STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Larry Pope,

Petitioner,

vs.

NO: 07 WC 53735

14IWCC0937

City of Chicago,

Respondent.

DECISION AND OPINION ON REMAND

This matter comes before the Commission pursuant to remand Order of the Circuit Court of Cook County, Judge Robert Lopez Cepero. In his April 16, 2014 remand Order, Judge Cepero remanded to the Commission to make specific findings with regard to the credibility of the witnesses.

In her Decision filed with the Commission on July 18, 2012, Arbitrator Kelmanson found that as a result of accidental injuries arising out of and in the course of his employment on October 15, 2007, Petitioner permanently lost 100% of the vision of his left eye. The Arbitrator found timely notice was given to Respondent and that a causal relationship exists between those injuries and Petitioner's current condition of ill-being. The Arbitrator further found that Petitioner had received all reasonable and necessary medical services, that Respondent had paid all appropriate charges and that Respondent was entitled to §8(j) credit for all medical charges paid by group health insurance.

Respondent filed a timely review. In its May 10, 2013 Decision and Opinion on Review, the Commission reversed the Decision of the Arbitrator finding that Petitioner failed to prove he

sustained accidental injuries arising out of and in the course of his employment and failed to prove a causal relationship exits and denied Petitioner's claim.

Petitioner appealed to the Circuit Court of Cook County and Judge Cepero issued his remand Order on April 16, 2014. The Commission, after reviewing the entire record, reverses the Decision of the Arbitrator finding that Petitioner failed to prove he sustained accidental injuries arising out of and in the course of his employment and failed to prove a causal relationship exits and denies Petitioner's claim for the reasons set forth below. The Commission also affirms the denial of Respondent's Motion to Consolidate issued by Arbitrator Carlson.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

The Commission finds:

1. Petitioner filed an Application for Adjustment of Claim on December 3, 2007, which listed a date of accident of August 2, 2007 and alleged he injured his left eye as a result of repetitive trauma, vibration/trauma from jackhammering. The claim was assigned to Arbitrator Kelmanson. An Amended Application for Adjustment of Claim was filed on June 20, 2012, which changed the date of accident to October 15, 2007. Arbitration was held on June 14, 2012 and June 21, 2012.

2. Petitioner, a 49 year old laborer on October 15, 2007, testified he was 54 years old at the time of the June 14, 2012 arbitration hearing. He last worked in 2007 (Tr 26). Petitioner started working for Respondent in 1981 in the asphalt department as a laborer doing potholes and patches in streets. In 1984, he came to the electrical department (Tr 26). His laborer duties required him to use a hydraulic jackhammer, shoveling and lifting concrete (Tr 27). Using a jackhammer vibrated him a lot (Tr 27). He was the only jackhammer operator on a crew (Tr 28). Some days Petitioner would use a jackhammer all day, some days he would use a jackhammer for 4 hours, some days for 2 hours, some days for 1 hour and some days not at all (Tr 29). Operating a jackhammer was a regular part of his job duties over the years (Tr 29). The jackhammer he used weighed from 100 to 110 pounds (Tr 29).

In the early part of the summer of 2007, Petitioner was in good health and had no vision problems at that time (Tr 29-30). On approximately August 2, 2007, Petitioner began to have left jaw pain (Tr 30). He had previously had some dental work done and was thinking it might have been something his dentist had done (Tr 30). Petitioner contacted his dentist, Dr. Bagai. On August 6, 2007, Petitioner saw Dr. Bagai, who examined him and prescribed medications. Petitioner identified Px10 as a printout from Walgreens of the prescriptions for pain medication and antibiotics (Tr 32). In the days and weeks to come, Petitioner's left jaw pain did not go away (Tr 32). He continued working.

In late August 2007, Petitioner injured his leg at work and began treating with Dr. Diadula, Respondent's company physician (Tr 33). He was working in September 2007 on a project. The foreman, Clayton Armstrong, told Petitioner he wanted him to break up concrete

with the jackhammer. The crew then took a break. After the break, Petitioner got on the back of the truck to get the jackhammer. He reached in the bin to get the pin and stood the jackhammer up. At that moment, the truck moved forward. The jackhammer tipped over and hit Petitioner on the left side of his neck and left jaw (Tr 33-34). Petitioner reported what had happened to Mr. Armstrong and they laughed it off (Tr 34). Petitioner got an ice pack and put it on his neck (Tr 35). After a while, he returned to work (Tr 35). Petitioner began to feel pain on the left side of his neck and jaw. He did not seek treatment at that time (Tr 35-36). Petitioner subsequently called Dr. Bagai and informed him he was still having pain in the left jaw (Tr 36-37). On October 3, 2007, Petitioner saw Dr. Bagai, but did not receive treatment from him (Tr 37).

Petitioner had been in physical therapy for his leg. On the morning of October 9, 2007, he was attending physical therapy. All of a sudden, Petitioner began to have pain in his neck and the room was getting dark. The physical therapist suggested he see the eye doctor in the same building, Chicago Eye, which Petitioner did after finishing his physical therapy session (Tr 38-39). The eye doctor examined his left eye and told him to go to Mercy Hospital right away (Tr 39). While driving to Mercy Hospital, Petitioner was involved in a motor vehicle accident. Petitioner stated he was not hurt and the accident was reported to the police (Tr 40). Petitioner stated that the reason for the motor vehicle accident was that he could not see (Tr 40). Petitioner then drove to Mercy Hospital emergency room (Tr 41). He was admitted and underwent a series of tests. He could not see with his left eye (Tr 42). While in Mercy Hospital, Petitioner was given some paperwork by the doctors. Petitioner identified this paperwork as Px3 and Px4 (Tr 42). He told a doctor what he did for a living and what had happened (Tr 43). Petitioner was discharged on October 16, 2007 and went to Respondent's main office of the electrical department and gave the paperwork to superintendant Nick Calase. The following Saturday, October 20, 2007, Petitioner began having neck, jaw pain and headaches again and he returned to Mercy Hospital, as he was instructed when he was discharged on October 16, 2007 (Tr 45). Petitioner was re-admitted and stayed for 3 days. His lack of vision did not change (Tr 45).

Petitioner testified he had lifted weights before this occurred (Tr 45). He has lifted weights off and on for 10 or 12 years in order to stay in shape (Tr 46). He would lift weights 2 to 3 times a week (Tr 46). He would lift weights for 2 months, then stop for 2 months, then lift weights again (Tr 46). He was not lifting weights in the summer of 2007 or in September or October of 2007 (Tr 47). He did not ever develop neck pain or jaw pain or ever develop any vision problems when he was lifting weights (Tr 47). He did not drop any weights or hit himself in the head (Tr 48). Petitioner stated, "I never smoked cigarettes." (Tr 48). His lack of left eye vision is still the same and he is completely blind in his left eye (Tr 48).

On cross-examination, Petitioner testified that he has filed workers' compensation claims (Tr 49). Respondent's attorney stated that it is Respondent's position that no accident occurred with respect to both the jackhammer incident where Petitioner alleges being hit in the left side of his neck and jaw and repetitive trauma operating a jackhammer (Tr 49). Petitioner did not recall

how many workers' compensation claims he has filed (Tr 50). Petitioner stated that it could sound accurate if the IWCC website showed that he has filed 9 workers' compensation claims (Tr 50). At Respondent's request, Petitioner saw Dr. Karen Levin. Petitioner might have mentioned to Dr. Levin that he worked 6 to 8 hours a day. He did not recall telling Dr. Levin that he was using a jackhammer 4 to 6 hours every day for 26 years and he may have been using it as many as 8 hours per day in September 2007 (Tr 53-54). Dr. Kramer at Mercy Hospital diagnosed him with job-related loss of vision (Tr 54). Petitioner did tell Dr. Kramer how often he was using a jackhammer the same as he had testified, sometimes 8 hours, sometimes 6 hours, sometimes 2 hours (Tr 54). Petitioner told Dr. Schultz this as well and told this to the doctors at the same time (Tr 54-55).

Petitioner testified he got hit in the head by a jackhammer in September 2007. He could not recall the exact day that happened (Tr 55). Petitioner did not seek any treatment for this incident (Tr 55). Petitioner denied he told Dr. Levin that he did not lift weights (Tr 56). He is aware that the records from MercyWorks show that he was a smoker on a daily basis (Tr 56).

On re-direct examination, Petitioner testified that since he lost his left eye vision approximately 5 years ago, he has not lifted weights (Tr 57). Anytime he was sent to a doctor by Respondent, Petitioner was not lifting weights around that time (Tr 57).

3. Clayton Armstrong testified he has been employed with Respondent for 26 years. He is a foreman of linemen in the Bureau of Electricity and has been so for the last 7 years (Tr 59). His duties include running the crew, which consists of a driver, 2 linemen, a laborer and sometimes an operating engineer doing various jobs for Respondent (Tr 59). Petitioner worked under him for about a year. Petitioner's duties were to cut and saw, run the rotohammer, run the jackhammer, get the tools out, shovel and pick up rock and debris (Tr 60). Mr. Armstrong identified Rx1 as the job description for Petitioner's position (Tr 60). Mr. Armstrong had reviewed Rx1 and it accurately described Petitioner's job (Tr 61).

Mr. Armstrong was working as a foreman of Petitioner during the months of June, July, August and September 2007 (Tr 61-62). As a foreman, he was required to complete paperwork in conjunction with his work assignments (Tr 62). Daily paperwork consisted of the sign-in sheet, the work report and the truck/backhoe operation report listing hours (Tr 62). Mr. Armstrong identified Rx2 as various work report sheets from June 2007 to September 2007 (Tr 62). He signed each of those work reports (Tr 63). According to those reports, Petitioner did use a jackhammer on June 20, 2007 to break concrete. Mr. Armstrong stated that depending on how hard the concrete was, this would take 45 minutes to an hour (Tr 64). The daily reports for June 2007 indicate that Petitioner used a jackhammer only on June 20, 2007 (Tr 65). The daily reports for July 2007 indicate that Petitioner used a jackhammer 5 days (Tr 65-66). At that time, Petitioner was doing the same thing, breaking down a foundation. Each time would have taken 45 minutes to an hour (Tr 66). On July 25, 2007, Petitioner used a rotohammer, a machine like a jackhammer which rotates a hole. Mr. Armstrong then stated that each day Petitioner used a jackhammer in July 2007, it would have taken 1 to 1½ hours (Tr 67). The daily reports for

August 2007 indicate that Petitioner used a jackhammer 3 days. On August 6, 2007, Petitioner used a rotohammer. On August 9, 2007, he used a jackhammer and on August 25, 2007, he used a jackhammer (Tr 68). On any of those days, Petitioner would have used a jackhammer for up to 2 hours (Tr 68). The daily reports for September 2007 indicate that Petitioner used a jackhammer only on September 10, 2007 for an hour (Tr 68). Mr. Armstrong did not recall Petitioner ever complaining of blurred vision or any problems with his eyesight (Tr 69). Mr. Armstrong did not recall Petitioner reporting an injury to the side of his head (Tr 69). Mr. Armstrong has never seen a laborer use or work with a jackhammer for 8 hours a day (Tr 69). Mr. Armstrong has worked in construction for 33 years (Tr 70). He has seen a laborer use or work with a jackhammer for a couple hours (Tr 70).

On cross-examination, Mr. Armstrong testified that during the time he worked with Petitioner, he never saw him smoke a cigarette (Tr 70). He did not know if Petitioner ever smoked cigarettes (Tr 70). Petitioner was part of his crew for about a year (Tr 70-71). Petitioner was the member of the crew who would run a jackhammer (Tr 71). Mr. Armstrong has operated a hydraulic jackhammer (Tr 72). An air jackhammer gets a job done much quicker than a hydraulic jackhammer (Tr 73). During the time Mr. Armstrong was with him, Petitioner operated a hydraulic jackhammer (Tr 73). The hydraulic jackhammer causes much greater vibration to an operator's body than an air jackhammer (Tr 73). The hydraulic jackhammer takes even longer to use in the wintertime because the fluid does not flow as fast when it is cold outside (Tr 74). There might be a period of a week where the jackhammer is used daily, but that was not the case in the summer of 2007 (Tr 76). Sometimes it was used more than that (Tr 76).

On re-direct examination, Mr. Armstrong testified that how long the hydraulic jackhammer on any given day is used depends on how thick the concrete is (Tr 77). A laborer would not use a hydraulic jackhammer for 8 hours a day (Tr 77). A laborer could use a hydraulic jackhammer for a couple hours at the most (Tr 77).

4. In an e-mail to Petitioner's attorney dated January 2, 2008, Px5, Dr. Bagai, a dentist, indicated Petitioner presented to him on August 6, 2007 with complaints of pain in his upper left jaw. Dr. Bagai noted that he explained to Petitioner that he had a large filling that may have decay present underneath, but there were no large cavities that would cause the pain that he was complained of. On October 3, 2007, Petitioner returned with complaints of pain and Dr. Bagai explained to him that it may be a gum infection and he was treated with scaling and root planning. Dr. Bagai referred Petitioner to a specialist to look at the possibility of an infection in the area caused by the tooth or the gums. Dr. Bagai noted that Petitioner called back the same day to say that his symptoms were not relieved by the root planning. Dr. Bagai recommended he see the specialist or his primary care physician.

5. MercyWorks medical records, Rx6, indicate that on August 29, 2007, Petitioner was seen for complaints of a right thigh injury when he slipped off the back of a truck.

6. Midland Orthopedics medical records, Px9, indicate that Petitioner was seen by Dr. Strugala on September 20, 2007 and it was noted that he had sustained a right thigh injury while exiting his work truck three weeks before. Dr. Strugala diagnosed a right thigh contusion and prescribed physical therapy.

7. Chicago Eye Specialists medical records, Px6, indicate Petitioner was seen by Dr. Ray on October 9, 2007 and complained of not being able to see with his left eye. Dr. Ray referred Petitioner to the emergency room at Mercy Hospital.

8. According to Mercy Hospital medical records, Px1, Petitioner presented to this facility on October 9. 2007. The Initial Patient Assessment of that date noted the following history: "Last Friday went to his dentist with c/o pain on the left side of neck and thought of a toothache. Today in early morning pt saw dots and around 9:00 a.m. could not see on left eye. Went to eye doctor in same building where he is doing therapy for his back pain. From eye doctor was referred for sudden loss of vision." It was noted that Petitioner smokes 3 packs a day for 20 years and he did smoke in the past. A smoking cessation program was refused. The Patient History/Admission Assessment form for that date has the same information as the Initial Patient Assessment, except it is noted that Petitioner smokes 3 cigarettes a day and has done so for the last 20 years. It was noted that he does not do drugs.

The History and Physical form of that date noted the following history: "Was well till today morning when he noticed "dots" in his vision when he got up from sleep. Had a headache – left temporal area, 1 day prior to onset of symptoms. Took 2 Aleve, headache resolved. Went to bed and found visual changes in a.m. He went to therapy for back pain – still felt the blurriness in vision in left eye and "dots" while taking his car out – went to eye doctor – tested – put some drops and told him to go to ER." No weakness and no sensory loss were noted. It was noted, "Has been noticing dots on and off for about a week, but never like blurry vision." Petitioner reported he had been in a lot of stress recently. Under substance use, there is nothing listed under tobacco. For alcohol use, an occasional beer is noted. Under drug use, it is noted, "smokes marijuana every day." Petitioner's occupation is listed as a jackhammer operator. On examination, visual acuity of the right eye was 20/25 and left eye was 20/200, there was no visual field defect and no color vision defect. Ocular movements were intact. There was no facial paralysis. Petitioner was diagnosed with a sudden loss of vision/ blurry vision left eye probably secondary to embolic phenomenon. Petitioner was put on stroke protocol. CT scan of the head and MRI were ordered.

The Eye Complaint form of that date noted the following history: "Woke today, had spots in left eye for a while, then decreased visually. Saw Dr. Ray and sent to ER to R/O central retinal artery occlusion. Started 9:00 a.m. today, 8 hours ago and is still present. Neck pain X 1 week. H/o toothache?" Petitioner reported he had not done any hammering and had no recent trauma. Petitioner reported decreased vision and blurred vision. It was noted, "May have had vascular event." Petitioner was diagnosed with 1) central retinal artery occlusion; 2) sudden vision loss, rule out cerebral event. Consultation was requested with Dr. Schultz and Dr. Kramer.

After being admitted, a CT scan of head was done that day. The radiologist's impression was: 1) soft tissue density in the suprasellar cistern, an aneurysm cannot be excluded; 2) no acute/subacute hemorrhage or infarction; 3) focal low density extra-axial collection in the left parietal region, this may represent an anatomic variant, residual of an old infarction, or less likely an atypical small arachnoid cyst.

A brain MRI with and without contrast was done on October 10, 2007. The radiologist's impression was: 1) age-indeterminate thrombotic occlusion of the petrous and cavernous left internal carotid artery; there is late subacute/chronic left parieto-occipital infarct, likely associated with this; no acute infarct is identified; 2) paranasal sinus disease; minimal mucosal thickening scattered about the ethmoid sinus.

CT scanning of the neck vessels and Circle of Willis was done on October 10, 2007. The radiologist's impression was: 1) There is complete occlusion of the left common and internal carotid arteries, from a level immediately above the left common carotid origin from the aortic arch through the cavernous left internal carotid segment. No significant retrograde flow is seen, suggesting that the entire nonopacified segment is occluded with thrombus. There is a small area of subacute to chronic left parieto-occipital infarct, suggesting that this vascular occlusion may also be subacute to chronic. One likely etiology for this includes subacute thrombus superimposed upon recent endovascular dissection, which could be post-traumatic/post-exertional. Alternatively, large vessel vasculitis remains in the differential, although there are no additional involved vessels to support this hypothesis. There is no atherosclerosis or aneurysm; 2) The ophthalmic arteries are not well defined, but there is likely secondary decrease in perfusion pressure through the left ophthalmic artery, which may explain the patient's reported visual symptoms; 3) Decreased perfusion through the entire left MCA territory, likely predisposing to the above left parieto-occipital infarction. The patient is at increased risk for additional left MCA territory infarctions in the future.

An Ultrasound Carotid Bilateral was done on October 10, 2007. The following findings were noted by cardiologist Dr. Tamlyn: "There is minimal atherosclerosis of the right common, internal and external carotid arteries. The flow pattern and velocities are in the physiological range. There is no evidence of significant carotid stenosis. Right vertebral artery is patent with antegrade flow. Right subclavian artery has triphasic flow. No flow is seen in the left common or internal carotid artery. Abnormal flow is seen with a very low resistance pattern in the external carotid artery. This suggests a complete occlusion at the origin of the common carotid artery with collateral flow into the external carotid." The impression was: complete occlusion of the left common carotid artery. There was evidence of some collateral flow in the external carotid artery.

On October 10, 2007, Petitioner saw Dr. Vaughn for a neurology follow-up. Dr. Vaughn noted, "Reviewed CT with Radiology which shows extensive thrombosis involving left internal carotid artery. Concern for left carotid dissection is high given pt's hx/o blunt head trauma few

weeks back followed by left fascial, head and neck pain 2 weeks ago." Dr. Vaughn noted that anticoagulants should be considered to prevent further thromboembolic events. He discussed this with primary care physician Dr. Schultz and Heparin infusion was begun.

On October 12, 2007, Dr. Ali noted, "Pt relates he works at a construction site and was hit in head with jackhammer 4 weeks ago and had left headache and neck pain in 2 weeks."

9. In a letter To Whom It May Concern dated October 15, 2007, Px3, Dr. Schultz noted that Petitioner suffered a stroke on October 9, 2007. Dr. Schultz opined, "This occurrence left him with significant loss of vision in his left eye. Diagnostic testing at Mercy Hospital revealed that he suffered a left carotid artery dissection several weeks ago. This was most likely a result of his work operating a jackhammer. He then threw a blood clot from the dissected carotid artery into the left optic artery, which caused the acute stroke event for which he was hospitalized. Mr. Pope's injury is a result of his work and should not return to work operating a jackhammer. He suffered no other neurological deficits. Therefore, he should be able to work in another construction position with the only limitation being almost total blindness in his left eye. Furthermore, as he will be on blood thinners for the next six months, he also should not perform any duties that place him at risk for head trauma."

In a slip dated October 15, 2007, Px4, Dr. Gohi noted, "This is to certify that Mr. Pope's diagnosis of carotid dissection with thromboembolism to left eye with central retinal artery occlusion is job related."

10. According to Mercy Hospital medical records, Px2, Petitioner presented to this facility on October 20, 2007. The History and Physical form of that date noted Petitioner complained of a right-sided headache for 1 day and sharp 10/10 pain radiating to the neck, which started in the morning while washing dishes. Petitioner reported this was similar to the left-sided headache he had a week before. Under Section 4, Drugs, it is noted, "marijuana a month ago; cocaine in the past." Petitioner also complained of chest tightness/pain and back pain. Petitioner was diagnosed with 1) chest pain; 2) headache.

CT of the head without contrast was done on October 20, 2007. The radiologist noted that the previously described left parietal occipital area of infarction has undergone further evolution and now demonstrates chronic appearance. The radiologist's impression was: 1) further evolution and no chronic appearance of a left parieto-occipital infarction; 2) no evidence of an acute intracranial process.

