 22). Dr. Jain indicated that the other recommendation was for a spinal cord stimulation in light of the fact that he had two spine surgeries, an L5 laminectomy and a three-level fusion, and was still having persistent back and lower extremity pain. (PX15 at 7). Dr. Jain elaborated that a trial spinal cord stimulator is recommended when a patient has persistent back and leg pain after previous back surgery, especially when something more definitive like a fusion is done. (PX15 at 10). Dr. Jain further testified that the necessity of the trial spinal cord stimulator was related to Petitioner's 2010 work injury. (PX15 at 8).

On August 8, 2012, Petitioner underwent a pre-surgical psychological screening by Dr. Ross Brown. (PX17). He recommended Petitioner proceed with the spinal cord stimulator trial.

Petitioner's next visit with Dr. Morgan was on August 14, 2012. (PX9 at 42). Neither the recommended SIRF nor the spinal cord stimulator trial have been approved to date. He is reporting little benefit with his current pain medications, indicating they decrease his pain to an 8/10, and he reported excessive sweating. Dr. Morgan recommended the following:

> "We continue our recommendations for SIRF and a spinal cord stimulator trial. The patient may benefit from bilateral SIRF since he did have noted pain relief following the lateral branch blocks. However, the spinal cord stimulator is recommended for more definitive treatment because the patient has tried and failed other treatments including a trial of many different medications including opioid pain medications, anti-inflammatories, anti-depressants, anti-spasmodics, and physical and occupational therapy. The patient is also unable to have futher steroid injections because they have increased his blood sugars and he did not benefit from them."

On August 29, 2012, a CT scan was done of the lumbar spine. (PX5 at 13, PX13).

Petitioner was seen by Dr. Demetrios Louis at Chicago Pain & Orthopedic Institute on September 11, 2012. (PX9 at 46). He made the following assessment:

> "He has post laminectomy pain syndrome after a subsequent fusion that occurred on 5/24/2011 in which he had three level fusion by Dr. Lorenz. Now the patient continues with pain. He also has a component of bilateral sacroilitis in which he has undergone sacroiliac joint injections, which have been beneficial about 40 to 50 percent relief. However, the patient has been unable to get approval for both bilateral radiofrequency ablation of the SI joint and lateral branches as well as spinal cord stimulation trial. He has been cleared for spinal cord stimulation trial and is an acceptable candidate by pain psychologist, Dr. Brown. However, he is still awaiting approval. CT scan did not demonstrate any significant changes in his hardware on CT scan that was performed of his lower lumbar spine. He does have some mild-to-moderate spondylosis with some disk bulging there. It has been seen before as well as disk osteophyte complexes causing mild-to-moderate canal stenosis. He is unable to undergo any further injections at this time because of the steroid-induced significant surges in his glucose levels." (PX9 at 48).

Dr. Louis continued to recommend the spinal cord stimulation and bilateral RFLS of the SI joints. (PX9 at 49).

Petitioner was next seen by Dr. Louis on October 9, 2012. (PX9 at 51). He indicated that Petitioner continues to wait for approval for recommended treatment.

On October 12, 2012, Respondent's independent medical examiner, Dr. Goldberg, wrote a letter that he had reviewed the CT scan done on August 29, 2012, and believed the petitioner to be at MMI. (RX11).

The recommended treatment had still not been approved at Petitioner's November 6, 2012 visit with Dr. Louis. (PX9 at 55).

On November 26, 2012, a utilization review report was issued, continuing to deny the spinal cord stimulator. (RX12).

The treatment continued to be denied at Petitioner's December 4, 2012 office visit. (PX9 at 59).

Petitioner was seen by Dr. Jain for follow-up on January 8, 2013, at which time the recommended treatment had not been authorized. (PX19). He was kept off work.

At Respondent's request, Petitioner was evaluated by Dr. Richard Lazar on January 22, 2013, who testified via evidence deposition on April 26, 2013. (RX13, RX14). He opined that Petitioner's pain complaints had nothing to do with his slip and fall at work. Dr. Lazar opined that any limits on his ability to work are due to extreme deconditioning and diabetic polyradiculopathy, with amyotrophy, autonomic features, and sensory neuropathy. He related that any disability was not work-related, but due to the progression of Petitioner's diabetes and deconditioning.

Temporary total disability benefits were paid through January 31, 2013.