11. Petitioner's attorney submitted into evidence a Case Report entitled "Flapping of the Dissected Intima in a Case of Traumatic Carotid Artery Dissection in a Jackhammer Worker." This Case Report was admitted into evidence as Px8. The Case Report indicates that traumatic carotid artery dissection (CAD) is usually associated with severe head trauma, but sometimes a trivial trauma is reported. The article presented a case of flapping of the dissected intima layer

within the internal carotid artery in a case of CAD following intensive use of a jackhammer. The patient had for several hours used a jackhammer with the continuous pulsating pressure on his chest and clavicle. The article noted that dissection occurs when the intima or the media of the arterial wall is disrupted, causing an intramural hematoma in the subintimal, in the medial, or in the subadventitial layers. The authors noted that in this case the causal mechanism was not clear, but it could be rationally assumed that the persistent and vigorous use of the jackhammer was responsible for the lesion.

12. According to Midland Orthopedics records, Px9, Petitioner saw Dr. Strugala on December 27, 2007 and was diagnosed with a right quadriceps muscle tear. On January 29, 2008, Dr. Strugala noted that Petitioner had plateaued with physical therapy. He recommended advanced physical therapy. On March 28, 2008, Dr. Strugala noted that Petitioner had good progress with work conditioning program and he was to continue work restrictions. On May 30, 2008, Dr. Strugala opined Petitioner had reached maximum medical improvement for his right leg injury and that he had plateaued at a medium heavy to heavy rating.

13. During his April 6, 2011 deposition, Px11, Dr. Kramer testified he is board certified in psychiatry and neurology and is chief of the neurology section at Mercy Hospital and director of the stroke program there. Dr. Kramer noted he saw Petitioner on October 15, 2007 (Dp 9). Dr. Kramer recited Petitioner's history as noted in the Mercy Hospital records. He also noted Petitioner's job (Dp 11). His assessment of Petitioner at that time was that he had a central retinal artery occlusion and a differential diagnosis of infarct secondary to left carotid artery occlusion vs. arthritis vs. dissection vs. vitreal sclerosis (Dp 12). He noted the diagnostic tests and their results. Dr. Kramer felt that in Petitioner's case, a blood clot formed at the dissection area and a piece broke off and went into the retinal artery to his left eye, blocked the flow of blood and killed the cells at the back of the retina and caused loss of vision (Dp 15-17). Petitioner's retinal artery was completely occluded/blocked. He noted that other pieces broke off and caused an infarction/stroke in the parietal occipital region of Petitioner's brain (Dp 17-18). Petitioner had no symptoms of this stroke (Dp 18). Dr. Kramer noted associate Dr. Vaughn's October 10, 2007 notes. Dr. Kramer opined that direct trauma to the head is the most common cause of CAD (Dp 20). His diagnosis of Petitioner was traumatic carotid artery dissection with retinal artery occlusion and parietal occipital stroke (Dp 20). Dr. Kramer opined that it was the trauma primarily that was the inciting factor which resulted in this carotid dissection (Dp 21). Dr. Kramer opined that there also are case reports in the literature regarding jackhammer use causing tears of the intima/inner lining of the carotid artery resulting in dissection (Dp 21). He cited the Case Report (Px8) (Dp 21-22). Dr. Kramer opined that CAD is a risk of jackhammer use (Dp 22). Dr. Kramer would consider Px8 an authoritative report of an incident showing that relationship (Dp 22). Dr. Kramer opined that it could be both the head trauma and the use of the jackhammer and it could be either one. Dr. Kramer opined that based on the history of Petitioner being hit on the side of the head then shortly thereafter developing neck pain and jaw pain, it was more likely the head trauma was the precipitating factor (Dp 22).

Dr. Kramer testified that the main symptoms of CAD are headache, neck pain and jaw pain (Dp 23). He opined that the stroke in Petitioner's brain had been there for at least a few days and could have been there for a few weeks, but given his loss of vision on October 9, 2007, more of the clot flipped off and got to the retinal artery (Dp 23). Dr. Kramer opined that the initial damage to the carotid artery would have occurred when Petitioner hit his head on the jackhammer (Dp 24). Dr. Kramer opined that it is very possible Petitioner had some micro damage from the vibration of the jackhammer (Dp 24). Petitioner was treated with blood thinners. Dr. Kramer opined that it was obvious the beginning of Petitioner's CAD was when he saw dentist Dr. Bagai on August 6, 2007 and again on October 3, 2007 for complaints of pain in the left side of his face without any obvious dental cause (Dp 26). Dr. Kramer noted that August 6, 2007 was before the blunt trauma to the head from being hit by a jackhammer. Dr. Kramer opined that the August 6, 2007 pain was from the vibration of jackhammer use (Dp 26). His resident Dr. Gohi wrote the October 15, 2007 slip (Px4) (Dp 27). Dr. Kramer concurred that Petitioner's condition was job related (Dp 28). Petitioner did not have vasculitis because tests showed that CAD was in one area and an angiogram showed no evidence outside the left carotid artery (Dp 28). ANA test for inflammatory conditions was normal (Dp 29). Vascultis was totally unproven (Dp 30). The sed rate of 50 did not show vasculitis (Dp 30). Petitioner's loss of vision is permanent (Dp 31). Dr. Kramer was shown Dr. Schultz' October 15, 2007 letter (Px3) and he agreed with Dr. Schultz that Petitioner is restricted from jackhammer use (Dp 32).

On cross-examination, Dr. Kramer testified that he saw Petitioner on October 15, 2007 and October 20, 2007 (Dp 33). His opinions are based on the histories in the Mercy Hospital records and his own experience (Dp 33-34). Dr. Kramer opined that the diagnosis of CAD is directly related to a traumatic event that occurred at work 4 weeks prior to Petitioner's admittance to Mercy Hospital on October 9, 2007 (Dp 34). It is also his opinion that his diagnosis could be the result of repetitive use of a jackhammer in Petitioner's work (Dp 34). Dr. Kramer opined the event of the jackhammer hitting Petitioner's head triggered a further dissection (Dp 35). Dr. Kramer opined that he thinks Petitioner could have had some little tearing of the artery before that, in August 2007 when he had symptoms and went to dentist Dr. Bagai on August 6, 2007 (Dp 35). For the traumatic event to cause dissection, it could be a glancing blow because Petitioner was already susceptible (Dp 35). The event would be something that hit him that made him move his neck, like in a car accident whiplash (Dp 35). Dr. Kramer opined that it was already there from the repetitive nature of his job (Dp 35-36). Dr. Kramer was not aware Petitioner was involved in a motor vehicle accident on October 9, 2007 on his way to Mercy Hospital. Dr. Kramer opined that Petitioner's symptoms and his MRI findings show his condition was before that motor vehicle accident (Dp 36). Dr. Kramer had no opinion whether the motor vehicle accident on October 9, 2007 was contributory to Petitioner's condition (Dp 36). Dr. Kramer opined causal relationship based on the repetitive nature of Petitioner's job duties with the jackhammer and the eventual trauma of getting hit by the jackhammer (Dp 36). Dr. Kramer opined that if it had not been for the repetitive trauma, we probably would not even have to worry about the secondary trauma (Dp 37). He did not discuss Petitioner's job duties with him on October 15, 2007 (Dp 37). Dr. Kramer was unaware how often Petitioner used a jackhammer in the course of his employment or the type of projects he

worked on (Dp 38). Dr. Kramer did not know that Petitioner stopped working for Respondent on September 20, 2007 (Dp 38).

Dr. Kramer testified that a smoker is at greater risk for having a stroke (Dp 39). He was aware that in his initial patient assessment that Petitioner had been smoking for the past 20 years at least 3 cigarettes a day (Dp 39). Dr. Kramer opined that Petitioner would be at greater risk for a stroke than the average person who did not smoke, but not for this kind of stroke (Dp 39). Dr. Kramer opined that cocaine users are at a greater risk for having a stroke. He was not aware that Petitioner had a history of cocaine use (Dp 40). Cocaine causes hemorrhagic stroke and causes spasm of the blood vessel at the time of the use, not in between uses. Dr. Kramer opined that the type of stroke Petitioner had with damage to the artery is inconsistent with drug use (Dp 40). Dr. Kramer agreed that power lifting is the type of exertion that has been reported to cause CAD.

On re-direct examination, Dr. Kramer testified that according to the medical records, Petitioner last worked on September 29, 2007, clearly within 4 weeks time of presenting at Mercy Hospital ER with loss of vision on October 9, 2007 (Dp 41). He noted Petitioner was working during the time he reported that he was hit by a jackhammer (Dp 41). Petitioner's attorney brought to his attention the medical records which state 3 packs a day, 3 cigarettes a day for 20 years and no smoking (Dp 41-42). Dr. Kramer could not make anything out of those histories that correlates at all with Petitioner's problems (Dp 42). He noted that Petitioner already had the head trauma, neck pain and loss of vision before the auto accident (Dp 43). Based on his symptoms, Petitioner already had the dissection and stroke before the motor vehicle accident happened (Dp 43). Dr. Kramer is not familiar with all the details of power lifting and the time frame to cause a stroke (Dp 43-44).

14. Respondent's attorney submitted a job description for a Laborer for the Bureau of Electricity and this was admitted into evidence as Rx1. The description notes that under supervision, the laborer performs general construction labor and maintenance activities and related activities as required. The following are listed as essential duties: operates concrete breaking and cutting equipment and hydraulic tools used for the installation of electrical conduit; digs and backfills excavations for electrical vaults, pole foundations and trenches for duct lines; mixes and pours concrete for various electrical installations; shovels debris from manholes to clear obstacles for electrical maintenance and repair; assists in the installation of concrete forms, conduit and other materials; loads and unloads materials for transport between warehouses, storage depots and construction sites; places barricades, safety cones and steel street plates for the safety of the general public; performs general building maintenance activities within the bureau; and assists various tradesmen with materials needed for electrical construction, maintenance and repair.

15. Respondent's attorney submitted daily work reports from June 2007 through September 2007 and these were admitted into evidence as Rx2. These reports show what Petitioner did on a daily basis at work during that time period. The reports show that Petitioner used a jackhammer or rotohammer on the following dates: 6-20-07 (jackhammer), 7-5-07 (jackhammer), 7-9-07

(jackhammer), 7-10-07 (jackhammer), 7-17-07 (jackhammer), 7-25-07 (rotohammer), 8-6-07 (rotohammer), 8-9-07 (jackhammer), 8-25-07 (jackhammer) and 9-10-07 (jackhammer). According to these daily reports, Petitioner last worked on 9-20-07. He had sustained a right thigh injury that date. The daily reports do not show for how long Petitioner operated a jackhammer or rotohammer on those days.

16. In her August 17, 2010 report, Rx4, DepEx2, §12 Dr. Levin noted that Petitioner reported that in July 2007 he sustained a right thigh injury. Petitioner reported he had been out on disability as of August 29, 2007 and was not working anywhere. The Commission notes that the daily reports show Petitioner was working until September 20, 2007. Dr. Levin noted, "He states that in August of 2007, he started developing pain in the left side of his neck and went to see a dentist, thinking it was related to his teeth. He also started developing dots in his vision the last week in August." The Commission notes that Petitioner did not testify to seeing dots at that time and in the October 9, 2007 History and Physical it is noted Petitioner reported he had been noticing dots on and off for about a week. Dr. Levin noted, "He is unsure when he went back to work, but believes it was some time in mid September of 2007." The Commission notes that the daily reports show Petitioner continually worked until September 20, 2007. Dr. Levin noted, "Just after returning back to work, he states he was hit in the head by a jackhammer. He was on the back of the truck and he went up to get the jackhammer. He bent down and the jackhammer hit him on the left side of his head. There was no loss of consciousness. He did feel dizzy. He states he got an ice pack and worked the rest of the day. He states that in the course of his job, he uses the jackhammer for four to six hours per day every day for 26 years and he may have been using it as many as eight hours per day in September." The Commission notes that the daily reports show that in September 2007, Petitioner used a jackhammer only on September 10, 2007. Dr. Levin noted, "Mr. Pope states that in either September or October, he started developing trouble where he could not see out of his left eye." The Commission notes that Petitioner did not testify to this and the October 9, 2007 History and Physical noted Petitioner reported he had been noticing dots on and off for about a week. Dr. Levin noted, "He states he was at physical therapy for his leg at that time and he believed that a clot from the tear in his right thigh traveled up to his carotid artery and caused a block." The Commission notes that there is no evidence regarding a clot from Petitioner's thigh. Dr. Levin noted, "He went to a doctor in the building where his therapy was and that doctor sent him to the emergency room at Mercy Hospital. He was admitted to the hospital where he states he stayed approximately seven days. Since that time, he has been unable to see out of his left eye." Petitioner denied power lifting and he was not asked this. A mild motor vehicle accident on October 9, 2007 was noted and Petitioner denied hitting his head in this accident. Petitioner denied any tobacco use. Petitioner reported he had not used marijuana since his youth. The Commission notes that the October 9, 2007 History and Physical and the October 20, 2007 Mercy Hospital record note otherwise. Petitioner denied any cocaine use. The Commission notes that the October 20, 2007 Mercy Hospital record note otherwise. Dr. Levin reviewed Petitioner's medical records.

Dr. Levin noted she reviewed Dr. Allen's June 30, 2008 §12 report. Dr. Levin noted, "Of note, in that evaluation, there was no specific mention of any day he was hit with a jackhammer,

but states that he had been jarred on multiple occasions while driving in the back of a truck. Dr. Levin noted that on page 2 of Dr. Allen's evaluation, it states, "He states that in the past, he has been a power lifter. He wears the neck piece of a power lifter. He denies power lifting in the period of time prior to his injuries." Dr. Levin noted that on page 4, it states, "It should be stated that this patient specifically denies being hit in the head with a jackhammer."

Dr. Levin's impression was that Petitioner had a left carotid dissection that resulted in occlusion of the left retinal artery and he was left with visual deficits in the left eye and no other neurologic deficits. Dr. Levin opined, "It is very difficult to blame this condition on his jackhammer use in as much as there is no significant increase of carotid dissections in jackhammer users." Dr. Levin noted that there is an increase of cerebral dissections with weightlifting. Dr. Levin noted Petitioner had an elevated sedimentation rate and a positive ANA and opined that a vasculitic condition could bring on similar types of problems. Dr. Levin noted that Petitioner may or may not have had any drug use and noted medical records which state so, even though Petitioner denied this. Dr. Levin noted the same of cigarette use. Dr. Levin opined that cigarettes are a significant increase for vascular abnormalities in the brain including dissections. Dr. Levin opined that the motor vehicle accident does not appear to have contributed to it.

Dr. Levin opined, "Although a direct injury to the neck, such as a jackhammer hitting it, could be a predisposing fact, it is somewhat curious to me that in prior evaluations the patient specifically denied being hit directly with a jackhammer, yet to me states he was." Dr. Levin opined Petitioner needed no further treatment and had reached maximum medical improvement. Dr. Levin opined that decreased left eye vision would only limit Petitioner in anything that would need binocular vision. Dr. Levin opined there should be no restrictions from the type of work Petitioner does. Dr. Levin did not see why Petitioner could not intermittently use a jackhammer in the future. Dr. Levin opined, "He should not operate it 8 hours per day every day for 26 years; however, I am somewhat skeptical that he was actually doing this."

17. During her September 19, 2011 deposition, Rx4, §12 Dr. Levin testified she was a board certified neurologist. Dr. Levin recited from her report, noted above. Dr. Levin noted that a toxicology screen taken at the hospital showed cannabis and opiates, but that opiates might have been something he was given at the hospital (Dp 14). Dr. Levin recited from §12 Dr. Allen's June 30, 2008 report (Dp 14-15).

On cross-examination, Dr. Levin testified that the most common cause of carotid artery dissection is trauma (Dp 21-22). Other causes include cocaine use and vasculitic processes. Trauma in an elderly person could be simply moving the head (Dp 22). Petitioner tested negative for cocaine use (Dp 22). Dr. Levin noted that Petitioner did report to her that he was hit in the head, but this is not noted in the medical records until October 12, 2007. Dr. Levin opined that if the records reflect that Petitioner was hit in the head by a jackhammer and that incident coincided with the onset of headache, neck pain, jaw pain within a couple days, her no causal connection opinion might change (Dp 23). Dr. Levin opined, "If you have an injury to your neck and within a couple days you have the symptomatology, yes, they can be related." (Dp 23). Dr.

Levin opined that a dissection may gradually tear the lining of the artery over a period of time (Dp 23). Symptoms would be within a few days, not months (Dp 24). Dr. Levin opined there could have been vasculitis, some type of inflammation process, that caused Petitioner's condition, shown by an elevated sed rate and positive ANA (Dp 28). ANA was mildly positive at 1:40, whereas negative would be 1:39.4 (Dp 29). An elevated sed rate of 50 could be a vasculitis which causes dissection and dissection does not elevate the sed rate (Dp 31). A muscle tear in the leg that is inflamed and painful would raise the sed rate if it were new, but Dr. Levin believed Petitioner's leg tear was several months old already (Dp 32). Dr. Levin opined that it is possible this muscle injury was a source of inflammation at the time Petitioner went to Mercy Hospital on October 9, 2007 (Dp 32). Dr. Levin noted there was no vasculitis anywhere else in the body (Dp 32).

Dr. Levin opined that cigarette use in young people is one of the biggest causes of stroke because it affects the blood vessels (Dp 35). Dr. Levin was shown the differing smoking histories in the Mercy Hospital medical records (Dp 35-37). Dr. Levin opined that there is not a recognized correlation between jackhammer use and carotid artery dissection (Dp 38). Dr. Levin opined that weightlifting is definitely a recognized correlation (Dp 38). Dr. Levin acknowledged there may be isolated case reports regarding jackhammer use and carotid artery dissection (Dp 38). Dr. Levin stated that jackhammer use is not reported as an increased risk factor for carotid artery dissection (Dp 38). Dr. Levin has not seen it in the literature (Dp 38). Dr. Levin noted she did a search and there was one case report and no big studies. Dr. Levin read Dr. Vaughn's October 10, 2007 report and opined a 2 week time frame would be appropriate, but she questions the trauma (Dp 40-41). Dr. Levin stated that if there was a document stating Petitioner was hit in the neck with a jackhammer, it would possibly change her opinions (Dp 43). Dr. Levin had no documentation that an injury like that occurred (Dp 43). Dr. Levin opined it would be safe for Petitioner to go back operating a jackhammer (Dp 46). Dr. Levin had not read Dr. Kramer's deposition as she was not supplied with it (Dp 46).

On re-direct examination, Dr. Levin opined that 4 weeks time between being hit in the head in mid September 2007 and loss of vision on October 9, 2007 would start to be quite long to get symptomatology after a carotid artery dissection (Dp 48-49). It is usually much quicker, immediate or in the first week or two thereafter (Dp 49). Dr. Levin acknowledged that pain in the neck can occur when the carotid artery dissection starts (Dp 50).

18. On March 22, 2012, Respondent filed a Motion to Consolidate this claim with claim 07 WC 47285, assigned to Arbitrator Carlson. On April 4, 2012, Arbitrator Carlson denied the Motion to Consolidate. This was submitted by Respondent and admitted into evidence as Rx7 at the June 21, 2012 arbitration hearing. Respondent also submitted IWCC records regarding Petitioner's prior claims and these were admitted into evidence as Rx8.

Based on the record as a whole, the Commission reverses the Decision of the Arbitrator finding that Petitioner failed to prove he sustained accidental injuries arising out of and in the course of his employment and failed to prove a causal relationship exits and denies Petitioner's

claim. Petitioner's claim is that repetitive jackhammer use caused his carotid artery dissection, which resulted in a blood clot and a piece broke off and went to the retinal artery and occluded it which caused his loss of vision. The daily work reports for June 2007 through September 20, 2007 show how often Petitioner used a jackhammer or rotohammer during that period. Petitioner also testified that he would use a jackhammer for 8, 6, 4 or 2 hours every work day. Foreman Clayton Armstrong testified that when Petitioner would use a jackhammer, he would use it from 45 minutes to an hour, up to 2 hours and never for 8 hours. The Commission concludes that Petitioner did not use a jackhammer or rotohammer very often and not repetitively and that Petitioner's testimony about his jackhammer use is rebutted by the daily work reports and the testimony of Mr. Armstrong. The Commission finds the testimony of Mr. Armstrong more credible than the testimony of Petitioner regarding his use of a jackhammer. Mr. Armstrong's testimony is supported by the daily work reports, Rx2.

Petitioner also claims that a jackhammer hit him in the head and neck sometime in September 2007, but he did not know the date this occurred and that he reported it to his supervisor Clayton Armstrong, who did not recall this incident. The daily work reports show Petitioner used a jackhammer in September 2007 only on September 10, 2007. Petitioner testified that on the day of the occurrence, he went to get the jackhammer from the truck. Therefore, if this occurred, it must have been on September 10, 2007. The Commission notes that this is not the date of accident of October 15, 2007 listed on Petitioner's Application of Adjustment of Claim.

On the Eye Complaint form dated October 9, 2007, Petitioner reported he had not done any hammering and had no recent trauma. The first mention in the medical records of a blunt trauma to Petitioner's head was in Dr. Vaughn's October 10, 2007 neurology follow-up report. Dr. Vaugh noted, "Reviewed CT with Radiology which shows extensive thrombosis involving left internal carotid artery. Concern for left carotid dissection is high given pt's hx/o blunt head trauma few weeks back followed by left fascial, head and neck pain 2 weeks ago." The Commission finds that this noted history of blunt trauma as reported by Petitioner is contradicted by his reporting of no recent trauma just the day before. On October 12, 2007, Dr. Ali noted, "Pt relates he works at a construction site and was hit in the head with a jackhammer 4 weeks ago and had left headache and neck pain in 2 weeks." The Commission also finds that this noted history of blunt trauma as reported by Petitioner is contradicted by his reporting on October 9, 2007 of no recent trauma. Furthermore, Petitioner specifically denied to Dr. Allen on June 30, 2008 that he was hit in the head with a jackhammer, yet he reported to Dr. Levin that he had been. Petitioner also denied smoking cigarettes, yet the medical records note no smoking, smoking 3 packs a day for 20 years and 3 cigarettes a day for 20 years. The medical records also note marijuana and cocaine use in the past, which Petitioner denied. Based on the inconsistencies noted above, the Commission finds Petitioner's testimony regarding his claim that he was hit in the head by a jackhammer not credible.

Dr. Kramer opined causal connection for either repetitive use of the jackhammer or being hit in the head/neck by the jackhammer, or both. Dr. Kramer opined that based on the history of

14IWCC0937

Petitioner being hit on the side of the head then shortly thereafter developing neck pain and jaw pain, it was more likely the head trauma was the precipitating factor. However, as noted above, if Petitioner was hit in the head on September 10, 2007, the medical records show he then did not complain of neck/jaw pain until he saw dentist Dr. Bagai on October 3, 2007. Also, Dr. Kramer did not know how often Petitioner used a jackhammer. Dr. Schultz opined in his letter Petitioner's carotid artery dissection was most likely a result of his work operating a jackhammer. §12 Dr. Levin opined no causal connection and doubted Petitioner was hit in the head, noting Dr. Allen's June 30, 2008 report wherein Petitioner specifically denied any trauma to the head. The Commission finds Dr. Levin's opinions more persuasive than those of Dr. Kramer and Dr. Schultz. The opinions of Dr. Kramer and Dr. Schultz are based on inaccurate histories provided to them by Petitioner.

The Commission affirms the denial of the Motion to Consolidate issued by Arbitrator Carlson, as the cases involved different body parts. There also was no TTD being claimed on this case and Petitioner was receiving TTD for the other case.

IT IS THEREFORE ORDERED BY THE COMMISSION that since Petitioner failed to prove he sustained accidental injuries arising out of and in the course of his employment on October 15, 2007 and since he failed to prove a causal relationship exits, his claim for compensation is hereby denied.

IT IS FURTHER ORDERED BY THE COMMISSION that the denial of Respondent's Motion to Consolidate issued by Arbitrator Carlson is hereby affirmed.

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

DATED: NOV 0 3 2014
MB/maw
o10/02/14
43

Mario Basurto

Stephen J. Mathis

David L. Gore

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Roselee Jackson,
Petitioner,

vs.

NO: 11 WC 3391

City of Chicago, Fleet Management,
Respondent.

14IWCC0938

DECISION AND OPINION ON REVIEW

Petitioner appeals the decision of Arbitrator Williams finding Petitioner sustained an accidental injury arising out of and in the course of her employment on January 13, 2011. Arbitrator Williams found that Petitioner's left shoulder condition is casually connected but her cervical condition is not causally connected to the January 13, 2011 work accident. As a result Petitioner was temporarily totally disabled from January 14, 2011 through February 7, 2011 for 3-4/7 weeks under Section 8(b) of the Illinois Workers' Compensation Act, Petitioner is entitled to the medical expenses related to the left shoulder but not the cervical condition under Section 8(a) of the Act and Petitioner is permanently disabled to the extent of 2% man as a whole/3.95% loss of use of the left arm under Section 8(d)2/8(e) of the Act. The Issues on Review are whether there is a causal relationship between Petitioner's current cervical condition and the January 13, 2011 accident, and if so, whether Petitioner is entitled to current and prospective medical expenses, the amount of temporary total disability and the amount of permanent disability. Having reviewed the entire record, the Commission modifies the Arbitrator's decision and finds that Petitioner's current cervical condition is related to the January 13, 2011 work accident, Petitioner is entitled to $48,316.20 in medical expenses as set forth in Petitioner's PX18 and in accordance with Sections 8(a) and 8.2 of the Act, Petitioner was temporarily totally disabled from January 14, 2011 through June 19, 2012 for 74-4/7 weeks under Section 8(b) of the Act. Lastly, Petitioner is permanently disabled to the extent of 30% man as a whole under Section 8(d)2 of the Act.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

The Commission finds:

1. Petitioner testified she is a truck driver. She works for the City of Chicago, Department of Fleet Management. She has worked for Respondent since 1998. She is currently 72 years old. She left school after the 10th grade and she obtained her GED. Her job title is motor truck driver. Her duties consisted of driving trucks from one City facility to another.

2. On December 19, 2008 she had a work accident resulting in injuries to her left shoulder and left knee and Petitioner underwent surgery for both her left shoulder and left knee. A workers' compensation decision was rendered in July of 2010. She returned to work on October 28, 2010. At first she worked a light duty computer job, next she was assigned to pump gas into city vehicles and then she went on to transporting lighter vehicles.

3. As a result of the December 19, 2008 work accident, Petitioner underwent left medial meniscus surgery on March 12, 2009. She also had surgery for a left rotator cuff tear on May 13, 2009. On March 26, 2010 Dr. Levin evaluated Petitioner and opined that she had reached maximum medical improvement. He released her to full duty work and stated that if she is unable to perform full-duty work then a functional capacity evaluation should be performed. On March 30, 2010, Dr. Kale evaluated Petitioner and found that she had reached maximum medical improvement for her left shoulder and left knee. However, he noted that Petitioner is continuously complaining about the inability to easily dress herself due to a lack of abduction, elevation, flexion and extension of her left shoulder and her inability to stand or walk for long due to her left knee occasionally giving way. On December 22, 2010 Petitioner had a left shoulder MRI which showed supraspinatous and infraspinous moderate tendinopathy without a full thickness rotator cuff tear along with mild acromioclavicular degenerative hypertrophy which was causing impingement of the underlying rotator cuff.

4. Petitioner testified that on January 13, 2011 she and a supervisor were trying to move a disabled van. She was seating in the van and was turning the steering wheel, which had power steering that was not working. As she struggled to turn the wheel, she felt something pop in her shoulder and neck. The pain was running up and down her left arm and back. Two fingers on her left hand were also numb.

5. On January 13, 2011, Petitioner was seen at Mercy Works. She reported developing pain in her left shoulder while turning a steering wheel in a van. She reported hearing a click in shoulder. Currently, she is rating her pain as being 10/10. Petitioner was diagnosed as having a left shoulder strain. Her left arm was placed in a sling. She was prescribed Tamadol, told to ice her left shoulder, to stay off of work and to follow up on January 20, 2011.

6. On January 15, 2011, Petitioner was seen at Advocate Trinity Hospital. A left shoulder x-ray was taken and it showed diffuse osteopenia compatible with osteoporosis, orthopedic staples projecting over head of the left humerus, probable small phlebolith or punctuate

area, benign sclerosis within the scapula and metallic clips most likely extraneous to the patient's overlying adjacent soft tissue. No acute fracture or dislocation was found Petitioner was diagnosed as having left shoulder rotator cuff tendinitis.

7. On January 17, 2011, Petitioner was seen at Advocate Medical Group by Dr. Dumford. Dr. Dumford diagnosed Petitioner with left shoulder tendonitis. He prescribed physical therapy, medication and told her to stay off of work until she saw an orthopedic doctor.

8. On January 28, 2011 Petitioner saw Dr. Heller who noted that Petitioner reported she was turning a steering wheel that became stuck when she felt a pop in her left shoulder. On examination, Petitioner described pain along her neck and the anterior and superior left shoulder. Dr. Heller placed Petitioner on light duty with no use of the left arm and he ordered an MRI arthrogram.

9. The February 3, 2011 left shoulder MRI showed post surgical changes suggestive of a prior rotator cuff tear. He noted that there was nothing to suggest a full-thickness tear of the supraspinatus tendon. However, there is irregularity and unevenness in the articular surface of supraspinatus tendon which is suggestive of fraying. On February 7, 2011, Dr. Heller referred Petitioner to Dr. Hynes at the Rehabilitation Institute of Chicago.

10. On February 8, 2011, Petitioner saw Dr. Aboughannam at Advocate Medical Group. Petitioner reported she was experiencing neck pain which goes toward her left shoulder. On examination, she demonstrated cervical spine pain with a right-sided motion. He diagnosed her as having rotator cuff tendonitis and muscle spasms. On February 21, 2011, Petitioner followed-up with Dr. Aboughannam. Again, she reported experiencing severe pain in left shoulder and on the left side of her neck area. On examination, her cervical spine motion was abnormal and pain was elicited with motion. He now diagnosed rotator cuff tendonitis, cervicalgia, cervical radiculopathy and muscle spasm. He referred her for a pain management and to obtain a cervical MRI.

11. On March 8, 2011, Petitioner saw Dr. Osman during a follow up visit at Advocate Medical Group. Dr. Osman noted that Petitioner reports that in the last two to three weeks she has been experiencing more pain in neck area. Dr. Osman diagnosed her with a chronic left rotator cuff sprain, adhesive capsulitis of left shoulder and cervical radiculopathy.

12. On April 13th and 21st, Petitioner was seen at the Rehabilitative Institute of Chicago where it is noted that Petitioner has been trying to perform her neck exercises but it is too painful.

13. The May 14, 2011 Cervical MRI shows that there is a straightening of normal cervical lordosis and mild to moderate degenerative changes in the cervical spine. At C6-7 there is central/left paracentral disc/osteophyte protrusion extending into the left foramen, and causing moderate to severe left foraminal stenosis. There is also moderate spinal stenosis

and moderate right foramen stenosis. Milder degenerative changes are noted at C3-4 to C5-6, causing mild spinal canal stenosis. There is no foraminal stenosis.

14. On June 2011, Petitioner is seen by Dr. Valbhav. He notes she presents with left shoulder and neck pain. She received a C7-T1 ILESI on May 26, 2011 with 10-20% relief in pain. She continues to have pain with numbness and tingling in her 4th and 5th digits, which is perhaps worse at night but definitely worse with turning her head. She continues to need to drive for work and has a difficult time turning her head when driving for work. On examination, her cervical range of motion is limited in extension, side bending and rotation. When her May 2011 cervical MRI is compared to her July 1, 2003 cervical MRI, there has been a progression of the degenerative changes at C6-7 resulting in at least moderate spinal canal stenosis and mild to moderate bilateral axillary recess stenosis. The left neural foraminal stenosis results in part from a left foraminal disc protrusion. She has neck and upper extremity left-sided pain with cervical spondylosis and radicular features and trapezius/cervical paraspinal myofascial pain. He noted that the Petitioner will discuss receiving a referral to a C-spine surgeon with her primary care doctor. He also ordered an EMG/NCV, told her to discontinue work and to follow up in 6-8 weeks. In an addendum report, Dr. Valbhav noted that the EMG/NCV was ordered and he referred her to Dr. Phillips for a neurosurgical evaluation.

15. The June 23, 2011 EMG report shows Petitioner presents with pain radiating from her neck to her left shoulder and down the medial aspect of her left arm into the 4th and 5th digits. Petitioner also reported that the pain is worse with neck movement, particularly turning her head to the right. The EMG/NCV indicates Petitioner has left C8 radiculopathy.

16. On August 16, 2011 Petitioner was seen by Dr. Philips. Petitioner reported that while at work she was trying to turn the wheel on a truck without power steering and she felt a pop in her neck. She developed neck and left arm pain. She is here for a second opinion. She reports that since the injury she has been experiencing neck pain with severe burning radicular pain in the left arm in a C7 distribution. She also has paresthesias in the C7 distribution. She describes subjective weakness of the left arm. She has been through physical therapy and has had epidurals without experiencing any relief. She has not worked since June 20, 2011. On examination, Petitioner is in acute discomfort. She constantly elevates her left arm to relieve her radicular complaints. She has posterior cervical scapular tenderness on the left side. Her cervical range of motion includes flexion of 20 degrees with extension of 30 degrees, both of which cause pain radiating into the left arm. Spurling's is markedly positive on the left side. Her motor exam reveals giving-way weakness related to pain diffusely in the left arm. However, I believe with coaxing most of the strength is intact. She does have 4/5 triceps strength on the left side. She has sensation in a C7 distribution. Her May 14, 2011 cervical MRI shows diffuse spondylitic changes and multilevel disc bulges and some loss of cervical lordosis. At C6-7 there is a very large central left-sided herniated disc effacing the spinal cord and causing obvious C7 nerve root

compression. Petitioner's current diagnosis is a C6-7 left-sided herniated disc related to the injury in question. She has undergone conservative treatment without improvement in her symptoms and is extremely disabled by the radiculopathy. She is also compromised by the weakness. At this point, I believe she is a candidate for C6-7 anterior fusion procedure.

17. On September 8, 2011 Petitioner was evaluated by Dr. Salehi who opined that Petitioner has a herniated cervical disc and cervical spondylosis. The doctor noted that the described mechanism of injury is consistent with having resulted in a herniated disc at C6-7 or exacerbated a pre-existing condition. The doctor also recommended proceeding with the recommended surgery.

18. In an October 21, 2011 letter from Dr. Phillips to Utilization Review, Dr. Phillips stated that Petitioner sustained a herniated disc at C6-7 in 2011. She has symptoms consistent with this diagnosis as well as objective findings including C7 muscle weakness as well as sensory changes that support this diagnosis. Her cervical MRI confirms concordant and consistent findings with a large C6-7 disc effacing the spinal cord and compressing the C7 nerve root. Petitioner has been through conservative course without any response. He opined that Petitioner is an appropriate candidate for a C6-7 anterior diskectomy and fusion procedure.

19. On January 25, 2012 Petitioner underwent surgery consisting of an anterior cervical diskectomy-foraminotomy and fusion at C6-7. The post-operative diagnosis was a cervical disc herniation at C6-7 with radiculopathy.

20. On June 19, 2012 Dr. Phillips gave Petitioner a work release in which he indicated that Petitioner is able to work with restrictions of lifting 10 pounds maximum. She is not to perform any over the shoulder work. Her work should be limited to sedentary work only. The work release was revised on August 30, 2012. Petitioner is able to work with restrictions of lifting 10 pounds maximum with no over the shoulder work.

21. On November 12, 2012 Dr. Palacci evaluated Petitioner. Her recent January 13, 2011 work accident resulted in neck pain that radiated to the left arm causing neurologic dysfunction. This radiculopathy stemmed from a herniated cervical disc with underlying cervical spondylosis, confirmed by a MRI and an EMG. She underwent cervical surgery on January 25, 2012. Despite her cervical surgery she continues to have radiating neck pain with radicular features and limitations in range of motion and grip strength. She also exhibits features of cervical paraspinal myofascial pain. Her current condition limits her daily activities and she requires pain medication to function. With respect to her low back pain and left lower extremity weakness, she appears to have symptoms consistent with radiculopathy likely secondary to degenerative disease. These symptoms occurred after her neck surgery. In my opinion Petitioner's cervical condition and subsequent surgery are directly the result of her January 13, 2011 work accident. Her prognosis is guarded and her condition is permanent. Dr. Palacci opined that given her advanced age and multiple

injuries and limitations, it is unlikely that she can return to any substantial gainful employment in the future.

22. On July 22, 2013, Dr. Salehi evaluated Petitioner. He noted that it appears that Petitioner's symptoms have improved post-operatively but she still has residual neck pain and limited range of motion. Objectively, I cannot explain her limitation of range of motion based on a single level fusion. The other concern as to whether her limitation is truly anatomic or not is the fact that her range of motion was much better only a few months ago. When Dr. Phillips' post-operative notes are compared to today's exam, it makes no clinical sense. It appears that the majority of her complaints revolve around low back pain and left lower extremity pain which started 1-2 months after the cervical operation and they are not related to her most recent work injury or any complication from the cervical operation. As far as her work injury resulting in a C6-7 herniated disc, I see one of two possibilities. Petitioner should either return to light duty and avoid driving trucks and sweepers or undergo a functional capacity evaluation. From a post-operative view, her maximum medical improvement was achieved 4 months after her cervical surgery. Per Dr. Palacci's November 12, 2012 note, Petitioner is not disabled and she can currently work in a light duty capacity.

23. On July 29, 2013 a labor market survey was conducted and it was the opinion of the case manager that there is a stable and reasonable labor market and that positions are potentially available for Petitioner within a reasonable commute from her home.

24. Dr. Palacci was deposed on June 25, 2013. She testified that given the mechanism of the injury, the sudden onset of her pain and the signs and symptoms Petitioner exhibited it is my opinion that she developed this cervical herniated disc directly as a result of the injury. She also opined that given Petitioner's advanced age and the multiple limitations in her range of motion and various joints, she I does not believe that Petitioner is employable. Her opinion is based on Petitioner's history and especially the clinical examination in which Petitioner exhibited pain and limitations in range of motion. Her opinion of employability also included her prior injuries and disabilities. She had surgeries performed on her left shoulder and left knee and she still had limitations in range of motion from the prior injured which would limit her ability to perform her work as a truck driver. Petitioner's myofascial pain diagnosis comes from Petitioner's report as well as her experience with other patients and Petitioner in the past. She agreed that Petitioner's myofascial pain came after her fusion surgery Dr. Palacci stated she does not have any training in vocational rehabilitation, job placement or job skills. Rather, she goes by the job duties someone tells her about and based on her assessment on the physical examination. In terms of her permanent total assessment she factored on Petitioner's left shoulder, left knee and lumbar spine conditions as well.

25. Petitioner testified she has not been released to return to work and has not returned to work since her cervical surgery. She denies being released to return to work in March of 2013. Petitioner testified that currently it is difficult to raise her arm, turn her neck or sit too long due to the pain. She has pain running down her neck, back and arm. Parts of her ring and pinky fingers are still numb. She cannot bend over as much. She lives with her daughter and her daughter helps her zip her clothes and comb her hair. She tries to independently stand. She cooks her own food, but she cannot stand up too long to do that task. So her daughter cooks for her before she goes to work. She tries to help with laundry but she feels pain in her neck and down her shoulder when she bends over, picks up clothes and puts the clothes into the machine. She does not sleep well at night because of the pain. She tried to do the exercises shown to her by the physical therapist. She does not take the medication because it makes her sleepy. She uses home remedies and rubs her injured body parts with alcohol.

Based on the above, the Commission reverses the Arbitrator's findings and finds Petitioner's cervical condition is causally related to the January 13, 2011 work accident. While Petitioner did not initially report an injury to her cervical area, within a period of two weeks Petitioner first started complaining of pain along her neck in the same general area of and on the same side as the left shoulder injury. It appears from the records that the initial focus of treatment was placed on Petitioner left shoulder as a result of Petitioner's prior left shoulder history and it was only shortly thereafter that Petitioner's cervical condition was noted and medical care was administered. Likewise, Petitioner's and Respondent's evaluation doctors both expressed a positive causation opinion in regard to the cervical condition. As such, the Commission finds that the Arbitrator's finding are reversed and the Commission finds that Petitioner's cervical as well as her left shoulder condition are causally related to the January 13, 2011 work accident.

Based on the finding of causal connection in relationship to Petitioner's cervical and left shoulder conditions, the Commission reverses the Arbitrator's medical finding and awards $48,316.20 in medical expense per Petitioner's PX18 and according to the fee schedule. Furthermore, based on the evidence in the record, the Commission modifies the Arbitrator's decision and awards temporary total disability benefits from January 14, 2011 through June 19, 2012, when Dr. Phillips provided Petitioner with a release to work slip indicating Petitioner could return to sedentary work with restrictions of lifting no more than ten pounds and no over the shoulder work. The Commission finds that the same release was reiterated again approximately two months later on August 30, 2012 as well.

Based on the evidence, the Commission finds that the evidence shows that Petitioner was released to return to work. The Commission further finds Petitioner's left shoulder condition stabilized shortly after the January 13, 2011 accident. Petitioner's cervical condition stabilized post surgery as evidence by Dr. Phillips' releases to return to sedentary work. The Commission notes that even prior to the January 13, 2011 work

14IWCC0938

accident Petitioner was working in a light duty capacity and reported that she was having trouble dressing herself and standing/walking for long periods of time. The Commission further finds that Respondent provided evidence via a labor market survey report that jobs were available to Petitioner within her restriction. While both Drs. Salehi and Palacci agree that Petitioner cannot return to work as a truck driver, both Drs. Phillips and Salehi agreed that Petitioner can return to either light duty or sedentary work. The Commission finds that Dr. Palacci's opinion that it is unlikely that Petitioner could return to work is too speculative in nature.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $806.02 per week for a period of 74-4/7 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 $48,316.20 for medical expenses under §8(a) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $725.42 per week for a period of 150 weeks, as provided in §8(d)2 of the Act, for the reason that the injuries sustained caused the 30% loss of a man as a whole.

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

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent is entitled to a credit in the amount of $87,848.80 for payment of temporary total disability benefits and is entitled to a credit of $2,991.75 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.

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

DATED: NOV 03 2014

Mario Basurto

David L. Gore

Stephen Mathis

O: 9/4/14

MB/jm

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

Franklin Wade,
Petitioner,

vs.