Petitioner was seen by Dr. Jain for follow-up visits on February 5, 2013, March 5, 2013, April 2, 2013, and April 30, 2013, at which time the recommended treatment had not been authorized. (PX19). Dr. Jain further indicated that delay in authorization adversely affects outcome in terms of habituation to medications, psychological decline and affliction while also decreasing the likelihood of functional return to work and symptom resolution. Petitioner was kept off work during this time.

Petitioner testified at hearing that his diabetes was under control and that he did not have any issues or hospitalizations with his diabetes since the diagnosis in December 2010. He further testified that it was his wish to proceed with the spinal cord stimulator.

He testified that the pain medication affects his stomach and causes drowsiness. He further testified that he has pain every day and it frustrates him that he cannot perform physical activities such as cutting his own grass.

In support of the Arbitrator's Decision as to F. WHETHER PETITIONER'S CURRENT CONDITION OF ILL-BEING IS CAUSALLY RELATED TO THE ACCIDENT, the Arbitrator finds the following:

Dr. Jain testified that he felt that Petitioner's current condition of ill-being and need for continued pain management care is related to the work accident. Dr. Lorenz and Dr. Goldberg both felt that the fusion was related to the work accident.

Dr. Lazar testified that he felt that Petitioner's continued complaints into his legs were the result of diabetic neuropathy and he felt that his diabetes was severe. He could not pinpoint any specific medical treatment records regarding diabetic status but thought he had reviewed them.

However, Petitioner testified at hearing that his diabetes was under control and that other than medication and checking his blood sugar multiple times per day he had not received any indication medically that his diabetes was not under control.

Based upon the greater weight of the evidence, the Arbitrator finds that Petitioner's current condition of ill-being concerning his lumbar spine is causally related to the accident. Even if the Petitioner's diabetes has contributed, the Arbitrator recognizes that Petitioner is limited in any significant exercise that would help him progress to a healthier body weight to improve his diabetic condition and his sedentary lifestyle may have an impact on his diabetic condition. Further, the Arbitrator finds that the evidence suggests that the accident and lumbar spine condition are at least, in part, a cause of Petitioner's current need for pain management treatment.

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 Petitioner's care following the previous 19(b) hearing. The expenses include treatment in the form of epidural steroid injections, the lumbar fusion, post operative care and therapy, and pain management injections and prescriptions. Based upon the Arbitrator's finding of liability, the Arbitrator finds that Petitioner shall be entitled to an award of these expenses.

Thus, the Arbitrator finds that Petitioner is claiming a total of $474,228.04 in medical expenses with Respondent to receive credit for direct payments of $215,344.39 and adjustments of $180,440.09, leaving a balance of $78,443.56 but for which the expenses claimed from 12/7/10 through 12/14/10 to Rush Copley of $38,299.38 shall be deducted as unrelated diabetic treatment leaving a balance to Petitioner of $40,144.18 due and owed to Petitioner subject to the limitations of the medical fee schedule of Section 8.2 of the Act.

In support of the Arbitrator's Decision as to K. WHETHER PROSPECTIVE MEDICAL CARE SHOULD BE AWARDED, the Arbitrator finds the following:

Dr. Jain is recommending trial spinal cord stimulator placement or the rhizotomies as continued pain management for Petitioner. Petitioner testified that he would like to try the stimulator as he believes that since he did have some improvement, though limited, from the injections, that he believes that the stimulator may improve his pain. Dr. Jain felt that it was a good option for Mr. Diaz rather than the continued narcotic use for pain management.

Dr. Lazar testified that he felt that putting a stimulator in Mr. Diaz was not a reasonable option and would not improve his pain because his pain was related to diabetic neuropathy.

Based upon the greater weight of the evidence, the Arbitrator finds that it is reasonable to award Petitioner the trial spinal cord stimulator treatment as recommended by Dr. Jain. Petitioner already underwent psychiatric screening by Dr. Peter Brown and also had some improvement with the injections. Given that it is a trial stimulator and the permanent stimulator would likely not be placed unless there is a positive result from the trial, the Arbitrator finds that the treatment plan is reasonable and necessary for Petitioner's continued pain management care.

In support of the Arbitrator's Decision as to L. WHAT AMOUNT OF TEMPORARY TOTAL DISABILITY BENEFITS SHOULD BE AWARDED, the Arbitrator finds the following:

The parties stipulated that all TTD benefits were paid through January 31, 2013. Petitioner has remained in pain management care through the date of hearing. Based upon the Arbitrator's finding of liability for continued medical care, he has not reached maximum medical improvement from a pain management standpoint. Thus, temporary total disability benefits are appropriate.