NO: 10 WC 12952

14IWCC0939

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 accident, causation, medical expenses and permanent disability and being advised of the facts and law, modifies the Decision of the Arbitrator as stated below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

The Commission finds that the Arbitrator erred in finding Petitioner's temporary total disability rate is $121.44 and that the correct rate is $850.07. The Commission further infers, contrary to the Arbitrator, that Petitioner's truck was parked on the street and not in the McDonald's parking lot. The Commission finds that as a result of the January 21, 2010 accident Petitioner incurred the cervical and thoracic strains along with left shoulder, back and chest pains. Lastly, the Commission views the amount of permanency differently than the Arbitrator and finds Petitioner is permanently disabled to the extent of 2% man as a whole under Section 8(d)2 of the Act.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $850.07 per week for a period of 1/7th 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 $7,656.00 for medical expenses under §8(a) of the Act.

14IWCC0939

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $664.72 per week for a period of 10 weeks, as provided in §8(d)2 of the Act, for the reason that the injuries sustained caused the 2% loss of a man as a whole.

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

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent is entitled to a credit in the amount of $3,486.54 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.

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

DATED: NOV 03 2014

O: 9/4/14

MB/jm

43

Mario Basurto

David L. Gore

Stephen Mathis

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

WADE, FRANKLIN
Employee/Petitioner

Case# **10WC012952**

14IWCC0939

CITY OF CHICAGO
Employer/Respondent

On 10/9/2013, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

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

3275 KEDZIE LAW OFFICES PC
MICHAEL KEDZIE
39 S LASALLE ST SUITE 811
CHICAGO, IL 60603

0010 CITY OF CHICAGO
MICHELLE BRYANT
30 N LASALLE ST SUITE 800
CHICAGO, IL 60602

14IWCC0939

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

Franklin Wade
Employee/Petitioner
v.
City of Chicago
Employer/Respondent

Case # **10** WC **12952**

An *Application for Adjustment 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 **August 1, 2013 and August 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

On **January 21, 2010**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$66,305.47**; the average weekly wage was **$1,275.11**.

On the date of accident, Petitioner was **67** years of age, *married* with **0** dependent children.

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

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

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

Respondent is entitled to a credit of **$3486.54** under Section 8(j) of the Act.

ORDER

Respondent shall pay Petitioner temporary total disability benefits of **$121.44**./week for **1/7th** weeks, for **January 26, 2010**, as provided in Section 8(b) of the Act.

Respondent shall pay **$7656.00** for medical services incurred at Trinity Hospital, as provided in Section 8(a) of the Act. Respondent is to hold Petitioner harmless for any claims for reimbursement from any health insurance provider and shall provide payment information to Petitioner relative to any credit due. Respondent is to pay unpaid balances with regard to said medical expenses directly to Petitioner. Respondent shall pay any unpaid, related medical expenses according to the fee schedule and shall provide documentation with regard to said fee schedule payment calculations to petitioner.

Respondent shall be given a credit of **$3486.54** for medical benefits that have been paid, and Respondent shall hold petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act.

Respondent shall pay Petitioner permanent partial disability benefits of **$664.72** /week for **15** weeks, because the injuries sustained caused the **3 %** 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

October 9, 2013
Date

OCT 9- 2013

FACTS

Petitioner is a motor truck driver for the City of Chicago Bureau of Forestry. His daily routine is to drive tree trimming equipment from one location to another on the city streets. He spends his day in the truck, driving a vehicle that pulls a machine which pulverizes tree branches which have been trimmed from various trees around the City. He is required to eat and use restrooms on the road wherever he may find them, and often stops at fast food locations for food or bathroom breaks.

On the date of the accident, January 21, 2010 at approximately 7:00 a.m. he had radioed in to his dispatcher that he was taking a personal bathroom break and had stopped at a local McDonald's to use the bathroom. After using the bathroom he was returning to his truck in the parking lot when he slipped on ice and fell, injuring himself in the McDonald's parking lot. He radioed his supervisor who came to the location and drove him to Mercyworks on Ashland Avenue in Chicago. He was seen by Dr. Joseph Mejia, who noted that the patient told him slipped on ice and fell on his left side and was complaining of neck pain and thoracic spine pain. The pain rated a level of 8 or 9 out of 10. There was tenderness over the left rib cage and left hip all the way up to the left shoulder. The cervical spine had limited range of motion with tenderness in the paravertebral muscles. Dr. Mejia diagnosed cervical spine and thoracic spine strain, prescribed medication, and authorized him off work to return to the clinic the following day. Petitioner returned the following day which was Friday and had similar symptoms and was told to return on January 25, 2010. Petitioner returned on January 25, 2010 and was seen by Dr. Diadula, who examined him, recommended medication, recommended home exercise, and released him to full duty as of January 27, 2010.

On the night of the incident, January 21, 2010 after he had gone home, Petitioner experienced chest and left shoulder pains. Petitioner had undergone open heart surgery in 2008. He was concerned about heart pain and the surgical site, so he went to the emergency room at Trinity Hospital. At Trinity Hospital he was examined,

tested, and eventually released. The records at Trinity Hospital indicate that the chief complaint was that the patient slipped on ice and fell on the left side. He was complaining of chest pain often on for a few days and it got worse after his fall. The EKG did show some changes and he was further evaluated in the emergency room. He was discharged at 1:15 p.m. on January 22, 2010.

Petitioner's total charges for treatment at Trinity hospital was $7,595.00, Petitioner paid 10%, and his health insurance paid a portion of the bill.

ACCIDENT

Petitioner was injured while returning to his vehicle from a bathroom break. Petitioner is a traveling employee, and it was known that he would take bathroom breaks. Petitioner radioed his dispatcher that he would be taking the bathroom break. Petitioner wrote the appropriate code for a bathroom break, 10 – 7, when he wrote the report at Mercy Works.

Even if Petitioner were not a traveling employee, he would be entitled to compensation pursuant to the personal comfort doctrine.

Based upon the foregoing, Petitioner sustained an accident that arose out of and in the course of employment.

CAUSATION

Petitioner's credible testimony was corroborated by the medical records and was consistent with the sequence of events.

Therefore, Petitioner's current condition of ill being is causally related to the injury.

MEDICAL

Respondent's defense on this issue is premised upon accident and causation, which has been found to be in favor of Petitioner. Therefore, the claimed Trinity hospital medical expenses are found to be reasonable and necessary.

TEMPORARY TOTAL DISABILITY

Petitioner was authorized off of work by Dr. Mejia and Dr. Diadula from Thursday, January 21, 2010 through Tuesday, January 26, 2010 with the return to work on Wednesday, January 27, 2010. Taking into account the statutory three day waiting period as well as the intervening two day weekend, Petitioner is entitled to one day of temporary total disability benefits.

NATURE AND EXTENT

Based upon the testimonial and medical evidence, Petitioner has sustained 3% loss of the person as a whole.

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

Robert Davis,

Petitioner,

14IWCC0940

vs.

NO: 12 WC 26386

Mt. Vernon Glass Company,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of 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 January 30, 2014 is hereby affirmed and adopted.

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

14IWCC0940

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: NOV 0 3 2014

David L. Gore

Stephen J. Mathis

Mario Basurto

DLG/gaf
O: 10/22/14
45

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

DAVIS, ROBERT
Employee/Petitioner

Case# **12WC026386**

14IWCC0940

MT VERNON GLASS COMPANY
Employer/Respondent

On 1/30/2014, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

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

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

4317 BOGGS AVELLINO LACH & BOGGS LLC
LISA A REYNOLDS
7912 BONHOMME AVE SUITE 400
ST LOUIS, MO 63105-1912

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)

14IWCC0940

Robert Davis
Employee/Petitioner

v.

Mt. Vernon Glass Company
Employer/Respondent

Case # 12 WC 26386

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 N. Lee**, Arbitrator of the Commission, in the city of **Collinsville**, on **December 30, 2013**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

14IWCC0940

FINDINGS

On the date of accident, **August 8, 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 **$47,627.71**; the average weekly wage was **$992.24**.

On the date of accident, Petitioner was **56** 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 **$any medical paid** under Section 8(j) of the Act.

ORDER

Respondent shall pay the reasonable and necessary medical expenses totaling **$81,702.48**, as outlined in Petitioner's group exhibit. Respondent shall have credit for any medical expenses previously paid, but shall hold Petitioner harmless from any claims made by any healthcare provider for which it is receiving this credit, pursuant to §8(j) of the Act.

Respondent shall authorize the treatment recommended by Dr. Gornet, including but not limited to further 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.

Edward Lee
Signature of Arbitrator

1/27/14
Date

ICArbDec19(b)

JAN 30 2014

FACTS

At the time of the injury, Petitioner was a 56-year-old glass glazier, or glass installation technician, for Respondent. (T.10-11; AX1). The Parties stipulated that on August 8, 2011, Petitioner sustained accidental injuries to his back while lifting a 100 lb. solid piece of glass. (T.11; AX1). Causal connection is likewise undisputed. (AX1). Respondent disputes Petitioner's indicated wage and that Petitioner requires prospective medical care. (AX1).

Petitioner testified that he had back surgery in 1998 from which he had fully recovered. (T.11). Petitioner was working full-duty without restrictions at the time of his August 8, 2011 injury. (T.11). Following the August 8th accident, Petitioner lost control of his right foot and leg, began taking narcotic pain medication, and began receiving injections. (T.12-13; PX4, 8/12/11; PX5). A CT Myelogram done on September 6, 2011, showed disc bulging at L2-3 with circumferential spinal stenosis, extradural defect upon the thecal sac secondary to disc bulging at L3-4 producing moderate to severe circumferential spinal stenosis, disc bulging at L4-5, and disc space narrowing at L5-S1. (PX6, 9/6/11). After failing extensive conservative treatment, including physical therapy, medication and injections, Petitioner saw Dr. Brett Weinzapfel, who ultimately discussed hardware removal at L5-S1 and L3 to sacrum laminectomy and fusion with Petitioner. (PX3; PX4; PX5; PX7, 5/7/12, 6/4/12).

Respondent had Petitioner examined by Dr. Rhoderic Mirkin on May 21, 2012. (PX13). Dr. Mirkin noted that Petitioner was unable to work since his August 8th injury and that Petitioner's physician was recommending surgery. *Id.* After reviewing Petitioner's radiographs. Dr. Mirkin noted that Petitioner's stenosis was most severe at L3-4, adjacent to his fusion at L5-S1 with pedicle screw instrumentation shown on x-ray. *Id.* He noted that Petitioner's surgical options included a decompression and fusion at L3-4 and L4-5 with removal of the instrumentation at L4-5. *Id.* After noting that Petitioner's work injury aggravated his low back condition, he stated that Petitioner would only be at maximum medical improvement if he did not have surgery. *Id.*

Petitioner subsequently sought treatment with Dr. Matthew Gornet on August 23, 2012. (PX8, 8/23/12). Dr. Gornet noted Petitioner's course of conservative treatment, which failed to improve his symptoms, and reviewed Petitioner's CT myelogram. *Id.* Dr. Gornet reviewed the actual films of Petitioner's myelogram, and noted that the plain films were suggestive of a broken screw at S1 and broken hardware. *Id.* He further noted that Petitioner had significant facet changes at L4-5 and central disc herniation resulting in significant stenosis. *Id.* Dr. Gornet believed that Petitioner's hardware caused significant artifact based on Petitioner's medical reports, and that Petitioner's facet condition at L4-5 was aggravated by his work accident. *Id.* Based upon these findings, Dr. Gornet recommended surgery at follows:

> *My first recommendation would be hardware removal . . . This will allow us to assess whether there is any continued pathology at the L5-S1 level. . . An*

> ***absolute requirement would be treating with spinal fusion at L4-5.*** *His disc pathology at L3-4 appears to be potentially amenable to a disc replacement: but again, his facet joints will have to be assessed as well as other perimeters* [sic] . . . *Id.*

Dr. Gornet restricted Petitioner to a 25 lb. lifting limit with no repetitive bending or living, and instructed him to alternate between sitting and standing. *Id.*

When Petitioner returned with additional films and his previous operative notes, Dr. Gornet formed a working diagnosis of irritation of pre-existing condition of facet joints at L4-5, aggravation of a previously asymptomatic failed fusion at L5-S1 with now broken hardware, and potential disc-related pain at L3-4. (PX8, 10/4/12). Following hardware removal, Dr. Gornet would assess whether Petitioner required a two-level fusion at L3-4 and L4-5 with revision at L5-S1, or whether Petitioner would require fusion with disc replacement. *Id.*

Respondent took the deposition of its examiner, Dr. Mirkin, on December 28, 2012. (RX15). Dr. Mirkin testified that while he was unable to appreciate any fractured screws or broken hardware on Petitioner's imaging studies done in his office. *Id.* at 10. However, he stated that if found during surgery, "you deal with it when you find it." *Id.* at 16. He did not dispute that Petitioner required surgical intervention, only that he believed it should be done in one procedure. *Id.* at 14.

On the same day, Respondent also took the deposition of a Dr. Gary Shapiro, who performed a claims evaluation in reference to Petitioner. (RX17, p.5). Dr. Shapiro agreed that Petitioner was a surgical candidate. *Id.* at 11. However, based on the Occupational Disability Guidelines (ODG) provided to him by his employer, he did not approve the staged intervention recommended by Dr. Gornet. (RX17, p.11, 20; Exhibit 2 [Report]). His primary concern seemed to be the cost of performing the stated procedure. *Id.* at 13-14. On cross-examination, Dr. Shapiro conceded that he had no specific knowledge of the ODG other than what was included in his report. *Id.* at 18. He testified that he did not know who promulgates or publishes the guidelines, and was completely unaware that its publishers were funded by insurance companies. *Id.* at 19-20. When asked why he would so heavily reference something he possessed so little knowledge of his report, he replied, "That's a good question. The – you know, many of these things are provided through Claims Eval." *Id.* at 20. He also did not dispute that Petitioner required surgery, only the method and intervention employed. *Id.* at 20.

On March 14, 2013, Dr. Gornet issued a letter in response to the Claims Evaluation done by Dr. Shapiro. (PX8, 3/14/13). Dr. Gornet explained that the ODG guidelines relied upon in Dr. Shapiro's report were not "standards of care," were in fact disputed by most practicing spinal surgeons, and were not considered authoritative by any medical societies who provide the indicated care. *Id.* He explained that while formerly serving as a contributing editor, he suffered an ethical dilemma when current standards of care were often not into the treatment guidelines.

which compelled him to resign his commission. *Id.* He further stated that the ODG is a for-profit company whose medical literature is "cherry picked" to facilitate conclusions within the body of the guideline itself; and for that reason, the guidelines were not accepted by the North American Spine Society, the largest spinal organization in the world, as well as the Academy of Orthopedic Surgery and the Academy of Neurosurgeons. *Id.* He stated, "In short, no large medical society considers these guidelines authoritative. *Id.*

With regard to the necessity of Petitioner's hardware being removed in a staged fashion, Dr. Gornet stated that Petitioner's fusion incorporated an older form of stainless steel metallic implants that obscured the ability to visualize any pathology present in his spine. *Id.* Hence, he would first remove the hardware to better understand Petitioner's clinical situation and render the proper reasonable and appropriate medical treatment. *Id.* He stated:

> *No surgeon enters the operative theater without a definitive plan. Given the fact that our visualization of his lumbar spine is obscured by his metallic implants, our plan to remove the hardware first to allow us to better understand the clinical situation in Mr. Davis is only reasonable and appropriate. Id.*

On March 12, 2013, Petitioner had the hardware removed from his spine. (PX9). The interoperative report detailed that the left S1 screw was completely broken with a portion unable to be removed from the bone on the left. *Id.* Petitioner's screw holes were sealed with bone wax and Surgicel. *Id.* Dr. Gornet noted that the procedure was significantly more difficult due to bony growth and complex scarring. *Id.* Dr. Gornet followed through with his plan to reimage Petitioner's spine following surgery. (PX11).

Petitioner's CT Myelogram and MRI on May 9, 2013 showed broad based disc protrusions and/or herniations at L3-4, L4-5 and L5-S1 with associated severe foraminal encroachment and spinal canal stenosis, with annular tears at L3-L5. (PX11; PX12). Dr. Gornet reviewed Petitioner's studies, noted the significant disc pathology at L3-4 and L4-5. (PX8, 5/9/13). Based upon Petitioner's pathology and severe facet arthropathy, Dr. Gornet believed that Petitioner would require fusion at L4-5 and possibly disc replacement at L3-4. *Id.* Dr. Gornet expressed satisfaction and relief that with proper imaging studies, he was able to determine that Petitioner had a solid fusion at L5-S1 and would not require surgery at that level. *Id.* This was not clearly seen on Petitioner's prior imaging studies. *Id.* He stated that the staged procedure saved Petitioner the expense and morbidity of receiving a spinal fusion at L5-S1. *Id.*

Dr. Gornet testified by way of deposition on August 12, 2013. (PX15). He stated that while he noted the structural issues at L3-4 and L4-5, he was also greatly concerned about Petitioner's L5-S1 level due to the fact that broken hardware is a significant indicator of failed fusion. *Id.* at 9-10. He testified that the hardware placed in Petitioner's spine in the 1990s was stainless steel and created significant artifact, which obscured his ability to visualize the level

and adequately determine whether or not Petitioner had a problem at that level. *Id.* at 10-11. He explained that this necessitated staged removal:

> *If indeed you have a situation like that, you would not want to be in a situation where you can't adequately determine whether there's a problem or not. So for instance, at least from what I could detail, Dr. Mirkin's report doesn't mention broken hardware in the lumbar spine. The previous studies did not mention broken hardware in the lumbar spine, but yet we found interoperatively broken hardware in his lumbar spine. So that's a perfect illustration of why he needed a staged hardware removal, just because even a surgeon like Dr. Mirkin or a qualified radiologist cannot accurately identify the pathology on the medical record because the date is obscured. Id.* at 10-11.

He testified that surgical intervention performed in the fashion recommended by Dr. Mirkin would have been detrimental to Petitioner:

> *. . . In the current fashion, the way it was described by Dr. Mirkin, hardware would have been removed at the time of the definitive surgery. At that point in time, Dr. Mirkin would have found a broken screw at L5-S1, and based on normal standard practice, he would have made an assumption that L5-S1 was not healed because the hardware was broken. That would have resulted in Mr. Davis having further surgery at L5-S1 when we know now with clear imaging studies that he had actually gone on to heal at that level in spite of the fact we couldn't tell that on the original studies because of the artifact. Id.* at 12.

For that reason, he stated the staged procedure was absolutely necessary:

> *It was absolutely necessary. Had you done anything less than that, what you would have done is cause Mr. Davis to have a surgery that was unneeded and unwarranted and therefore potentially changed his outcome, because the only thing you would be able to see at the time of surgery is broken hardware. The assumption has to be made that if he has broken hardware he has failed fusion. Again, our plan was very definitive. It was quite clear. We have used this plan before. It's the appropriate plan. Essentially, at that point, we had fallback because we wanted to analyze him more fully before we did a large, definitive procedure which obviously had the potential to alter his life one way or another. Id.* at 12-13.

Dr. Gornet testified that since it was absolutely medically necessary for him to perform surgery in a staged fashion, he proceeded with the hardware removal on March 12, 2013. *Id.* at 14.

Dr. Gornet testified that he considered the option of a disc replacement versus fusion in Petitioner's case because disc replacement would be more beneficial than creating a three-level spinal fusion, giving Petitioner a better long-term outcome and higher level of function. *Id.* at 17. Dr. Gornet testified that he received approval to perform surgery, but not in the staged fashion which Petitioner required. *Id.* at 22. He testified, however, that performing surgery in the recommended procedural fashion is both more cost effective and less hazardous in terms of risk for Petitioner. *Id.* at 22-26. With regard to cost, he stated:

> *Well, the reason that the insurance company would want that done, obviously, is it's less expensive because you're saving one anesthesia cost and one cost of hardware removal. That being said, in the overall scheme of things, that money that is generated as part of that separate procedure is actually going to be saved now because L5-S1 is not going to be treated, and so overall the insurance company has actually saved money by us defining the procedure more appropriately than they would have had we done it all at the same time.* *Id.* at 23.

With regard to the risk of infection to Petitioner and other hazards, he testified as follows:

> *Q: Is it true that by doing once procedure versus three that there are also benefits in terms of reducing risk to the patient?*
>
> *A: No. It's actually the opposite. What we've determined is – and again, I would call [it] a staged procedure with one episode of care just a second procedure, but suffice it to say that doing one long procedure increases your risk of post-operative infection because time in the OR has the strongest correlation with infection. Number two, it has the strongest correlation with other complications such as blood clots, pneumonia, and other potential issues. So in our experience – and we actually evaluate and categorize all of these surgeries – the complication rate is lower in the fashion that we recommended it be performed. Id. at 23-24.*

He testified that while there is some risk associated with each stage, the aggregated risk is far less than that of the risk associated with one long procedure. *Id.* at 24-26.

Dr. Gornet testified that the surgery fees for the required procedure would be the same, regardless of the staged fashion in which the procedure is performed. *Id.* at 29-31.

Dr. Gornet also testified that one could not have examined Petitioner's spine interoperatively and determined whether or not Petitioner's L5-S1 level fusion would require revision due to the intensity of Petitioner's scar tissue without literally pulling Petitioner's back apart. *Id.* at 26-27. He further stated that the CT scan is much more accurate at identifying failed fusion than interoperative exploration. *Id.* at 27.