Further, even though Respondent terminated benefits based upon Dr. Lazar's opinions, both Dr. Lorenz and Dr. Goldberg felt that FCE restrictions were appropriate. Petitioner testified that he has not been offered a job nor any type of vocational assistance since those restrictions were placed. At the least, he would have been entitled to vocational assistance and maintenance benefits for this period.

The Arbitrator finds that Petitioner is entitled to benefits from February 1, 2013 through May 7, 2013, a period of 13 5/7 weeks, at a rate of $385.39, or a total of $5,285.35.

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

TIMOTHY ROZHON,

Petitioner,

vs.

NO: 11 WC 9141
12 WC 43728

PENSKE,

14IWCC0831

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of causal connection, temporary total disability, medical expenses, and prospective medical, and being advised of the facts and law, reverses the Decision of the Arbitrator on the issue of causal connection but attaches the Decision of the Arbitrator for the statement of facts with the modifications noted below. The Commission further remands this case to the Arbitrator for further proceedings for a determination of a further amount of temporary total compensation or of compensation for permanent disability, if any, pursuant to Thomas v. Industrial Commission, 78 Ill.2d 327, 399 N.E.2d 1322, 35 Ill.Dec. 794 (1980).

The Commission finds that Petitioner's lumbar condition remains causally related to his undisputed work injuries on October 5, 2010 and March 18, 2011, and that the incident at home in October 2011 was not an intervening accident that broke the chain of causation.

Petitioner's uncontroverted testimony was that he had no prior back problems or treatment prior to the first work injury on October 5, 2010. This accident was undisputed and occurred while he was lifting/holding a 150 to 200 pound tire. Petitioner was taken to the emergency room and his complaints were mostly low back pain and some pain in the left buttock area. After physical therapy and medication, he was returned to full duty on January 18, 2011 but he continued to treat with Dr. Franklin.

Petitioner sustained his second undisputed work accident on March 18, 2011. We note that the Request for Hearing form and the Arbitrator's decision indicate that this occurred on March 20, 2011. However, the Amended Application for Adjustment, Petitioner's testimony, and the medical records are consistent and indicate that the accident occurred on March 18, 2011. We hereby find that Petitioner's second accident occurred on March 18, 2011, while he was lifting a hinged cab that weighed 200 to 300 pounds to access the engine. After this accident, Petitioner started having increased back pain and pain in the left leg with numbness and tingling.

On April 5, 2011, Dr. Franklin noted new onset of leg pain after lifting the cab at work on March 18th. Petitioner reported that he had more back pain and some in the left buttock but he continued working full duty and was "just dealing with the pain symptoms" until on March 29th Petitioner had "pain that was in his back shooting down the left leg into his foot. He was getting a little numbness and tingling in his foot." Petitioner's pain had subsided over the past several days. Dr. Franklin diagnosed acute exacerbation of low back pain and new onset of left-sided sciatic pain. He recommended an MRI and light duty.

The MRI on April 6, 2011 reflects a history of low back pain radiating into the left buttock and leg with occasional groin pain. The impression was:

1) At L5-S1: small central disc extrusion w/ mild superior and inferior extension. Mild ventral impression on the thecal sac without central stenosis;
2) At L4-5: small, broad-based central to left intraforaminal disc protrusion w/ ventral impression on the thecal sac but no central stenosis. Mild left foraminal stenosis without evidence of nerve root impingement;
3) At L3-4: mild disc bulge w/ a tear of the posterior periphery of the annulus that is centered on the midline.

On April 8, 2011, Dr. Franklin added diagnoses of lumbar disc protrusions, SI joint dysfunction, and mild foraminal stenosis. Petitioner was offered injections but declined them at that time. On April 27th, Petitioner was frustrated that he was not improving and Dr. Franklin recommended a second opinion and to finish physical therapy. On May 11th, Dr. Franklin noted that Petitioner felt like he was ready to return to work but was told to inform Dr. Franklin if the pain flared up so he could be put back on work restrictions. On May 18th, Petitioner saw Dr. Franklin after the pain increased at work the previous day and an epidural steroid injection (ESI) was planned. On June 23rd, Dr. Franklin recorded 6/10 pain in the low back that was going into the buttock, thigh, and into the calf. The ESI was performed.