Dr. Mirkin re-examined Petitioner and issued a supplemental report at the request of Respondent, and testified again by way of deposition on September 18, 2013. (RX16). He believed that Petitioner's condition had improved and that he was "relatively normal" after removal of his broken hardware without redress of his pathology at L3-4 and L4-5. *Id.* at 21-22. He previously recommended fusion at L3-4 and L4-5 based on that same pathology. *Id.* at 42. On cross-examination, however, he testified that he was not even aware of whether or not Petitioner was able to return to work. *Id.* at 29-30. He also acknowledged that Petitioner's stainless steel hardware created artifact that blurs the radiograph picture of the spine. *Id.* at 39. He declined to answer the question of whether or not that scar tissue would obscure interoperative findings and instead commented on Petitioner's hardware removal. *Id.* at 38-39.

When questioned regarding his recommendation of a solid fusion versus disc replacement, Dr. Mirkin conceded that there are drawbacks to having three consecutive levels of solid fusion in the spine, including arthritis above and below the fusion and stiffness. *Id.* at 43. He acknowledged that Dr. Gornet considered disc replacement in order to increase Petitioner's range of motion and level of function. *Id.* at 42-43.

Dr. Mirkin testified on cross-examination that he performs six independent medical examinations per week, and that 80% of his workers' compensation examinations are performed for employers or insurance companies. *Id.* at 24-25. He charges $900 per examination and $1,400 for depositions. *Id.* at 25.

Dr. Gornet testified during his deposition that Dr. Mirkin's opinion that Petitioner "improved" with a simple hardware removal is illogical and inconsistent with the facts of Petitioner's case. (PX15, p.19). He testified that when he sees Petitioner during office visits, what Petitioner tells him about his quality of life and his symptoms is completely different from what Dr. Mirkin states in his report. *Id.* at 19. He testified that Petitioner is not functioning normally, as he has not been able to return to work. *Id.* at 19. He further noted that since Dr. Mirkin originally felt that Petitioner was a candidate for surgery based on his pathology, his opinion that Petitioner has improved with hardware removal only and no action to improve Petitioner's condition is enigmatic. *Id.* at 19-21. He testified that he found it even more curious that Dr. Mirkin recommended no further surgery on a patient in whom there was determined to be broken hardware without seeing the subsequent radiographic studies, while stating that he would "certainly be interested to see the radiographic studies." *Id.* at 20-21. Dr. Gornet stated in his final note that he would move forward with a two-level fusion as planned. (PX8, 11/4/13).

Petitioner testified at Arbitration that the hardware removal did not improve his condition in any way and that "nothing has been fixed." (T.14). He continues to experience problems symptoms of constant soreness in his back and legs, and has been unable to find work within his restrictions. (T.14-15). He wishes to undergo surgery to relieve his pain and the numbness in his legs and return to work. (T.16-17, 37).

G: What were Petitioner's earnings?

The Act provides in relevant part of §10 that, "The compensation shall be computed on the bases of the 'average weekly wage' which shall mean the actual earnings of the employee in the employment in which he was working at the time of the injury during the period of 52 weeks ending with the last day of the employee's last full pay period immediately preceding the date of injury, illness or disablement excluding overtime, and bonus divided by 52; but if the injured employee lost 5 or more calendar days during such period, whether or not in the same week, then the earnings for the remainder of such 52 weeks shall be divided by the number of weeks and parts thereof remaining after the time so lost has been deducted." 820 ILCS 305/10.

Respondent submitted a wage statement documenting Petitioner's earnings in the 52 weeks prior to his injury. (RX1). This showed Petitioner's wage calculable under the Act to be $47,627.71 in the year preceding the injury, and that Petitioner worked a total of 48 weeks. Based upon the foregoing, the Arbitrator finds Petitioner's average weekly wage to be $992.24.

J: Were the 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?

O: Has Petitioner reached maximum medical improvement?

The right to be compensated for medical costs associated with work-related injuries is at the very heart of the Workers' Compensation Act. *Hagene v. Derek Polling Construction*, 902 N.E.2d 1269 (5th Dist. 2009). An employer's liability to provide the necessary medical care contemplated by Section 8(a) of the Illinois Workers' Compensation Act is continuous as long as the care is reasonably required to relieve the injured employee from the effects of the injury. 820 ILCS 305/8(a) (2011). The claimant is entitled to recover reasonable medical expenses that are causally related to the accident and that are required to diagnose, relieve, or cure the effects of claimant's injury. *F & B Mfg. Co. v. Indus. Comm'n*, 758 N.E.2d 18 (1st Dist. 2001). The provisions relating to medical care are unlimited in time under the doctrine set forth in *Efengee Elec. Supply Co. v. Indus. Comm'n*, 223 N.E.2d 135 (1967).

At the outset of Petitioner's treatment, all physicians; namely both of Petitioner's treating physicians, as well as Respondent's examiner, Dr. Mirkin, and its claims evaluator, Dr. Shapiro; agreed that he was a surgical candidate, although disagreeing as to the fashion in which it should be performed. (PX7, 5/7/12, 6/4/12; PX8, 8/23/12; RX15, p.14; RX17, p.11). Petitioner's imaging studies showed broad based disc protrusions and/or herniations at L3-4, L4-5 and L5-S1 with associated severe foraminal encroachment and spinal canal stenosis, with annular tears at

L3-L5. (PX11; PX12). As a result of his spinal condition, Petitioner has been unable to return to work. (T.14-15; PX8, 12/12/13). Based upon the foregoing, the Arbitrator does not find Dr. Mirkin's opinion that Petitioner improved after his hardware was removed and does not require any further treatment to be persuasive. Petitioner testified at Arbitration that the hardware removal did not improve his condition in any way and that "nothing has been fixed." (T.14). Petitioner has clearly not reached maximum medical improvement and has not yet received all necessary medical care required to relieve him of the effects of his injury.

With regard to the reasonableness and necessity of Petitioner's prospective medical care, the Arbitrator gives great deference to his treating physician, Dr. Gornet, who was able to map the terrain in which he would be deployed in reference to Petitioner's spine, and took great care in making sure that he obtained clear imaging studies to avoid any unnecessary surgical intervention in Petitioner's spine and reduce the risk of infection or complications for Petitioner. (PX15, 9-14, 22-27). Dr. Gornet also testified that his method of intervention was also cost effective, as it saved Respondent the expense of an operation at a level in which Petitioner did not require treatment. *Id.* at 22-23, 29-31. Logically, this would also reduce the duration and expense of the subsequent recovery. Petitioner wishes to undergo surgery to relieve his pain and the numbness in his legs and return to work. (T.16-17, 37).

Based upon the foregoing, the Arbitrator hereby orders Respondent to pay the reasonable and necessary medical expenses outlined in Petitioner's group exhibit and shall authorize the treatment recommended by Dr. Gornet, including but not limited to further surgery. Respondent shall have credit for the medical expenses previously paid, but shall hold Petitioner harmless from any claims made by any healthcare provider for which it is receiving this credit, pursuant to §8(j) of the Act.

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

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

BRYON KAWA,

Petitioner,

14IWCC0941

vs.

NO: 07 WC 23805

FORD MOTOR COMPANY,

Respondent.

DECISION AND OPINION ON REMAND

This matter had previously been heard and the Decision of the Arbitrator had been filed October 26, 2010. 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 of ill being. On appeal the Circuit Court affirmed. Petitioner then appealed to the Appellate Court, which remanded the case to the Commission to modify the Decision as follows:

FACTUAL BACKGROUND

Following a stipulated work-related motor vehicle accident on February 13, 2007, Petitioner suffered injuries to his neck, chest, right shoulder, low back and right knee. He received conservative treatment and eventually underwent right shoulder surgery for a separated shoulder on May 10, 2007.

Following the surgery, Petitioner underwent physical therapy and pain management, but continued complaining of severe pain and loss of range of motion in his shoulder. On June 15, 2007 an MRI revealed small joint effusion in his right knee. Physical therapy notes in July 2007 revealed Petitioner was progressing slowly with respect to his shoulder and knee.

In September 2007 a lumbar MRI revealed mild degenerative changes in the lower spine but no spinal canal or neuroforaminal stenosis. Physical therapy was prescribed.

After two additional months of pain complaints, in November 2007 an IME physician (Dr. Rhode) noted a significant psychological component to Petitioner's shoulder condition that required attention. Dr. Rhode recommended continued aggressive physical therapy with respect to the right shoulder and a multidisciplinary approach with respect to the lumbar spine.

In December 2007 Dr. Koh, Petitioner's treating physician, met with a vocational rehabilitation consultant. They determined that a comprehensive pain evaluation complete with a psychological evaluation was in order. Dr. Koh recommended Petitioner undergo this with the Rehabilitation Institute of Chicago (RIC). They have a multidisciplinary program. This recommendation was approved by the employer.

On February 25, 2008 Petitioner was interviewed at RIC by various doctors and vocational specialists. A report indicated that his pain problem appeared to be affected by psychological factors that could be addressed with psychological intervention. Petitioner indicated that he was not comfortable treating with RIC because he did not like the topics he was questioned about during the evaluation. He was also not fond of having to drive to Chicago everyday from Indiana to attend the program, despite the fact that the employer agreed to furnish Petitioner with lodging nearby RIC. Petitioner never participated in the program.

Dr. Koh recommended another program at St. Margaret Mercy Hospital in Northwest Indiana. The vocational rehabilitation consultant stated that the program was not multidisciplinary in nature, but rather anesthesiology-based. Due to this fact, Respondent did not approve this program.

Nevertheless, Petitioner began treating at St. Margaret in September 2008 with Dr. Kanakamedala. By April 2009, Dr. Kanakamedala reported that Petitioner's pain was being managed by Norco and Celebrex and had reduced his pain by 70%. Dr. Kanakamedala also recommended chiropractic treatment.

DECISION ON REMAND

Based on the Appellate Court's instructions, Petitioner's current condition of ill-being is causally related to the accident in question. In keeping with this ruling, the Commission finds that the evidence establishes that the onset of Petitioner's conditions began no sooner than his work-related accident, and nothing in the record broke the chain of events prior to arbitration.

Regarding temporary total disability (TTD) benefits, the Appellate Court found that Petitioner's refusal to participate in the RIC program is no basis for the denial of TTD benefits. This is the only program Petitioner declined to participate in, and the employer failed to suggest or approve any other multidisciplinary program despite Dr. Koh's recommendation that an alternative program be considered.

Despite an early June 2008 letter from Respondent to Petitioner indicating that Respondent had the ability to accommodate Petitioner's work restrictions, no formal job offer was ever made. Thus, since Petitioner was still suffering from accident-related symptoms at that time, benefits were incorrectly terminated by the Arbitrator on February 25, 2008.

There is no evidence that there has been any change in Petitioner's symptoms from February 25, 2008 through the §19(b) arbitration hearing date of October 5, 2009, thus TTD benefits should have remained payable through this date, at a rate of $776.16 per week.

14IWCC0941

The Appellate Court effectively found that all medical expenses related to Petitioner's neck, chest, right shoulder, low back and right knee injuries subsequent to February 25, 2008 were reasonable and necessary. This includes any expenses related to the treatment program at St. Margaret Mercy Hospital, including chiropractic treatments.

The Appellate Court remanded the case to the Commission for a determination on the issues of vocational rehabilitation and maintenance benefits. This after the Appellate Court determined that Petitioner is in fact entitled to said benefits.

After reviewing the evidence, the Commission finds that it is unclear when or if Petitioner completed the pain program at St. Margaret Mercy Hospital. Thus it is unclear what his physical condition was at that time. However, in keeping with the Appellate Courts order to determine Petitioner's vocational rehabilitation and maintenance benefits, the Commission remands the case to the Arbitrator for a determination on these issues and any other outstanding issues subsequent to October 5, 2009.

The denial of penalties and fees and the wage calculation are affirmed.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $776.16 per week through the Arbitration hearing date of October 5, 2009, that being the period of temporary total incapacity for work under §8(b) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of all medical expenses related to his accidental injuries.

IT IS FURTHER ORDERED BY THE COMMISSION that this case be remanded to the Arbitrator for a determination on vocational rehabilitation and maintenance benefits.

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 his accidental injury.

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $200.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: NOV 0 3 2014
O: 3/6/14
DLG/wde
45

David L. Gore

Mario Basurto

Stephen J. Mathis

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

TIMOTHY BUSH,

Petitioner,

vs.

14IWCC0942

NO: 08 WC 44502
12 WC 21131

THYSSEN KRUPP ELEVATOR CORP.,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the Order of the Arbitrator granted August 9, 2013, and being advised of the facts and law, affirms and adopts the Order of the Arbitrator, which is attached hereto and made a part hereof.

After reviewing the procedural history of this case, the Commission affirms and adopts the Arbitrator's August 9, 2013 Order granting Respondent's Motion to Set Aside the April 16, 2013 Order. The Commission finds that there was no abuse of discretion by the Arbitrator, as the April 16, 2013 Order was based on the misrepresentations made by Petitioner's Counsel in the 12 WC 21131 case.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Order of the Arbitrator filed August 9, 2013 is hereby affirmed and adopted.

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:
O: 9/4/14
DLG/wde
45

NOV 0 3 2014

David L. Gore

Mario Basurto

Stephen Mathis

STATE OF ILLINOIS)
)
COUNTY OF COOK)

ILLINOIS WORKERS' COMPENSATION COMMISSION
ORDER

14IWCC0942

Timothy Bush
Employee/Petitioner

v.

ThyssenKrupp Elevator Corp.
Employer/Respondent

Case # 08 WC 44502, 12 WC 21131

This matter came before the undersigned Arbitrator pursuant to Respondent's Motion to Set Aside April 16, 2013 Order ("Respondent's Motion") on July 25, 2013. Events on April 16, 2013 involving Petitioner's counsel in Case No. 12 WC 21131 gave rise to Respondent's Motion.

The Commission's records reflect that Petitioner's cases were set for April 19, 2013 at the April status call. Petitioner's counsel in 12 WC 21131 appeared in court three days earlier on April 16, 2013. He was not accompanied by Respondent's counsel or Petitioner's counsel in 08 WC 45502. The undersigned Arbitrator entered an order on April 16, 2013 relative to Petitioner's "Motion to Substitute Petitioner" ("Petitioner's Motion") which sought to substitute the deceased injured worker as the party in interest with his widow. Based on Petitioner's counsel's representations on April 16, 2013 that there was no objection to his motion by either other attorney, the Arbitrator granted Petitioner's Motion.

On April 19, 2013, Respondent's counsel and Petitioner's counsel in Case No. 08 WC 45502 appeared in court; Petitioner's counsel in Case No. 12 WC 21131 did not appear in court. Respondent's counsel indicated that he did object to Petitioner's Motion. Respondent's Motion was filed in response to Petitioner's Motion and the events on April 16, 2013. Respondent's Motion was set at the July status call for a July 25, 2013 hearing date. Petitioner's counsel in both cases and Respondent's counsel were present together for a hearing on July 25, 2013. Petitioner's counsel in Case No. 12 WC 21131 filed a response to Respondent's Motion on August 5, 2013.

After due deliberations, I hereby ***GRANT*** Respondent's Motion to Set Aside the April 16, 2013 Order, ***STRIKE*** the April 16, 2013 order, and ***ORDER*** that any amended application for adjustment of claim filed by Petitioner pursuant his Motion to Substitute Petitioner or the April 16, 2013 order be stricken.

Arbitrator Barbara N. Flores

August 8, 2013
Date

AUG 9 - 2013

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 down	☐ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Richard Drobac,

Petitioner,

14IWCC0943

vs.

NO: 07 WC 29247
11 WC 14035

Harrah's Casino,

Respondent.

DECISION AND OPINION ON REVIEW

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

1. Petitioner was a Blackjack Dealer for Respondent. He has held this position since 1986. Respondent imposed a quota on him, where he had to deal between 650 and 700 hands per hour and shuffle the deck within a three-minute time period. He shuffled half a deck at a time until full decks were shuffled. While dealing, he also had to reach across his body with his right hand into the card "shoe" to pull out 2-3 cards for up to seven players at a time. Supervisors timed him with a stop watch.

2. On July 20, 2006 Petitioner visited Dr. Fakhouri with complaints of numbness and tingling in his right hand fingers. He was having problems dealing at work, and noticed he was dropping cards off of the table. The rule is that when a card is dropped, the dealer must take all the cards out of the shoe and re-count them. This slows up the game, which causes Respondent to lose money.

3. Dr. Fakhouri diagnosed Petitioner with carpal tunnel and performed a steroid injection, which was unsuccessful. Eventually he operated on Petitioner on December 8, 2006. This was the first of 3 surgeries. After the first surgery, Petitioner's numbness subsided temporarily but then returned.

4. Petitioner underwent a second carpal tunnel release on February 13, 2008. He returned to work July 24, 2008 but was unable to work in the high roller area because he could not work fast enough. He was placed in another area where the quota was only 500 hands per hour.

5. Petitioner resumed treatment for his wrist in March of 2009. At that time Dr. Chang restricted Petitioner's use of his right arm, the use of vibratory tools and the repetitive use of his right hand. In September 2009 Petitioner took 6 months off work to care for his wife, who eventually died of cancer on March 20, 2010.

6. Upon returning to work Petitioner developed problems in his left hand. He reported this to his supervisor and filed a new claim on November 8, 2010. He had not received any treatment at that point. 6 days later he was involved in a non work-related car accident.

7. Petitioner underwent a third surgery March 25, 2011. He has not returned to work since. He underwent an Independent Medical Evaluation (IME) on May 25, 2011 and was terminated June 17, 2011 due to his failure to return to work. In January 2012, Dr. Chang opined that the car accident in no way affected Petitioner's carpal tunnel.

8. On October 3, 2011 a Dr. Richter permanently restricted Petitioner from dealing.

9. Petitioner notices that his right hand has deteriorated. His finger numbness has returned and the back of his wrist feels brittle. The incision location is also painful, his hand is cold 90 percent of the time and he has no strength.

10. Petitioner has not looked for work since being terminated. He filed for unemployment against Respondent in 2011. He received benefits for 5 months. At that time a vocational evaluation determined that he was unable to work, thus he could not receive unemployment benefits any longer.

11. Petitioner is not currently treating for his back, neck or hands.

12. Ms. Keri Stafseth is a Rehabilitation Counselor for Vocamotive Inc. After interviewing Petitioner she learned that prior to working for Respondent, Petitioner had worked in hospital maintenance, construction, painting and had earned money investing in the stock market.

13. Petitioner reported that he could sit for 60 minutes prior to changing positions due to spine pain; he could stand for 60 minutes and walk for 75 minutes. He could drive a car for 30 minutes.

14IWCC0943

The Commission affirms the Arbitrator's rulings on the issues of accident, notice, causal connection, medical expenses and temporary total disability.

The Commission, however, reverses the Arbitrator's ruling on odd-lot permanent and total disablement. The Commission views the evidence slightly differently than the Arbitrator, noting Petitioner's previous work experience working in hospital maintenance, construction, painting and investing in the stock market. The Commission also notes that Petitioner has not looked for work since being terminated by Respondent. Based on this evidence, the Commission vacates the Arbitrator's odd-lot permanent and total disablement award, instead granting Petitioner a permanent partial disability (PPD) award based on his current hand complaints. The Commission awards Petitioner PPD benefits for a 65% loss of use of his person as a whole under §8(d)(2) of the Act.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $619.97 per week for a period of 325 weeks, as provided in §8(d)(2) of the Act, for the reason that the injuries sustained caused a 65% loss of use of his person as a whole.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent is liable for all medical expenses awarded by the Arbitrator under §8(a) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent is liable for all temporary total disability benefits awarded by the Arbitrator.

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: NOV 0 3 2014
O: 9/4/14
DLG/wde
45

David L. Gore

Mario Basurto

Stephen Mathis

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

14IWCC0943

DROBAC, RICHARD
Employee/Petitioner

Case# **07WC029247**

11WC014035

HARRAHS CASINO
Employer/Respondent

On 7/12/2013, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

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

1869 PRESBREY & ASSOC PC
KURT A NIERMANN
821 W GALENA BLVD
AURORA, IL 60506

1139 NOBLE & ASSOCIATES PC
DENNIS J NOBLE
1979 N MILL ST SUITE 200
NAPERVILLE, IL 60563

STATE OF ILLINOIS)
)SS.
COUNTY OF WILL)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

14IWCC0943

RICHARD DROBAC
Employee/Petitioner

v.

HARRAHS CASINO
Employer/Respondent

Case # 07 WC 29247

Consolidated cases: 11WC14035

An *Application for Adjustment 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 **3/18/2013**. 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. X What was the date of the accident?
E. ☒ Was timely notice of the accident given to Respondent?
F. ☐ Is Petitioner's current condition of ill-being causally related to the injury?
G. ☐ What were Petitioner's earnings?
H. ☐ What was Petitioner's age at the time of the accident?
I. ☐ What was Petitioner's marital status at the time of the accident?
J. ☒ Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. ☒ What temporary benefits are in dispute?
☐ TPD ☐ Maintenance ☒ TTD
L. ☐ What is the nature and extent of the injury?
M. ☐ Should penalties or fees be imposed upon Respondent?
N. ☐ Is Respondent due any credit?
O. ☒ Other **Permanent Total Disability**

FINDINGS

On **7/20/06**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$60,443**; the average weekly wage was **$1,162.36**.

On the date of accident, Petitioner was **51** 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

Respondent shall pay Petitioner temporary total disability benefits of $ 774.91/week for 84-2/7 weeks, commencing 12/8/06 through 3/6/07, 2/13/08 through 7/8/08, 3/25/11 through 3/12/12 as provided in Section 8(b) of the Act.