Petitioner followed up with Dr. Franklin on July 20, 2011, and reported that his pain had improved. At that time, he reported 0/10 pain but that it could occasionally flare up to 5/10 in the low back after prolonged sitting. On August 3rd, Petitioner asked Dr. Franklin how long the injection would last and Dr. Franklin wrote, "I told him that I do not know if his symptoms will continue to improve or whether they will worsen at some point and time." Since Petitioner was continuing to improve and was working full duty, Dr. Franklin encouraged him to do his home exercise program and return in two months to "see how he is doing at that time." We note that

Petitioner was not released from care and Dr. Franklin wrote, "Hopefully with time, his symptoms continue to improve."

Petitioner testified that, although was released to full duty, he would ask for help from fellow employees to lift heavy objects and modified the way he did certain things. He tried to go slower and more carefully so as to not increase the pain in his low back and left leg. (T.16-17). Petitioner testified that his "pain had lessened" after the ESI but then the pain levels returned to where they were before the injection (T.15) and that he continued to notice flare-ups of pain in his lower back and left leg. (T.16).

Petitioner testified that in early October 2011, he took down a 25-pound bicycle that was hanging from hooks on the ceiling of his garage. The October 5th record of Dr. Franklin indicates that Petitioner had been doing "okay for the last couple of months" but he had pain in the left low back area after getting the bicycle down in his garage. Petitioner's pain was 8/10. Dr. Franklin diagnosed an acute exacerbation of low back pain. He took Petitioner off work and recommended an MRI, prednisone, and Norco.

A second MRI, on October 5th, indicated "compared to the prior exam, no definite interval change or acute abnormality." On October 6th, Petitioner was frustrated that he injured his back again and Dr. Franklin wrote, "I told him that that may be a part of his future, his periods of times where there are exacerbations" and he recommended a second opinion for potential surgical options.

Petitioner saw Dr. Rebecca Kuo on October 11, 2011, with complaints of 5-10/10 low back and left buttock pain and occasional tingling down the left leg. She noted a history of Petitioner's October 2010 and March 2011 work injuries along with the bicycle-lifting incident in October 2011. She wrote, "he was at home in his garage lifting a bicycle when the same pain that he had at work flared significantly and now he has been off work for the last two weeks." Dr. Kuo diagnosed lumbar radiculopathy, herniation of the lumbar spine, lumbar stenosis, lumbar spondylosis, and degenerative disc disease. She recommended a fusion but ordered a discogram first. The discogram was performed on November 14, 2011, which was non-concordant at L3-4 but was concordant at L4-5 and L5-S1. On November 17th, Dr. Kuo recommended an L4-5 and L5-S1 fusion and gave Petitioner 10-pound restrictions.

Respondent's Section 12 physician, Dr. Lewis, examined Petitioner on December 12, 2011, and performed a records review. He opined that Petitioner's current condition and need for treatment was not related to his October 2010 work injury because Petitioner did not have leg symptoms following this injury but "[h]e complained of radicular pain following subsequent injuries." The Commission notes that Dr. Lewis did not actually give an opinion as to whether Petitioner's current condition is causally related to the March 2011 work injury. Dr. Lewis specifically stated that Petitioner did not have radiating left leg symptoms after the first injury but he did have pain in his back shooting down his left leg into his foot with numbness and tingling in his foot following the March 2011 work injury. The Commission finds Dr. Lewis' opinion to not be credible because he did not address the causal relationship between Petitioner's current condition and the March 2011 work injury.

14IWCC0831

On May 22, 2012, Dr. Kuo noted that Petitioner's pain was about the same with some numbness and tingling in his left leg. Dr. Kuo opined that, based on Petitioner's subjective history, there is a "causal link between his initial work injury and his current symptoms." She continued to keep Petitioner off work.

On June 18, 2012, Respondent had Petitioner's medical records reviewed by Avi Dr. Bernstein who, similarly to Dr. Lewis, limited his causation opinion to the October 5, 2010 accident and did not opine regarding causation with the March 18, 2011 work accident. Dr. Bernstein wrote, "I do not feel that there is a causal connection between the patient's current complaints and the original incident of October 5, 2010. I do feel that the lifting incident regarding the patient lifting a bicycle off of a garage ceiling is a new inciting event responsible for a new discogenic injury of the lumbar spine." However, Dr. Bernstein also noted that the October 2011 MRI demonstrated no significant change in any of the findings as compared with the previous MRI. The Commission finds that Dr. Bernstein's opinion is not credible because it did not address the March 2011 work accident and also because he found that the bicycle lifting incident was a "new inciting event responsible for a new discogenic injury" even in the absence of any new MRI findings and the fact that Petitioner's symptoms were similar and in the same distribution as they had been following the March 2011 work accident.