Respondent shall pay Petitioner the temporary total disability benefits that have accrued from 7/20/06 through 3/18/13, and shall pay the remainder of the award, if any, in weekly payments.

Respondent shall be given a credit of $ 23,556.59 for temporary total disability benefits that have been paid.

Respondent shall pay reasonable and necessary medical services, pursuant to the medical fee schedule, of $49,450 for treatment provided by Dr. Fakhouri, $5,057 for treatment from Tinley Woods Medical Center, and $10,321 for treatment from Novacare, as provided in Sections 8(a) and 8.2 of the Act. Per stipulation between the parties, Respondent shall pay and hold Petitioner harmless for charges for treatment involving the right arm and hand from Ralph Richter MD, Salvatore Fanto, Dr. Chang/Midwest Spinecare, Nicholas Angelopoulos MD, CINN, and Ingalls Memorial Hospital. Per further stipulation between the parties, Respondent shall be given an 8(j) credit for medical benefits that were paid through Respondent's group carrier to the date of Petitioner's termination, and Respondent shall hold petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act.

Respondent shall pay Petitioner permanent and total disability benefits of $ 774.91/week for life, commencing 3/13/12, as provided in Section 8(f) of the Act.

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

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

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

Signature of Arbitrator

7/11/13
Date

JUL 12 2013

STATEMENT OF FACTS:

Petitioner became a blackjack dealer for Respondent in 1986 and worked in that capacity until his position was terminated in 2011. Petitioner dealt blackjack hands to up to seven players at his table. Petitioner testified that the casino required its blackjack dealers to deal at a rate of 650 and 700 hands of cards each hour. The cards were located in a shoe on the left side of Petitioner's body. To take a card out of the shoe, Petitioner swept his right hand across his body to the shoe and an upward sweeping motion with the right hand to lift the door on the shoe to access each card. This was followed by a downward sweeping motion to pull each card out of the shoe. Petitioner provided that he then grabbed each card to place the card in front of the player, again using the right hand to flip the card upward for viewing. Petitioner handed out two to four cards per player. At the end of each game, Petitioner collected and paid out chips to the players. Petitioner stated that he grabbed the chips around the edges to place and to remove them from the table. Paying out chips required Petitioner to grab chips from stacks located in front of him which he then distributed to winning players. Petitioner used his right hand for all payouts except for the two players sitting farthest left. He also used the right hand to pick up the cards left by each of the players. Petitioner testified that he worked 8 hours shifts with 15 minute breaks after each hour and a half of work. Petitioner worked for much of his time in the high roller tables.

Petitioner explained that he developed pain and numbness in his right hand in early 2006 while performing this work. The pain worsened and he started dropping chips and cards. Petitioner indicated the drops resulted in even more hand maneuvers as casino protocol required him to display his hands to both supervisors and the overhead security cameras after each drop. Petitioner testified that he repeatedly discussed his worsening problems with his supervisors when he dropped chips or cards. Petitioner testified that he last spoke with the supervisor about the problems he was having with the work no less than two weeks before he sought treatment with Anton Fakhouri MD.

Petitioner began treatment with Dr. Anton Fakhouri on 7/20/06. (PX2) Fakhouri documented a history of four months of progressively worsening tingling, numbness and pain in the right hand. Dr. Fakhouri diagnosed right carpal tunnel syndrome and ordered electrical tests. An EMG/NCV was done on 7/26/2006, revealing right carpal tunnel syndrome and evidence of old left carpal tunnel syndrome. Cortisone was injected into the right wrist on 8/3/06 with minimal relief. Dr. Fakhouri noted that Petitioner's symptoms were aggravated with day to day activities such as dealing cards at work. Dr. Fakhouri performed the first carpal tunnel release on 12/8/2006. Petitioner's numbness partially resolved with surgery and Petitioner returned to full dealing activities on 3/6/07. Petitioner missed a total of 62 days of work following this surgery.

Petitioner's symptoms gradually returned while he worked and Petitioner again saw Dr. Fakhouri in May of 2007. (PX2) Petitioner complained of right shoulder pain, wrist pain and forearm pain at this point. Dr. Fakhouri performed a cortisone injection into the shoulder and sent Petitioner for scans. X-rays, a CT scan and then a MRI were done of the wrist.

Petitioner's complaints continued to worsen with his dealing activities and Fakhouri performed the second carpal tunnel release on 2/13/2008. (PX2) Petitioner missed 101 days of work for this surgery, returning to work on 7/3/08. Before Petitioner returned to work, he went through a functional capacity evaluation on 5/12/08. The FCE found Petitioner to be capable of light duty work, with lifting 25lbs occasionally and 20 lbs frequently. (PX2) Notably, Petitioner's fine finger dexterity scores were in the 15th percentile or less when compared to the overall population. The coordination section of the test noted that Petitioner was occasionally dropping pegs and discs during testing. The FCE warned that it was beyond the scope of its evaluation to assess whether Petitioner could return to work as a blackjack dealer. Even so,

Petitioner did return to full blackjack duties on 7/4/08. On 7/14/08, Dr. Fakhouri authored a letter opining that Petitioner's work activities may have aggravated or been causally involved in the diagnosis and condition of his carpal tunnel syndrome. Dr. Fakhouri noted that most of Petitioner's symptoms were coming from the carpal tunnel syndrome and not the bony lesion in the wrist.

Petitioner's symptoms partially resolved with the second surgery. Petitioner testified that the carpal tunnel symptoms again worsened while he was fully engaged in blackjack dealing.

In October of 2008, Petitioner began receiving treatment for cervical complaints with Dr. Angelopoulos. (PX5) A cervical MRI was followed with two epidural steroid injections and then a radiofrequency ablation on 2/17/09. An EMG/NCV from 11/12/08 found evidence of moderate median neuropathy at the right wrist of both the motor and sensory fibers. No evidence was found for cervical radiculopathy or myopathy.

By March of 2009, Petitioner's right hand symptoms had worsened, he had numbness and tingling in the right hand and pain in both upper extremities. Petitioner sought treatment with Dr. Chang on 3/10/09, reporting a two year history of neck and right hand pain which worsened throughout the workday. (PX4) On a return to work form, Dr. Chang diagnosed herniated discs at C5-6 and C6-7 and placed work restrictions against lifting more than 10 lbs, vibratory tool use, overhead lifting, and repetitive use of the right arm and hand. He also restricted Petitioner to minimal bending and stooping.

During the return visit on 5/19/09, Dr. Chang noted that Petitioner was working full duty which had aggravated his neck and left arm pain, numbness and tingling. (PX4) Petitioner was also experiencing symptoms on the right side as well as lumbar complaints.

On 8/31/09, Dr. Angelopoulos documented Petitioner's increasing right neck pain which radiated down the right arm. (PX5) On 9/10/09, Dr. Angelopoulos diagnosed the condition as C6-7 spinal stenosis and degenerative disc disease from C4 to C7. Dr. Angelopoulos recommended additional cervical steroid injections.

Petitioner testified that his wife was suffering from end stage cancer at this point and he took six months off to be with his wife. Mrs. Drobac passed away in March of 2010. Petitioner returned to blackjack dealing with resumption of his right hand complaints.

Petitioner underwent a course of therapy from 5/3/10 to 6/1/10. (PX9) A 6/7/10 cervical MRI was reported as showing no change from the October 2008 MRI. Respondent sent petitioner for an IME with Dr. Kern Singh on 8/30/2010. Dr. Singh felt there was no causal relationship between Petitioner's work and his cervical and lumbar spine conditions. Singh did not address the carpal tunnel syndrome. (RX 7)

Petitioner returned to Dr. Chang on 6/15/10. (PX5) Dr. Chang read the MRI as showing a slightly larger herniation at C5-6, causing moderate to severe left sided foraminal compression. On 6/28/10, Petitioner returned to Dr. Angelopoulos complaining of an increase in his neck pain and radiation into the right upper extremity since the last visit in November of 2009. (PX5) Dr. Angelopoulos also felt that the MRI revealed worsening of then herniation at C5-6. Dr. Angelopoulos performed additional cervical epidural steroid injections on 7/26/10 and 8/9/10.

On 11/14/2010, Petitioner was involved in a non-occupational car accident. Petitioner filed for leave under the FMLA on 11/18/10 and began treatment with Dr. Salvatore Fanto. (PX3) Dr. Fanto documented numbness and tingling in the bilateral hands along with some new neck pain since the motor vehicle accident. Dr. Fanto recommended that Petitioner obtain an updated EMG/NCV and arterial studies.

Petitioner next had a neurosurgical consultation with Amish Patel MD on 11/24/10, reporting prior neck pain but no shooting pains in arms. Petitioner also reported that the shooting pains were preventing him from working after his car accident. Dr. Patel felt that there were signs of radiculopathy and/or of bilateral carpal tunnel syndrome. He agreed with the recommendation for an EMG/NCV. (PX 3) The updated test was done on 11/24/10, revealing evidence of moderate to severe bilateral carpal tunnel syndrome and mild to moderate bilateral ulnar neuropathy, most likely with compression at the wrist. (PX 3) Arterial studies done at Ingalls Hospital on 11/26/2010 revealed no definite evidence of significant upper extremity arterial disease which might account for the complaints. (PX7)

A repeat cervical MRI was done on 11/29/10. (PX4) Dr. Chang thought the MRI findings were similar to the pre-motor vehicle accident MRI. (PX4) Petitioner had multilevel degenerative changes, most significantly at C5-6 with left greater than right foraminal narrowing and moderate compression of the left ventral thecal sac. The MRI also revealed prominent degenerative facet changes on the left side at C3-4 and a central disc protrusion at C4-5. At the 12/2/10 office visit, Dr. Chang noted that Petitioner's car accident probably resulted in an acute aggravation of the cervical radiculopathy which was magnifying the carpal tunnel symptoms. Dr. Chang removed Petitioner from work for 5 weeks and sent Petitioner for therapy at Novacare. In his 1/5/12 note, Dr. Chang noted that the car accident aggravated Petitioner's cervical and lumbar conditions, but it in no way affected the carpal tunnel syndrome.

Petitioner started therapy at Novacare on 3/7/11 and his neck and back improved. (PX9) Therapy did not resolve the carpal tunnel symptoms. On 3/15/11, Dr. Chang released Petitioner to work with respect to the neck and back. (PX4) He did not release Petitioner for the hands. (PX4) Petitioner continued treatment with Dr. Fanto for the hands. (PX3)

On 3/25/2011, Dr. Fanto performed an open release of the right carpal tunnel, release of the ulnar nerve, and a Guyon's canal decompression of the flexor carpi radialis and carpi ulnaris tendons. (PX7) Dr. Fanto restricted Petitioner from work through 6/11/11. (PX3)

Respondent sent Petitioner for its second IME with a hand specialist on 5/25/11. (PX1) Dr. Ralph Richter documented an extensive history relating to the work injuries. A carpal tunnel release on 12/8/06 partially resolved the numbness in the median distribution of the right hand. Petitioner's nocturnal complaints did resolve. Petitioner returned to work and then returned to Dr. Fakhouri in May of 2007 with new complaints of shoulder pain and the wrist and forearm pain. Petitioner had a repeat carpal tunnel release on 2/13/08 and returned to his dealing duties. Petitioner developed recurrent symptoms in his right hand around 2009. He also developed pain in both upper extremities as well as numbness and tingling in the right hand. Petitioner underwent a third carpal tunnel release on 3/25/11 under the care of Dr. Fanto. This surgery included a Guyon's canal release and decompression of the flexor carpi radialis and ulnaris tendons in the right wrist. Petitioner reported to Dr. Richter that the last surgery had not done much to relieve his symptoms. Petitioner continued having pain, numbness and tingling in his right hand. Patient was engaged in therapy and had not yet returned to work as of the date of Richter's evaluation. Dr. Richter diagnosed the condition as carpal tunnel syndrome. Dr. Richter felt that Petitioner's current symptoms were related to his dealing activities and the treatment he had undergone to treat the condition. Dr. Richter did not believe that Petitioner engaged in any non-work activities which would have given rise to the condition. Dr. Richter explained his causal opinion on his belief that Petitioner performed forceful repetitive motion with his duties as a dealer. Dr. Richter noted that this type of activity had been shown to be a significant factor in the development of carpal tunnel syndrome. Dr. Richter advised against additional surgery given the lack of relief obtained from the third surgery.

Petitioner testified that he was terminated by Respondent on 6/17/11. Petitioner provided that he was terminated for failing to return to work before expiration of the leave deadline which Respondent had imposed.

Petitioner returned to Dr. Richter on 10/3/11 for treatment. (PX1) Petitioner complained of continuing numbness and tingling in the hand as well as coldness. He was also beginning to report symptoms in his left hand at this point. Dr. Richter noted that workers compensation carrier had not approved occupational therapy for Petitioner. Dr. Richter again advised against surgery and told Petitioner to use the hand as best as he could. Dr. Richter also imposed permanent work restrictions against rapid repetitive motions and against heavy activity with the hands. Dr. Richter's diagnosis was bilateral carpal tunnel syndrome.

Petitioner made demands for vocational rehabilitation and maintenance upon Respondent on 10/4/11, 11/22/11, 12/6/11 and 1/17/12. (PX13) Petitioner then sought a vocational evaluation with Vocamotive on 3/12/2012. (PX14) Petitioner presented testimony from a certified rehabilitation counselor in support of his claim. Kari Stafseth CRC performed vocational services with Vocamotive on behalf of workers, employers and carriers. Ms. Stafseth noted that she even did vocational work for Sedgwick who was handling the immediate case. Ms. Stafseth interviewed Petitioner, outlining the details she obtained from him which were relevant to her opinions. She noted that Petitioner had a limited work history and limited transferable skills. She also reviewed work restrictions and a number of Petitioner's recent physicians. She then performed a transferable skills analysis where she entered all of these variables into a computer database to see what jobs were actually available for Petitioner. The results revealed no available positions for a worker with Petitioner's background, restrictions and age. Based on all of this information, Ms. Stafseth testified that Petitioner had lost access to his customary occupation and further, that he had lost access to a stable labor market in general. Petitioner was unemployable. Respondent challenged Ms. Stafseth on several points during cross examination. Respondent challenged her on whether Petitioner told her about the intervening car accident from November of 2010. Ms. Stafseth testified that she was aware of the accident through the medical records she had reviewed as part of her assignment. Ms. Stafseth further clarified that the auto accident was largely irrelevant to her analysis as she had based her opinions on the restrictions and limitations which Petitioner had for his hands and arms. She noted that any additional restrictions for the neck and back would even further impair Petitioner's access to the labor market. Respondent next had Ms. Stafseth read an email into the record from Petitioner's counsel. In substance, the email asked Vocamotive to determine whether Petitioner was employable, and if so, to draft up a rehabilitation plan. Finally, Respondent challenged Ms. Stafseth's assumption as to whether any doctor had released Petitioner to return to work using the right hand.

The vocational expert determined that Petitioner had lost access to his usual and customary line of work as a dealer as he was restricted from rapid/repetitive motions and restricted from dealing cards and manipulations with the right hand. The evaluator concluded that Petitioner did not have access to a meaningful labor market due to his level of education, limited work history, lack of transferable skills and the condition of his hand. In the evaluator's opinion, Petitioner was totally disabled.

Respondent sent Petitioner for IMEs with four separate examiners. Drs. Nagle, Richter and Vender were engaged to address the hand injury. Dr. Singh was engaged to evaluate the alleged cervical injury.

Dr. Nagle performed the first IME on 11/15/07. (PX10) Dr. Nagle reported a history of a correlation between Petitioner's work activities and his symptoms. By the end of the workday, Petitioner experienced increased discomfort and paresthesias in his hands. Petitioner also had pain the base of the thenar eminence and his long and ring fingers were numb. Petitioner also complained of some discomfort in the right shoulder and the front of his proximal forearm. As the work day progressed, Petitioner experienced an increase in the discomfort in his hand, forearm and shoulder. Dr. Nagle diagnosed Petitioner with carpal tunnel syndrome on the right side as well as a bony lesion in the distal radius. Dr. Nagle felt that the work activities had not caused the bony lesion in the distal radius. However, Dr. Nagle also thought that the majority of Petitioner's symptoms were attributable to continued irritation of the median nerve in the carpal canal. Dr. Nagle noted that Petitioner engaged in no outside activities which would aggravate his current condition. Dr. Nagle recommended that Petitioner follow up with his treating physicians as he had not yet reached maximum medical improvement.

Respondent next sent Petitioner for an independent medical examination with Ralph Richter MD on 5/25/11. (PX1) Dr. Richter is a hand specialist. Dr. Richter documented an extensive history relating to the work injuries. Petitioner's first carpal tunnel release partially resolved the numbness in the median distribution of the right hand. Petitioner's nocturnal complaints resolved with the surgery. Petitioner returned to work with development of new complaints of shoulder pain and wrist and forearm pain. Dr. Fakhouri performed a repeat carpal tunnel release and Petitioner again returned to his dealing duties. Petitioner developed recurrent symptoms in his right hand around 2009. He also developed pain in both upper extremities as well as numbness and tingling in the right hand. Dr. Fanto next operated on Petitioner, releasing the right carpal canal, right Guyon's canal, and decompressing the flexor carpi radialis and ulnaris tendons in the right wrist. Petitioner told Dr. Richter that the last surgery had not done much to relieve his symptoms. He continued having pain, numbness and tingling in his right hand. Patient was engaged in therapy and had not yet returned to work by the date of Richter's evaluation. Dr. Richter diagnosed the condition as carpal tunnel syndrome and he related Petitioner's current symptoms to carpal tunnel syndrome and the treatment he had received for that condition. Dr. Richter agreed that Petitioner engaged in no non-work activities that would have given rise to the condition. He explained his causal opinion on his belief that Petitioner performed forceful repetitive motion with his duties as a dealer. Dr. Richter explained that this type of activity has been shown to be a significant factor in the development of carpal tunnel syndrome. Dr. Richter advised against additional surgery as Petitioner had not obtained relief from the third surgery.

Respondent ultimately engaged Dr. Michael Vender MD for an examination on 6/22/12. Dr. Vender offered disputes on diagnosis as well as causation. As to causation, Dr. Vender did not believe that dealing cards would cause carpal tunnel syndrome. (Vender dep.24) He did not inquire as to specifics on what Petitioner's job actually required. (Vender dep.21) He was aware that people dealt by holding the deck of cards or by pulling them out of a shoe one by one. (Vender dep.22) Dr. Vender thought Petitioner would deal, he would then wait, he would then pull out a card, pull out another card and that he would enjoy rest periods between these activities. (Vender dep.23) Dr. Vender explained that you needed a combination of both repetitiveness and forcefulness to develop "new" carpal tunnel syndrome. (Vender dep.23) Dr. Vender also disputed whether Petitioner's job was sufficiently forceful to lead to carpal tunnel syndrome. (Vender dep.23-24) Dr. Vender also did not know what force was required to develop carpal tunnel syndrome. Vender knew of no research addressing the causal relationship between card dealing and carpal tunnel syndrome. (Vender dep.114-115)

In addition to challenging causation, Dr. Vender disputed that carpal tunnel syndrome was the correct diagnosis. Dr. Vender admitted there were three separate electrical tests performed in the case showing moderate median mononeuropathy of the wrists. (Vender dep.49) Dr. Vender also did not dispute that each of the doctors performing the EMGs concluded there was evidence of carpal tunnel syndrome. (Vender dep.50) He did also not dispute that each of the operating surgeons felt they were addressing carpal tunnel syndrome. (Vender dep.50-51) He also recognized that Respondent's two IME doctors before him had made the carpal tunnel syndrome diagnosis. (Vender dep.54-55) With respect to correlating clinical symptoms to the electrical test findings, Dr. Vender admitted that Petitioner reported resolution of some of the nocturnal paresthesias following the first release. (Vender dep.55) Dr. Vender explained that this symptom was a classic sign for carpal tunnel syndrome, further admitting that the improvement in the symptoms suggests that the surgery had its intended effect of releasing pressure in the carpal canal. (Vender dep.55-56)

For the second surgery, Dr. Vender disputed whether the surgeon had removed synovitis from the tendon during the surgery, even though the surgical report documented removal of synovitis. He criticized the surgeon for making the synovitis diagnosis without getting a pathology report to support the diagnosis. (Vender dep.74) When Vender was asked about the pathology report which the surgeon had actually obtained following surgery, Dr. Vender admitted he had not seen the report. (Vender dep.75)

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 with respondent?

D. What was the date of the accident?

F. Is petitioner's current condition of ill-being causally related to the 7/20/06 accident?

The Arbitrator finds that Petitioner suffered an accident which arose out of and in the course of his employment as a blackjack dealer for Respondent. The Arbitrator finds that carpal tunnel syndrome resulted from the accident and the manifestation date of the accident was properly designated as the first date of diagnosis by Dr. Fakhouri on 7/20/06.

Petitioner's testimony shows us that he was constantly flexing and sweeping his right hand while pulling cards, dealing cards, collecting and disbursing chips and shuffling the deck. 700 hands per hour with an average of three cards per player involves 2,100 sweeping movements upwards per hour to open the door to access cards, 2,100 flexion movements downward to pull the card from the shoe, 2,100 pinching and rotational movements just to put the cards in an upright position before each player, 700 pinching movements to collect finished hands, and at least 500 pinching and rotational movements to payout or to collect chips (5 out of 7 players paid by right hand). If we consider Petitioner was at this level of production over 6 hours and 45 minutes each shift (30 minute lunch plus three 15 minute shifts), we have a minimum of 51,689 hand movements a shift, not including movements needed for shuffling the deck. A full week of this work involved 258,445 movements with the right hand and a 48 week year gives us 12,405,000 right hand movements. Ten years of this work involved 124,050,000 right hand movements. Even if Petitioner only worked at the minimal rate of 650 hands per hour, he was still performing right hand movements at 93% of those figures.

Petitioner noted that his worsening symptoms were correlated with the work activities and he sought treatment with Dr. Fakhouri on 7/20/06.

The timeline of the appearance and progression of carpal tunnel symptoms also supports the findings on causation and accident. As outlined in the findings of fact, the symptoms appeared gradually after years of work, the symptoms progressed with a recognized correlation with the dealing activities (see PX2 –Fakhouri's 8/31/06 note; PX10), the first two surgical releases provided relief of the symptoms and the symptoms reappeared and worsened when Petitioner return to his dealing activities.

Furthermore, with the exception of Respondent's third IME doctor, the opinions of the treating and examining physicians universally support the carpal tunnel diagnosis and its relationship to Petitioner's dealing. Dr. Fakhouri opined that Petitioner's work activities may have aggravated or been causally involved in the diagnosis and condition of his carpal tunnel syndrome. (PX2- 7/14/08 letter) Dr. Fanto expressly noted that Petitioner's carpal tunnel syndrome was work related on his 4/5/11 "Attending Physicians Statement" for disability insurance benefits. (PX3) Dr. Chang felt that the intervening car accident aggravated the cervical spine condition which, for a time, was magnifying carpal tunnel symptoms. (PX4- 12/2/10 note) However, Chang further noted that the carpal tunnel syndrome was in no way worsened by the car accident. (PX4-1/5/12 note)

Two out of three of Respondent's examiners did not dispute causation. Dr. Nagle reported a history of a correlation between Petitioner's work activities and his symptoms. Dr. Nagle diagnosed Petitioner with carpal

tunnel syndrome on the right side as well as a bony lesion in the distal radius. Dr. Nagle was certain that work activities had not caused the bony lesion in the distal radius and all physicians appear to agree on this point. However, Dr. Nagle thought that the majority of Petitioner's symptoms were attributable to continued irritation of the median nerve in the carpal canal, further stating that Petitioner engaged in no outside activities which would aggravate the carpal tunnel syndrome. (PX10) Respondent's second examiner was even more supportive of causation. Dr. Richter diagnosed the condition as carpal tunnel syndrome and he related Petitioner's current symptoms to carpal tunnel syndrome and the treatment he had received for that condition. Dr. Richter agreed with Nagle that Petitioner engaged in no non-work activities that would have given rise to the condition. Richter described Petitioner's dealing activities as involving forceful repetitive motions. Dr. Richter noted that this type of activity had been shown to be a significant factor in the development of carpal tunnel syndrome. (PX1)

Respondent next hired Dr. Michael Vender MD for an IME. Dr. Vender offered disputes on the diagnosis as well as on causation. As to causation, Dr. Vender did not believe that dealing cards would cause carpal tunnel syndrome. (Vender dep p.24) However, Dr. Vender's did not make an inquiry regarding the physical requirements of the work, he could not identify research even arguably supporting his denial and he admitted that science had not reached the stage where it could tell us how many movements were needed to cause carpal tunnel syndrome.

Although Dr. Vender did not make an inquiry about the physical demands of the dealing job. (Vender dep p.21), he thought Petitioner would deal a card, he would then wait, he would then pull out another card, pull out an additional card and that he would enjoy rest periods between these activities. (Vender dep p.23) As noted above, this was not the job that Petitioner had performed for over a decade for respondent. Dr. Vender explained that we needed a combination of both repetitiveness and forcefulness to develop "new" carpal tunnel syndrome. (Vender dep p.23) Dr. Vender never explained what he meant by "new" carpal tunnel. He also disputed whether Petitioner's job was sufficiently forceful to lead to carpal tunnel syndrome. (Vender dep p.23-24) He also knew of no research addressing the causal relationship between card dealing and carpal tunnel syndrome. (Vender dep p.114-115)

Dr. Vender was not persuasive when he challenged the carpal tunnel syndrome diagnosis. Dr. Vender admitted there were three separate electrical tests performed in the case showing moderate median mononeuropathy of the wrists. (Vender dep p.49) Dr. Vender did not dispute that each of the doctors performing the EMGs concluded there was evidence of carpal tunnel syndrome. (Vender dep p.50) He did also not dispute that each of the operating surgeons felt they were addressing carpal tunnel syndrome. (Vender dep p.50-51) He further noted that Dr. Fakhouri was a competent doctor who was unlikely to have performed multiple improper surgeries. (Vender dep p.31) Dr. Vender was questioned about Dr. Nagle's conclusion that we were dealing with relatively advanced carpal tunnel syndrome in the right hand which led to the first surgery. (Vender dep p.54-55) With respect to correlating clinical symptoms, Dr. Vender admitted that Petitioner reported resolution of some of the nocturnal paresthesias following the first release. (Vender dep p.55) Dr. Vender admitted that nocturnal paresthesias was a classic sign for carpal tunnel syndrome, further admitting that the improvement in the symptoms suggests that the surgery had its intended effect of releasing pressure in the carpal canal. (Vender dep p.55-56) In this case, the electrical tests, physician consensus and the surgical results all point toward carpal tunnel syndrome as the proper diagnosis.

Dr. Vender took a similar approach to the second surgery performed by Dr. Fakhouri. Dr. Fakhouri performed a second release and a flexor tenosynovectomy on 2/13/08. (Vender dep p.61-62) Dr. Fakhouri reported that he found an overabundance of tenosynovitis in the flexor digitorum profundus and flexor digitorum superficialis tendon. (Vender dep p.64-65) Dr. Vender explained that tendons in the carpal canal have a coating called synovium which permits gliding of the tendons past each other. (Vender dep p.62-63) An overabundance of such material in the canal can cause pain and contribute to carpal tunnel syndrome. (Vender

dep'p.63) According to the operative report, Dr. Fakhouri took off some of the coating during the surgery. (Vender dep p.63) Dr. Vender disputed whether Fakhouri really found an overabundance of synovium at the time of the surgery. (Vender dep p.65) Vender provided that Fakhouri could not have properly made the synovitis diagnosis without a biopsy of the synovium to confirm the inflammation. (Vender dep p.74) However, when Vender was presented with the fact that Fakhouri had sent the synovium off for a pathological analysis, Dr. Vender admitted that he had not seen the pathology report. (Vender dep p.75) Dr. Vender was then challenged on whether he could really dispute Fakhouri's diagnosis when Vender had not seen the pathology report. (Vender dep p.75) Dr. Vender's disputes over causation and diagnosis are not persuasive.

The Arbitrator notes that Dr. Vender provided that excessive synovium can give rise to pain from the canal. While he identified a connective tissue disease as a potential source for excessive synovium, he admitted that there was no evidence that Petitioner suffered from that metabolic problem. (Vender dep p.63)

The Arbitrator is not persuaded by Respondent's arguments about the intervening car accident. Even Dr. Vender would not opine to a reasonable degree of certainty that the car accident caused or aggravated the carpal tunnel syndrome in the right hand. Dr. Vender could not make that claim at the same time he was disputing the validity of the carpal tunnel diagnosis. Further, by the time of the car accident, numerous doctors and electrical tests had documented the existence of the syndrome on the right side. Dr. Chang had been treating Petitioner for 20 months at that point and he had the benefit of following Petitioner for years as treatment unfolded. While Dr. Chang thought the car accident aggravated the cervical spine and magnified the carpal tunnel complaints, he also noted that the accident in no way affected the carpal tunnel syndrome. (PX4-1/5/12 note) By 3/15/11, Petitioner's cervical spine had responded to treatment well enough that Petitioner was released with respect to the spine. (PX4) Dr. Chang did not release Petitioner to work with respect to his right hand. Dr. Fanto was also treating the right hand at this point. However, Dr. Fanto expressly noted that Petitioner's carpal tunnel syndrome was work related on his 4/5/11 "Attending Physicians Statement" for disability insurance benefits. (PX3) Fanto does not support Respondent's theory about the intervening car accident. While there is evidence to point to a flare-up in Petitioner's carpal tunnel symptoms following the car accident, there is nothing to indicate that they were anything more than a temporary flare of symptoms. Dr. Chang's cervical aggravation theory is credible considering that the symptoms were identified as "bilateral" following the car accident whereas the symptoms were limited to the right side before the accident. Once the cervical inflammation was reduced, Petitioner returned to his baseline state of disability with respect to the right hand and arm and Dr. Fanto performed the third operation.

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

The Arbitrator finds that Petitioner provided timely notice of his injuries to Respondent. Petitioner's unrebutted testimony indicates that he had an ongoing conversation with his supervisors about his developing right hand problems. His last conversation with the supervisors came two weeks prior to his first visit with Dr. Fakhouri on 7/20/06. Respondent presented no witnesses to challenge the adequacy of notice.

J. Were the medical services that were provided to petitioner reasonable and necessary? Has respondent paid for all reasonable and necessary charges?

The Arbitrator finds, after reviewing the medical records introduced into evidence, as well as the testimony offered by Petitioner, that the medical treatment provided by Dr. Fakhouri, Tinley Woods Medical Center, Novacare, Ralph Richter MD, Salvatore Fanto MD, Dr. Chang/Midwest Spinecare, Nicholas Angelopoulos MD, CINN, and Ingalls Memorial Hospital was both reasonable and necessary under section 8(a) of the Act. Therefore, Respondent shall pay reasonable and necessary medical services, pursuant to the medical fee schedule, of $49,450 for treatment provided by Dr. Fakhouri, $5,057 for treatment from Tinley

Wobds Medical Center, and $10,321 for treatment from Novacare, as provided in Sections 8(a) and 8.2 of the Act. Per stipulation between the parties, Respondent shall pay and hold Petitioner harmless for charges for treatment involving the right arm and hand from Ralph Richter MD, Salvatore Fanto, Dr. Chang/Midwest Spinecare, Nicholas Angelopoulos MD, CINN, and Ingalls Memorial Hospital. By stipulation between the parties, Respondent shall pay the medical bills for services rendered by said providers in conjunction with the fee schedule, subject to the provisions and limitations of sections 8(a) and 8.2 of the Act.

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

The Arbitrator finds that Petitioner was temporarily and totally disabled over three separate periods. Petitioner is entitled to TTD for the periods associated with his surgeries to the right hand and arm. Mr. Drobac initially missed work from 12/8/06 to 3/6/07 for the first carpal tunnel release. Petitioner next missed work from 2/13/08 to 7/3/08 for the second release. Petitioner's final absence from work for the third surgery ran from 3/25/11 through 3/12/12. The Arbitrator finds that 3/12/12 is the logical date of maximum medical improvement as the vocational analysis was completed on 3/12/12, determining that Petitioner had lost access to the labor market as a result of his injuries.

Respondent paid a total of $ 22,556.59 in TTD benefits over these periods. Respondent is entitled to a credit for TTD it has paid.

O. Whether Petitioner Is Permanently and Totally Disabled?

The Arbitrator finds that Petitioner has proven that he is permanently and totally disabled from work as a result of his work related injuries. This finding is based on the condition of Petitioner's right hand and arm by the time of the hearing as well as the testimony from the vocational specialist.

By the time of the hearing, Petitioner noted that his right hand lacked any strength, he constantly dropped things with the hand, his knuckles hurt and the back of his hand felt like it would break when he used it. His right hand was cold for 90% of the time and he relied on his left arm to cover for the right. Petitioner complained that his right arm was now useless.

As noted above, the sole source of evidence about Petitioner's access to the labor market came from Kari Stafseth CRC, a certified rehabilitation counselor who evaluated Petitioner. Ms. Stafseth performs vocational services on behalf of workers, employers and insurance carriers. Ms. Stafseth noted that she even did vocational work for the insurance carrier who was defending against the immediate case. To reach her conclusions, Ms. Stafseth interviewed Petitioner, outlining the details she obtained from him which were relevant to her opinions. She noted that Petitioner had a high school education, a limited work history and limited transferable skills. She noted that Petitioner had even tried to increase his marketability by using a typewriting program to enhance his typewriting capabilities. She also outlined the various work restrictions she was considering from Petitioner's recent physicians. She then performed a transferable skills analysis where she entered all of these variables into the Oasis computer database to see what jobs were actually available for Petitioner. The results revealed no positions for a worker with Petitioner's background, restrictions and age. Based on all of this information, she testified that Petitioner had lost access to his customary occupation and further, that he had lost access to a stable labor market in general. Petitioner was unemployable.

Respondent offered no vocational testimony to the contrary. Respondent did attempt to challenge Ms. Stafseth on several points during cross examination, none of which actually brought into question her opinions.

Respondent repeatedly asked her whether Petitioner told her about the intervening car accident from November of 2010. Ms. Stafseth testified that she was aware of the accident through the medical records she had reviewed as part of her assignment. Ms. Stafseth further clarified that the auto accident was largely irrelevant to her analysis as she had based her opinions on the restrictions and limitations which Petitioner had for his hands and arms. She noted that any additional restrictions for the neck and back from the car accident would further impair Petitioner's access to the labor market. However, she had not considered the injuries from the car accident.

Respondent's final challenge to Ms. Stafseth was against her assumption that no physician had released Petitioner to work with her hand since the last surgery. Respondent began the attack with a claim that Dr. Vender had given such a release to Petitioner. Dr. Vender only disputed whether Petitioner's disability was related to his work activities. (RX p.45) Dr. Vender never disputed that Petitioner was disabled from working.

Petitioner's vocational evidence is unrebutted and as such, the Arbitrator finds that he has proven that he is entitled to permanent and total disability award.

STATE OF ILLINOIS)
) SS.
COUNTY OF)
SANGAMON

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Richard Olmsted,
Petitioner,

vs.

NO: 08 WC 30368

Freeman United Coal Mining Co.,
Respondent .

14IWCC0944

DECISION AND OPINION ON REVIEW

Petitioner and Respondent appeal the decision of Arbitrator Gallagher finding that Petitioner was exposed to an occupational disease arising out of and in the course of his employment. His last date of exposure was August 30, 2007. The Arbitrator further found Petitioner's average week wage is $1,106.97 and Petitioner is permanently partially disabled to the extent of 10% man as a whole. The Issues on Review are whether Petitioner's claim falls under §§1(d)-1(f) of the Occupational Diseases Act, whether Petitioner sustained an occupational disease arising out of and in the course of his employment or which has become aggravated and rendered disabling as a result of the exposure of his employment, whether there is a causal connection between his current condition of ill-being and the exposure on August 30, 2007, and if so, the amount of Petitioner's average weekly wage and the nature and extent of Petitioner's permanent disability. The Commission, after reviewing the entire record, reverses the Arbitrator's decision and finds while Petitioner complied with §1(f) of the Act, Petitioner failed to prove his claim falls under §§1(d)-1(e) of the Occupational Diseases Act, failed to prove he sustained an occupational disease arising out of and in the course of his employment or which has become aggravated and rendered disabling as a result of the exposure of his employment, and failed to prove there is a causal connection between his current condition of ill-being and the exposure on August 30, 2007.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

The Commission finds:

1. At the February 13, 2014 Arbitrator hearing, Petitioner testified he is 59 years old. He was an underground coal miner for 31 years. He worked his last shift on August 30, 2007 and he was 53 years old at that time. While working at the mine, he worked as a

repairman and performed maintenance underground. On his last day of work, the mine shut down. He was placed on a recall panel for an above ground position. He probably would not be called back by limiting his panel to above ground work only. He was on the bottom of the list for above ground work and he was never recalled. Above ground work would have been bid on by people with more seniority. If he had said he would work underground, he would have been given the worse job because of his lack of seniority and he did not want that. He would not take a coal mining job today because of the dust and physical exertion he would be exposed to. At the time the mine shut down, he had no plans to retire and he was planning on continuing to work at the mine. He received his full pension on November 7, 2007. He has not had any vocational rehabilitation. In the first year after the mine shut down he performed some mechanical work at his home on a limited basis. He has had a business for the last 25 years called Richard's Machine Shop where he puts in 8-16 hours a week. In February of 2011, he began working as a full-time road commissioner. The most he made in this job was $17,400.00. He believed that this was the best job he could get since he did not complete high school and did not obtain a G.E.D. He left the road commissioner job in May of 2013. Petitioner testified he noticed he was having breathing problems probably about ten years before the mine shut down. It progressively got worse. He experienced shortness of breath with exertion. He had a cough with phlegm. Since leaving the mine his condition has gotten worse. He estimates he would walk two blocks on level ground or walk up two flights of stairs before he became short of breath or had to stop and rest. Currently, he cannot walk as far and he cannot do as much exertion as he used to. He does not smoke. Petitioner filed his Application for Adjustment of claim on June 18, 2008.

2. Petitioner submitted his medical treating records going back to 1988. A summary of the records is as follows: Petitioner had sinusitis on 2/11/00, 4/3/00, 9/18/00, 10/17/02, 11/8/02, 11/28/03, 12/1/03, 3/3/04, 10/14/04, 3/16/06, 3/20/06, 10/23/06,11/16/06, 4/14/07, 4/19/12 and 11/12/12. Petitioner had a viral upper respiratory infection on 10/31/94, 2/27/95, 12/8/97, 10/19/01, 4/5/11, 4/20/11 and 10/10/11. Petitioner had an upper respiratory infection, acute bronchitis on 11/15/90, 11/19/90, 1/24/92, 4/20/92, 3/1/93, 10/25/93, 1/4/00, 12/01/04, 12/08/05, 8/16/06, 12/3/07 and 3/8/13. Petitioner had a cold with a non-productive cough on 12/13/06. Petitioner complained of experiencing shortness of breath on 3/8/13 and 4/2/13. On March 25, 2013 Petitioner was seen by Dr. Zeffren, an allergist, who indicated Petitioner had an FEV1 of 78%, which improved to 83% after use of inhaled bronchondilator.

3. Petitioner's 2/14/00 chest x-ray showed that his lungs are free of focal infiltrate and effusion. There were no soft tissue osseous abnormalities and it was deemed to be a normal chest. The October 9, 2002 chest x-ray showed calcified right hilar lymph nodes, no pleural effusion and it was deemed to be a normal chest. The September 9, 2004 chest x-ray and report from Dr. Garner showed no acute pulmonary abnormalities.

4. The parties placed into evidence the following chest x-ray reports.

A. PX3, B-reading x-ray report from Dr. Smith:

9/9/04 Chest x-ray film quality is a 2, overexposed (dark) Chest x-ray showed early mild coal-worker pneumoconiosis with interstitial fibrosis of classification s/p, bi mid to lower zones involved, profusion 1/0.

10/12/05 Chest x-ray film quality 1 CWP with mild interstitial fibrosis of classification p/s bi mild to lower zones involved of a profusion 1/0 with associated mild chest wall plaque A/2 in profile laterally in the left mid to lower lung.

4/24/08 Chest x-ray film quality is a 2, improper position, scapula overlay showed pneumoconiosis with interstitial fibrosis of classification s/p, mid to lower zones involved, profusion 1/0.

B. PX4, B-reading x-ray report from Dr. Alexander:

10/12/05 Chest x-ray film quality is a 1; the lung volumes are normal. Small round opacities are present bilaterally, consisting with pneumoconiosis, category p/p, 1/0. No areas of coalescence or large opacities are present No chest wall pleural thickening or pleural calcification are present. The costophrenic angles and diaphragms are clear. The cardiomediastinal structures and distributions of the pulmonary vasculature are normal. The bones are intact. All zones except lower left.

C. PX5, B-reading x-ray reports of Dr. Cohen:

4/24/08 in which he opined that the film quality is a 2, improper position, scapula overlay. The exam is positive for opacities of pneumoconiosis p/q in shape at a profusion of 1/0 in all zones.

2/23/10 in which he opined that the film quality is a 2, improper position, scapula overlay. The exam is positive for opacities of pneumoconiosis p/q in shape at a profusion of 1/0 in all zones.

D. RX4, NIOSH-Coal Worker Surveillance Program: 5/29/98, 7/13/98, 5/7/07: Chest x-ray: Film quality 1; films are negative for pneumoconiosis

5. Dr. Wiot reviewed Petitioner's 9/9/04, 10/12/05 & 4/24/08 chest x-rays and issued a report. He found that the studies of 10/12/05 & 4/24/08 were quality 1. The 9/9/04 chest x-ray was totally unreadable because it was overexposed. As such under ILO guidelines the film should not be interpreted as it was unreadable. On the 10/12/05 & 4/24/08 films

there was no evidence of CWP. There were calcified lymph nodes in the right hilum and right mediastinum, which are not clinically significant. Most of the time they are due to an old histoplasmosis, which is a fungus disease found in the soil. It is ubiquitous. There was very mild atherosclerotic change in the thoracic aorta.

6. Dr. Rosenberg found the 10/12/05 chest-x-ray was a quality 1, the 4/24/08 film was quality 3 underexposed with scapular overlay & the 2/23/10 chest-x-ray was a quality 2 underexposed. In his deposition he opined the x-rays were all adequate quality and were 0/0 for the presence of micronodularity. They did not reveal evidence of pneumoconiosis.