Petitioner was examined on March 5, 2013, by Dr. Mark Sokolowski who opined that Petitioner's current lumbar condition is causally related to his two work accidents. Dr. Sokolowski testified that Petitioner was not symptomatic prior to his work injuries, he was never completely asymptomatic after his work injuries, he never returned to his pre-injury baseline, and his symptoms persist in precisely the same distribution as they did previously. He characterized the bicycle lifting incident as "kind of the normal stuff that he would do in his activities of daily living, and had a significant flare-up, much like the flare-ups he had documented throughout the record." He testified that there was no significant difference between the pre and post bicycle incident MRIs. The Commission finds Dr. Sokolowski to be credible based on his thorough understanding of Petitioner's history, mechanisms of injuries, and the MRI comparisons.

Based on the above, the Commission finds that Petitioner's current lumbar condition of ill-being remains causally related to his October 5, 2010 and March 18, 2011 work injuries. Although Petitioner testified that his "pain had lessened" in July and August 2011 and he was returned to work full duty on August 3, 2011, we find it significant that this was after he had a lumbar epidural steroid injection (ESI) on June 23, 2011. It is reasonable that Petitioner's symptoms would have improved temporarily and we note that even though he was returned to full duty work, Dr. Franklin never released Petitioner nor found him to be at maximum medical improvement. On the contrary, Petitioner was scheduled to follow up with Dr. Franklin in October 2011, which is when Petitioner notified him about the bicycle lifting incident a few days earlier. We find that, if not for Petitioner's work injuries, he would not have been in such a weakened state as to have the relatively minor bicycle incident cause back pain such that he would need to be taken off work and be recommended for surgery. We disagree with the Arbitrator's characterization of the medical opinions and his ultimate conclusion and find that Petitioner's current lumbar condition remains causally related to his work injuries and that the bicycle incident was not sufficient to break the chain of causation.

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Based on our finding of causal connection, we find that Petitioner is entitled to 89 weeks of temporary total disability benefits from October 5, 2011 through the date of hearing on June 18, 2013. We find that Petitioner is entitled to $1,271.18 in outstanding medical expenses (Px10) and note that Respondent only disputed liability based on causal connection. We also award the prospective L4-S1 fusion as prescribed by Dr. Kuo, which Dr. Bernstein and Dr. Sokolowski also felt was appropriate treatment for Petitioner's condition.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent shall pay to the Petitioner the sum of $778.13 per week for a period of 89 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 $1,271.18 for medical expenses under §8(a) of the Act pursuant to the fee schedule in §8.2.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall authorize and pay for the L4-S1 fusion as prescribed by Dr. Kuo for medical expenses under §8(a) of the Act pursuant to the fee schedule in §8.2.

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.

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Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $69,400.00. 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 30 2014

Charles J. DeVriendt

Daniel R. Donohoo

CJD/se
O: 9/9/14
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DISSENTING OPINION

I respectfully dissent from the majority opinion. The majority reversed the Decision of the Arbitrator who found that Petitioner failed to prove his current condition of ill-being with respect to his lumbar spine was caused by undisputed work-related accidents. I would have affirmed and adopted the well-reasoned Decision of the Arbitrator which denied compensation after October 5, 2011.

As noted above, Petitioner sustained two undisputed work-related accidents on October 5, 2010 and March 20, 2011. At those times he was lifting objects weighing between 150-200 pounds and 200-300 pounds respectively, and he injured his lumbar spine in both accidents. Petitioner received treatment for these injuries and was returned to full duty work on January 18, 2011 after the first accident and on August 3, 2011 after the second accident. Respondent authorized and paid for this medical treatment and associated temporary total disability benefits related to those injuries.

Petitioner continued to work full duty until October 5, 2011. At that time he reinjured his lumbar spine while lifting a bicycle while in his garage at home. Petitioner returned to his treating doctor, Dr. Franklin, on the date of the bicycle-lifting incident. In his treatment note on that date, Dr. Franklin indicated that Petitioner had been "doing okay for the last couple of months." Petitioner reported to Dr. Franklin that he had "been doing all of his normal work activities and tolerating fine last week." It should be noted that Petitioner's normal work activities involved lifting extremely heavy objects.

In this case I would have affirmed the Decision of the Arbitrator who found that the non-work related bicycle-lifting incident was an intervening accident which broke the causation between the work-related accidents and his current condition of ill-being. In my opinion if the October 5, 2011 injury had been sustained in the course of, and arising out of, his employment, the Commission would find that this was a new injury and not simply a temporary exacerbation

of the earlier injuries. Therefore, in this case I see no reason why this non-work accident should not be considered a subsequent intervening injury and the actual cause of his current condition of ill being breaking the causal connection between his current condition of ill-being and his work-related accidents.

For the reasons specified above, I respectfully dissent.

RWW/dw
O-9/9/14
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Ruth W. White

Ruth W. White

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

ROZHON, TIMOTHY
Employee/Petitioner

Case# **12WC043728**
11WC009141

PENSKE
Employer/Respondent

14IWCC0831

On 8/26/2013, 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 0.07% 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 AL
PETER C BOBBER
161 N. CLARK ST SUITE 2080
CHICAGO, IL 60601

1120 BRADY CONNOLLY & MASUDA PC
MATTHEW P SHERIFF
ONE N LASALLE ST SUITE 1000
CHICAGO, IL 60602

14IWCC0831

STATE OF ILLINOIS)
)SS.
COUNTY OF KANE)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

Timothy Rozhon
Employee/Petitioner

v.

Penske
Employer/Respondent

Case # **12** WC **43728**

Consolidated cases: **11 WC 9141**

An *Application for Adjustment 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 **Geneva**, on **June 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. [x] Is Petitioner's current condition of ill-being causally related to the injury?
G. [ ] What were Petitioner's earnings?
H. [ ] What was Petitioner's age at the time of the accident?
I. [ ] What was Petitioner's marital status at the time of the accident?
J. [x] Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. [x] Is Petitioner entitled to any prospective medical care?
L. [x] What temporary benefits are in dispute?
[ ] TPD [ ] Maintenance [x] TTD
M. [ ] Should penalties or fees be imposed upon Respondent?
N. [ ] Is Respondent due any credit?
O. [ ] Other _____

FINDINGS

On the date of accident, **March 20, 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 **$60,715.20**; the average weekly wage was **$1,167.20**.

On the date of accident, Petitioner was **46** years of age, ***married*** with **0** dependent children.

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

ORDER

No further benefits are Awarded..

No prospective medical care is 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.

George J. Andros
Signature of Arbitrator

8-15-13
Date

ICArbDec19(b)

AUG 26 2013

PROLOGUE

This case is determined by a preponderance of the medical evidence. The Arbitrator has studied and reviewed the medical evidence multiple times and compared the opinions of all the doctors. Of note is the quite colloquial and simplistic testimony of Petitioner's expert. In particular pages 11 and 12 are underscored for his lack of depth and statement of generalities. Dr. Sokolowski is not at all persuasive in the case at bar despite this Arbitrator historically giving injured workers the best opportunity to be restored to full potential via prospective treatment. The best example is his characterizing the lifting of a bike overhead as activities of normal living while minimizing the sequela in Dr. Franklin records. In this particular case it seems unusual in weighing the evidence that no record of Dr. Rinella one of the treating spine surgeons was presented for any factual basis by either side. Dr. Franklin's records, notably Respondent's exhibit shows the petitioner had stabilized. Dr. Franklin fails to sufficiently address the key medical issues to find the probabilities in favor of his patient when compared to the well-reasoned and dense content of the written reports of Drs Lewis and Bernstein.

I. STATEMENT OF FACTS

On October 5, 2010 the petitioner was working as a journeyman technician for the respondent. The petitioner testified that he had been in that position since approximately July of 1998.

The petitioner testified that on that particular date at some point in his shift he was pulling the fifth wheel off of a truck and holding for a co-worker when the wheel, which he testified weighed anywhere from 150-200 pounds, slipped underneath. He was working, and when he bent over to pick up the tire he felt a sharp pain in his back.

The petitioner was taken by the foreman to the Emergency Room at which time the petitioner was x-rayed, given pain killers, and advised to follow-up with a back specialist.

Ultimately, several days later the petitioner began seeing Dr. Jason Franklin, who ultimately diagnosed the petitioner with lumbar spondylosis, and recommended physical therapy. (Pet. Ex. 5).

The petitioner testified and the medical records indicate the petitioner underwent a course of physical therapy ultimately progressing to work-hardening which resulted in his return to work full duty effective January 19, 2011 pursuant to Dr. Franklin. (Pet. Ex. 5).

The petitioner testified that he was operating on a full duty basis at work until March 20, 2011 at which time he felt an increase in his pain that began in the low back after lifting the cab of the truck to work on the engine. Petitioner testified that he was not aware of what time in his shift that occurred, but he did finish that shift.

Ultimately, the petitioner returned to Dr. Franklin and an MRI performed at Deer Path MRI on April 6, 2011 indicated disc protrusions and compression at L5-S1 and L4-5. (Pet. Ex. 6).

The petitioner continued to treat with Dr. Franklin and had an epidural steroid injection under the direction of Dr. Franklin in June of 2011 which ultimately again led to his return to work on a full duty basis effective August 3, 2011, pursuant to the instructions of the treating physician, Dr. Franklin. Petitioner testified that throughout July and August of 2011 he felt that the pain was lessening.

The petitioner also testified that although he was working on a full duty basis following that return it was somewhat modified by himself, as he would ask for assistance from his co-workers if he was involved in any sort of heavy lifting that he felt would aggravate his condition.

On October 5, 2011 the petitioner returned to Dr. Franklin for follow-up examination. The records indicate that in the petitioner's own discussion with the doctor on that date indicating that in his words he "had been doing okay for the last couple of months", however the previous Sunday he had been at the rifle range, and more significantly "later that day he went to get a bicycle that was hanging in his garage overhead and since that time he has had pain in that left low back area." The petitioner testified that the statements made to the doctor on that date were correct in his mind and what occurred on that particular date. The records indicate that Dr. Franklin diagnosed the petitioner with acute exacerbation of low back pain, and was recommending an MRI be performed. The petitioner was also taken off of work by Dr. Franklin effective that date. (Resp. Ex. 3).

Shortly thereafter, the petitioner was referred to Dr. Rebecca Kuo who ultimately indicated that the petitioner would need a discogram and likely surgery. (Pet. Ex. 7). The petitioner underwent a discogram at St. Joseph Medical Center on November 14, 2011 which was positive for annular tears at L4-5 and L5-S1. (Pet. Ex. 8).

On November 22, 2011 the petitioner presented for an independent medical examination at the respondent's request with Dr. Michael Lewis. It was the doctor's opinion that there was no causal connection between the petitioner's current back complaints and he did the incident of October 5, 2010 or March 2011, and pointed to the records indicating that the bike lifting incident in October of 2011 appeared to cause the flare-up which was causing the current problems. The doctor also indicated that a fusion or discectomy would not be appropriate treatment at that particular time. (Resp. Ex. 1).

The petitioner indicated that he wanted to pursue the surgery as recommended by Dr. Kuo though workers' compensation would not authorize the surgery.

The petitioner's medical treatment records were subsequently sent to Dr. Avi Bernstein for review by the respondent in June of 2012, and a report dated June 18, 2012 by Dr. Bernstein indicates that following his review of the records in this case, it was his opinion that there is no causal connection between the petitioner's current complaints and the incident of October 5, 2010. The doctor felt that the lifting incident regarding the bicycle off of the garage ceiling is a new inciting event "responsible for a new discogenic injury of the lumbar spine." (Resp. Ex. 2). Dr. Bernstein further stated that further treatment for the petitioner would include possible courses of physical therapy and epidural steroid injection and finally consideration of spinal surgery if the conservative treatments are not successful, though all of these would relate to the bike lifting incident. (Resp. Ex. 2).

Subsequent to these events, the petitioner presented to Dr. Sokolowski for an independent examination at the request of his own attorney, and Dr. Sokolowski's opinion is that the petitioner's back condition was not changed by the bike lifting incident, and that his current condition does in fact relate to the incidents of October 5, 2010 and March 20, 2011. Dr. Sokolowski is also of the opinion that the petitioner likely requires surgery.

The petitioner has testified that he has not worked since October of 2011, and has been kept off of work by the treating physicians. Petitioner also testified that he would like to pursue the surgical option as previously recommended by Dr. Kuo.

II. CONCLUSIONS OF LAW

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

In support of the Arbitrator's finding that the petitioner's current condition of ill-being is not causally related to the accidents of either October 5, 2010 or March 20, 2011, the Arbitrator states as follows:

The petitioner's testimony and the medical treatment records introduced into evidence by both parties indicate that the petitioner did in fact suffer a low back injury on October 5, 2010. The records also indicate that the petitioner is diagnosed with lumbar spondylosis, for which he received physical therapy and eventually work-hardening under the direction of his treating physician, Dr. Franklin. The petitioner was ultimately returned to work on a full duty basis approximately three months later in early January of 2011.

The medical treatment records and the petitioner's own testimony indicate that the petitioner continued to work on that full duty basis without serious issues until, as the petitioner alleges, March of 2011. The records of Dr. Franklin indicate that the petitioner did complain of some periodic flare-ups at work, and this was treated by physical therapy in 2011 as well as epidural steroid injections in the middle of 2011. Subsequent to this, the petitioner's own testimony indicates that the "pain lessened" in July and August of 2011 and he was ultimately returned to work on a full duty basis effective August 3, 2011.

Following this full duty release, the petitioner's own discussions with the physician and the medical treatment records of Dr. Franklin dated October 5, 2011 clearly indicate that the petitioner suffered an incident at his home in early October which caused an "acute exacerbation" in the words of Dr. Franklin necessitating additional diagnostic testing, and ultimately referral for surgical intervention.

Two separate independent examiners, Dr. Lewis and Dr. Bernstein have opined that consistent with the medical treatment records the petitioner's need for any surgery and need to be off of work is related to this non-work incident which is clearly detailed by the petitioner in not only his testimony but also in the records of his treating physician, Dr. Franklin.

The Arbitrator finds that due to the clear testimony of the petitioner as well as the medical treatment record information introduced by both petitioners and respondents, that the petitioner was at a full duty basis following both the alleged incidents of October 5, 2010 and March 20, 2011 until he had the non-work-related incident in October of 2011 which has necessitated his continuing problems and alleged need for continuing care.

Based upon the totality of the evidence, the Arbitrator finds as a matter of fact there is no causal connection between the petitioner's current condition of ill-being for which he seeks surgery alleged in these two cases and the accident. The Arbitrator adopts the opinion of Dr. Lewis.

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

In support of the Arbitrator's finding that all of the reasonable, necessary, and related medical services have been paid by the respondent, the Arbitrator states as follows:

The petitioner has introduced into evidence Exhibit 10 which details alleged medical expenses incurred by the petitioner which begin on October 11, 2011 into late 2012. These treatments all date following the non-work-related incident of early October of 2011, and thus are not causally related to either of the accidents involved in these two cases, and therefore respondent is not responsible for payment of these bills.

The evidence indicates that the respondent paid medical bills up to that point, which were causally related to either of the incidents.

Hence, based upon the totality of the evidence the Arbitrator finds as a matter of law that no further medical expenses are awarded.

K. Is the petitioner entitled to prospective medical care?

In support of the Arbitrator's finding that the petitioner is not entitled to any prospective medical care, the Arbitrator states as follows:

As indicated above, the Arbitrator finds there is no causal connection between the petitioner's current condition of ill-being and either the accident of October 5, 2010 or March 20, 2011. Due to the fact that no causal connection exists between the petitioner's current condition of ill-being and alleged need for perspective medical treatment and either of the incidents involved in these cases, the petitioner is not entitled to perspective care as ordered in this case.

L. What temporary benefits are in dispute? (Temporary Total Disability)

In support of the Arbitrator's finding that no additional temporary total disability benefits are owed in this case, the Arbitrator states as follows:

The parties agree that the petitioner was taken off of work by the treating physician and temporary total disability benefits were paid from late 2012 through January 18, 2011 when the petitioner returned to work on a full duty basis pursuant to Dr. Franklin.

The petitioner is alleging that he is owed temporary total disability benefits from October 5, 2011 to the present date. The respondent states that the last temporary total disability period should be October 5, 2011 through December 27, 2011 the date of receipt of the first independent medical examination report of Dr. Lewis.

The Arbitrator finds that the temporary total disability benefits of the petitioner were properly suspended following December 2011 and the receipt of the Dr. Lewis report. Both Dr. Lewis and subsequently Dr. Bernstein indicate that the petitioner's reason for being off of work by Dr. Franklin is related to the incident of October2011 and not related to either the work incident of October 2010 or March 2011. Due to the fact that there is no causal connection between the petitioner's need to be off of work for that time period to the present date and either of the incidents, indicates that no temporary total disability is owed.