7. Dr. Cohen was deposed on November 17, 2011. He testified that he is the senior attending doctor at Stroger Hospital of Cook County. He is the medical director of the pulmonary physiology and rehabilitation section. He works in the pulmonary clinic and occupational medical clinic running three occupational lung disease clinics per week. He also works at the hospital performing general pulmonary medical consults and he works in the intensive care unit. He is the medical director of the Black Lung Clinic's program at Stroger Hospital. He is the medical director of the National Coalition of the Black Lung and Respiratory Disease Clinic, which are the federally funded clinics that take care of black lung throughout the country. He provides both education and training to those facilities. He has been a B-reader since 1998. The National Institute of Occupational Safety and Health (NIOSH) oversees the B-reader program. He has served as a panel member or presenter at NIOSH conferences. When patients come into our hospital they are charged for a clinical visit to the hospital. He, personally, does not get paid anything. When he reviews outside records from a patient he charges $250 an hour, which gets paid into our research fund and is not taken as income by him. He derives no income from the deposition. Any income from that goes into the Occupational Medicine Research Fund.

When he reads an x-ray for coal workers pneumoconiosis (CWP) there can be a rather subtle difference between 0/1 and 1/0. Those abnormalities/shadows we see on the chest x-ray occurring in a coal miner likely represent areas of dust deposition in the lungs that have been transformed into scar tissue. In order for a person to have pneumoconiosis, they must have a tissue reaction to the coal dust that is trapped in the lungs. The lung disease from CWP takes the form of fibrosis which leads to scar tissues which pull apart the adjacent lung and lead to focal emphysema. Usually people start developing CWP after a minimum of ten years of exposure. Emphysema causes an obstructive impairment. People who have CWP often have a fair amount of focal emphysema. By definition if a person has CWP they have a lost normal functioning of the lung tissue. If a person has mainly airway toxicity and emphysema, it would be predominantly obstructive and if they have interstitial lung disease, it can be restrictive. Patients with CWP often complain of shortness of breath. NIOSH has recommended using NHANES III over the Crapo or Knudson study. He reviewed the respirator chapter for the 5th ed. AMA Guides to Permanent Impairment before it got published. The AMA is probably going to be using NHANES III, which is very representative of the U.S. population as a whole. The

diffusion capacity is a very important test because it measures the ability of the lung to transfer gas from the air sacs into the bloodstream, which is the main function of the lung. So if someone has damage air sacs or the loss of lung tissue they will not be able to transfer an appropriate amount of carbon monoxide into the bloodstream. A reduced diffusion capacity is a direct measure of obliterated capillary beds. CWP causes destruction of the lung and obliteration of the capillary beds. The third measure of lung function would be the measurement of the actual blood gases. It is an important measure of the lungs' ability to transfer gas. CWP can be considered a progressive disease. It has no cure and is permanent.

Besides coal dust there is dust that comes from rock strata above and below the coal seam and there is rock dust which is a nuisance dust that can cause significant lung irritation. There are also bio-aerosols that are bio organisms/fungi, algae that mix with the water used to cut the coal and these as well can cause hyper-reactive airway disease and loss of lung function. Occasionally, there are hydraulic lines breaks the cause aerosolized hydraulic fluid. There's diesel exhaust in the mines which is a significant respiratory hazard and pulmonary carcinogen. In some older mines there is asbestos.

If a man has 1/0 reading, he would recommend that he avoid any exposure to any pulmonary toxins, including coal and silica dust, other respiratory hazards and tobacco smoke. He would not recommend that he continue to be exposed to coal mine dust.

He examined Petitioner and generated a report on November 23, 2010. He took a Petitioner's history, performed a pulmonary function test and cardiopulmonary exercise testing along with reviewing chest x-rays. Petitioner reported shortness of breath that began 13 years prior to the time we saw him and he reported it was worse with exertion and relieved when he rested. He reported a cough that was at times nonproductive and at other times productive with a white-colored sputum up to 3 teaspoons a day. He reported needing to sleep on a slightly elevated bed due to drainage in the back of his throat. He had no smoking history. He reported a history of bronchitis and based on his history he met the criteria for chronic bronchitis. His June 1, 2007 pulmonary test showed mild obstructive impairment on spirometry. He has a FEVI of 78% and had a FEVi/SVC ratio of 66%, indicating mild obstructive defect. He diagnosed Petitioner as having CWP and chronic bronchitis based on the fact that he had 30 years of exposure to coal mine dust. He used the NHANES II for his predictor, which is the predicting equations published by John Hankinson in 1999 and is recommended by the AMA Guides to impairment and by NIOSH. Petitioner had a normal work capacity, anaerobic threshold and cardiovascular response to exercise. His April 24, 2008 chest x-ray was a quality 2 because there was a slight bit of overlay of the scapula. He thought that there were opacities that were consistent with pneumoconiosis present on the chest x-ray, that were P/Q in shape and that were present in all lung zones at a 1/0 profusion. He did not see any large opacities and any pleural abnormalities or granuloma. He had also reviewed a February 23, 2010 chest x-ray and it was identical to the one taken two years earlier. Based on his diagnosis

of CWP and chronic bronchitis he does not believe that Petitioner could have or should have further exposure to coal mine dust.

Dr. Cohen testified he does not believe that there is any data that pneumoconiosis always starts in the upper zones and never in the mid or lower zones. There is a recent article by Petsonk and Laney, scientist from the National Institute of Occupational Safety and Health looking at the distribution of opacities in different lung zones. In their study the pneumoconiosis was pretty well equally distributed between the upper, mid and lower lung zones.

Dr. Cohen testified that CWP can progress even after a miner leaves the coal environment. If someone has 1/0 that means they have some scar tissue in their lungs. He does not agree that the chronic bronchitis if it is from the coal mine will resolve after a few months after the exposure is over. Chronic bronchitis is part of chronic obstructive pulmonary disease (COPD).

He noted that Petitioner has no improvement with a bronchodilator. In his November 23, 2010 report he stated there was no clear response to bronchodilators. However, the FEVI became low normal with the use of a bronchodilator. Coal mine exposure can cause sinusitis to be worse. People that have damaged their lungs from chronic bronchitis from coal mine dust or tobacco or other exposures are more susceptible to pulmonary infections and can have them more frequently. He believes it would be difficult for a doctor to say that all of Petitioner's exposure to the coal mine environment would not have been an aggravating factor to sinusitis. It is possible for a person to have CWP and not have a measurable gas exchange problem. There is not a great correlation between the presence of opacities of CWP on x-rays and either resting pulmonary function test or exercise test. He agrees with the AMA Guides and the ATS-ERS that the FEVI is the most important measure of impairment.

He agreed that he has performed 100s of exams at the request of Petitioner's attorneys. He agreed that from the late 1990's to 2007 he has performed on average 20 medical/legal exams for Petitioner's attorneys. He has acted as an unpaid consultant for the United Mine Workers. He did not review any treatment records for this Petitioner. He agreed that treatment records are valuable in evaluating a patient for Occupational Disease. He believes the history he obtained from Petitioner was complete. He agreed that Petitioner said he was able to walk one mile or climb three flights of stairs without shortness of breath. He reported that with heavy lifting or brisk walking he could develop shortness of breath. It is consistent with what he saw during Petitioner's exercise test. He agreed that there is no lower profusion rating than 1/0 and having it still be positive for pneumoconiosis. Based on the statistics from the NIOSH coal workers' x-ray surveillance program, approximately 3% of Illinois coal miners are found to have pneumoconiosis. He agreed that the chest x-ray abnormality that he observed in Petitioner could have been present for a decade or more prior to his last day worked. Petitioner reported to him that

he participated in surveillance for lung disease during the last 3 years at the mine and that there were no positive findings from that program. Petitioner did not say he left the coal mine when he did due to respiratory problems. He did not relate his inability to perform the duties of his last job at the mine. He agreed that, more than likely than not, CWP will not progress once the exposure has ceased. He cannot say that the CWP progressed in Petitioner. He agreed that his FEVI/FVC of 73 was near the lower level of normal which is 67. The forced vital capacity and the slow vital capacity should be the same in normal people. Petitioner's SVC was entirely normal. His recent medical opinion and his conclusion after looking at all of the information on Petitioner is that he does have impairment given the fact that the ranges of normal are so wide. He thinks that in view of this, Petitioner and most coal miners and workers in very heavy, industrial jobs tend to have higher than normal values. As such the finding of an abnormal value is significant in this Petitioner's case. He opined that a person can develop CWP as manifested on chest x-ray in the first two years after they leave the mine.

Dr. Cohen was deposed a second time on November 13, 2012. Dr. Cohen testified that he did not consider Petitioner's 2013 pulmonary function test based on Petitioner's less than optimal effort during the test. He felt that Petitioner has a mild obstructive defect with a mildly reduced FEV-1. So based on the 2005 ATS statement, which is the current standard for interpretation of lung function testing, Petitioner met the criteria for a mild obstructive defect with no significant response to bronchodilators. He testified that the Lancy and Petsonk article has not only been peer reviewed it was published in the American Journal of Industrial Medicine. He further testified that there is no published literature to support Dr. Rosenberg's testimony that chronic bronchitis from mining will resolve within a year after the miner leaves the coal mine environment and that his mucous production and glandular changes would also be resolved. He stated that there is no published literature to support distinguishing obstructive lung disease from smoking versus coal mine dust utilizing patterns of pulmonary function tests.

He testified that chronic bronchitis is a very common cause of obstructive lung disease. Lastly he testified that the coal workers' health surveillance program includes all miners at the workplace who are offered and accept the opportunity for screening. The results are tabulated overall and then by mining tenure.

8. Dr. Wiot was deposed on October 14, 2010. He is a doctor and a board certified radiologist. He is a diagnostic radiologist. He was a full professor from 1966-1998. He was the director of the Department of Radiology from 1968-1992 and the chairman of the Department of Radiology from 1973-1992. He is a professor emeritus. He works half days and reads between 50-60 x-rays during that time. He is still teaching. He is the past president of the American Board of Radiology, which is responsible for the design and test for someone to become board certified. He has served as an examiner of the board for many years. He is the past president for the American College of Radiology. He was part of the original task force for developing a program to teach about the ILO system and

occupational lung disease. He worked with Dr. Nelson who developed the categorical course. Today we refer to those programs as B-reader programs. They designed the educational program that people are given when they come for their training before the B-reading exam. His goal in the weekend seminar is to teach doctors to read x-rays properly and consistently.

Dr. Wiot testified that CWP and silicosis invariably begin in the upper lung fields. If they begin on one side it is most often the right side. It always begins on the top and as it progresses it will move to the mid to lower zones. To accurately diagnosis reading of chest x-ray for CWP you are talking about profusion, opacity type, lung zone and film quality. You have to understand what normal is and that only comes with experience. It has to be something that you see thousands and thousands of times so when something is not normal it strikes you right away. He was the past president of the Roentgen Ray Society which is one of two big educational societies for radiology. The other is the RSNA. He also read films for the US Navy Asbestos Medical Surveillance team and the US Public Health Service. He charges $85.00 for a B-reading and ILO report.

He testified that when someone is in a coal mine environment for 10-30 years they are all going to come out with some coal dust deposit in their lungs, but they will not all have tissue reaction to the coal dust. If there is enough reaction there will be CWP that we can see radiographically. CWP can be progressive with continued exposure. CWP tends not to progress after the exposure ceases but it can do so. There is no treatment for CWP. A person can have CWP by x-ray and still have a normal physical examination, normal pulmonary function testing and normal arterial blood gas testing. In general, they are upper lung filed and they are not mid and lower lung filled but that is not a 100%.

He reviewed Petitioner's 9/9/04, 10/12/05 and 4/24/08 chest x-rays. The studies of 10/12/05 & 4/24/08 were quality 1. The 9/9/04 x-ray was totally unreadable because it was overexposed. As such under ILO guidelines the film should not be interpreted as it was unreadable. On the 10/12/05 & 4/24/08 films there was no evidence of CWP. There were calcified lymph nodes in the right hilum and right mediastinum, which are not clinically significant. Most of the time they are due to an old histoplasmosis, which is a fungus disease found in the soil. It is ubiquitous. There was very mild atherosclerotic change in the thoracic aorta.

9. Dr. Rosenberg was deposed on February 22, 2012. He is board certified in internal medicine, pulmonary disease and occupational medicine. He has a master's in public health. He was on the staff of Mt. Sinai Medical Center in the pulmonary division. He was the director of the medical intensive care unit and director of residency training in internal medicine and was also involved with the pulmonary fellowship training program. He has admitting privileges at the University Hospital of Cleveland. He was on the pulmonary staff and had become the director of corporate health. He teaches medical

students at Case Western Reserve University School of Medicine. He is a B-reader. He is a member of the American Thoracic Society, American College of Chest Physicians, and American College of Occupational and Environmental Medicine. He is licensed in Ohio, Kentucky and Tennessee. Over the years, 95% of his exams have been for the mine industry. He is a medical specialists for both the Social Security administration and the Industrial Commission of the state of Ohio. He is a member of the Occupational Lung Disease Commission. He has taught pulmonary physiology, pulmonary medicine, respiratory physiology and pulmonary disease. He has lectures on interstitial lung disease, chronic obstructive lung disease, pulmonary stress testing, pulmonary function testing, exercise testing and occupational lung disease. He has published in the American Review of Respiratory Disease, the Journal of Respiratory Diseases. He treats patients with black lung in his clinic. Ninety perceny of his practice is clinical. His charges for the record review were probably a couple of thousand dollars. His deposition cost is $500 an hour and his preparation is $400 an hour. He spends 5% of his time on medical/legal evaluations. He performs 10-15 evaluations a month.

He reviewed medical records and films for Petitioner. The 10/12/05, 4/24/08 and 2/23/10 chest-x-rays were all adequate quality and were 0/0 for the presence of micronodularity. They did not reveal evidence of pneumoconiosis. Based on a review, despite what Dr. Cohen has stated, Petitioner's chest x-rays do not reveal the presence of micronodularity related to past coal mine dust exposure. Furthermore, even if Dr. Smith's interpretation was valid, Petitioner has parenchymal opacities in the mid and lower lung zones, this does not correlate with coal mine dust-related disorder. Coal mine dust-related opacities occur in the upper lung zones and as the condition worsens these opacities can spread to all lung zones. However, even in this situation, there is a predominance of parenchymal changes in the upper lung zones. Furthermore, it should be appreciated that one of the best ways to determine whether or not parenchymal opacities have resulted in interstitial scarring is to assess gas exchange in association with exercise. Petitioner's exercise gas exchange was totally normal, which supported the fact that he does not have any significant interstitial lung disease. This correlates with his normal diffusing capacity measurement and his normal lung volume measurements. Also on auscultation, his lung fields were clear. Based on the above information, Petitioner does not have clinical pneumoconiosis. Next, it should be appreciated that Petitioner has no restriction or even obstruction when his spirometric measurements are gauged against the Knudsen predicated values. Additionally using the NHANES III-Stroger predicted values, Petitioner's post-bronchodilator FEV1 is normal at 85% predicted. Furthermore, one would not expect a bronchodilator response in relationship to past coal mine dust exposure. The chronic scarring caused by coal mine dust would not be associated with improvement in airflow after bronchodilator administration. Rather, fixed airflow obstruction would be observed. Finally, it should be appreciated that Petitioner has a long history of sinusitis and bronchitis. Undoubtedly, this is causing his cough and sputum production. One would not expect cough and sputum production developing in relationship to past coal mine dust exposure to persist three years after a coal miner has

left his coal mine employment. It can be stated with a reasonable degree of medical certainty that Petitioner does not have pulmonary disease or impairment consequent to his past coal mine dust exposures. His FEVI/FVC ration was above 73% and that would be normal. His FEVI was within the normal limits. The 2005 Guides say that when one has a lower limit of normal that you do further investigation through giving broncholdilators, looking at the flow volume curves, doing diffusing capacity measurements, etc. Using a bronchodilator in Petitioner's case his FEVI, FEVI/FVC and FEVI/SVXC were all normal. The flow curve was normal for Petitioner. With his lung volume test there was no evidence of any restriction or obstruction. In regard to his diffusing capacity, there was no abnormality. In terms of both at rest and with exercise, his blood gasses were normal. His exercising test was normal. Based on the totality of the tests that were performed Petitioner did not suffer any pulmonary impairment.

The abstract authored by Laney and Petsonk has not been published in a peer reviewed medical journal and has no meaningful scientific basis. The pathology textbook by Churg and Green published in 1998 talk about the fact that the micronodular changes resulted to CWP are greater in the upper lung zone. There is also an article by Bergin in the American Journal of Radiology which looks at CT manifestations of silicosis and the same conclusion is drawn by that investigation. There was also a CT scan study by Remy-Jardin that there was a predominance of upper lobe micronodularity with these disorders.

The doctor agreed that if someone is diagnosed with CWP there is no safe level of exposure. The study of Petsonk and Laney is not an article. It is an abstract and all abstracts are printed. They concluded that the overall distribution of small pneumoconiotic opacities on the chest x-rays of coal miner participants in the surveillance program was not consistent with the conventional expectation of upper lung zone predominance in pneumoconiosis. He agreed that it is possible that repeated sinusitis infections could result in permanent scarring. He agreed that Petitioner has chronic cough and sputum production. He agreed that chronic bronchitis can be caused by coal mine exposure. He did not agree that scarring and a thickened mucosa are permanent changes, but agreed that they can be permanent. He opined that mucus production and glandular changes will revert after cessation of exposure occurs. Petitioner's PO2 increased to 108 millimeters of mercury, which indicated he did not have diffusing capacity abnormality.

Dr. Rosenberg did agree that one can have a loss or a reduction of lung function and still be within the range of normal. CWP can still progress once one leaves a mine but it only occurs in a small percentage of cases, which would be less than 10%. It is possible to have radiological CWP and have normal blood gasses and normal physical examination. He agreed that being within the range of normal does not mean that the lungs are free of injury/disease.

Petitioner was a coal miner with 31 years of exposure to coal dust. The Commission was provided with Petitioner's treating records going back to 1988. While Petitioner testified and told Dr. Cohen that he experienced short of breath 10 years before the mine closed, the medical records do not support the fact that he relayed the same to his treating doctor. While the treating records shows numerous instances of sinusitis and bronchitis over the years, it is not until the March 8, 2013 and April 2, 2013 entries that Petitioner reports shortness of breath. During this treating period there were three chest x-rays taken and they are all determined to be normal. Additional there are three quality B-reading chest x-rays performed by NIOSH. Two were performed in 1998 and one was performed on May 7, 2007, only three months before the mine closed, and all three were found to be negative for CWP. Petitioner's last date of exposure to coal dust was on August 30, 2007. Petitioner last worked in the mine due to the mine being shut down and not due to Petitioner becoming disabled as a result of his exposure. Petitioner testified had the mine not shut down he was planning on continuing to work in the mine and he had no retirement date in mind. After the mine shut down Petitioner placed himself on a recall panel but limited himself to above ground only work with the understanding that he would not be recalled based on a lack of seniority. He said he did not want to work underground because due to a lack of seniority he would be given the worse job and he did not want that. Petitioner then took his retirement in November of 2007, some three months after the mine shut down.

In this instance some of the doctors deemed Petitioner has CWP while other have not. Based on the evidence it appears that the diagnosis is strictly based on interpretation of the various B readers of Petitioner's chest x-rays. Petitioner's pulmonary tests were deemed to be normal/low normal both by Dr. Cohen and Dr. Zeffren and his blood gases were within the normal range as was his exercise test.

The first of these chest x-rays is dated September 9, 2004 and it was taken approximately three years prior to the mine closure. The film quality was rated as a 2, overexposed (dark) by Dr. Smith. Never the less, he found that the chest x-ray showed early mild coal-worker pneumoconiosis with interstitial fibrosis of classification s/p, bi mid to lower zones involved, profusion 1/0. Dr. Wiot found that the September 9, 2004 chest-x-ray was totally unreadable because it was overexposed and he testified that as such under ILO guidelines the film should not be interpreted as it was unreadable.

The next chest x-ray was taken on October 12, 2005. All of the doctors found that the chest x-ray was a quality 1. Dr. Smith found CWP with mild interstitial fibrosis of classification p/s bi mild to lower zones involved of a profusion 1/0 with associate mild chest wall plaque A/2 in profile laterally in the left mid to lower lung. Dr. Alexander found that the lung volumes are normal. Small round opacities are present bilaterally, consisting with pneumoconiosis, category p/p, 1/0. No areas of coalescence or large opacities are present. No chest wall pleural thickening or pleural calcification are present. The costophrenic angles and diaphragms are clear. The cardiomediastinal structures and

distributions of the pulmonary vasculature are normal. The bones are intact in all zones except the lower left, Dr. Wiot reviewed the same and found no evidence of CWP. He found there were calcified lymph nodes in the right hilum and right mediastinum, which are not clinically significant. Most of the time they are due to an old histoplasmosis, which is a fungus disease found in the soil. It is ubiquitous. There was very mild atherosclerotic change in the thoracic aorta. Dr. Rosenberg found there was no evidence of CWP.

The next chest x-ray was dated April 24, 2008. Drs. Smith and Cohen found that the file was a quality 2 while Dr. Wiot found that the same was quality 1 and Dr. Rosenberg found that the same was a quality 3. Dr. Smith found it showed pneumoconiosis with interstitial fibrosis of classification s/p, mid to lower zones involved, profusion 1/0. Dr. Cohen found the exam is positive for opacities of pneumoconiosis p/q in shape at a profusion of 1/0 in all zones. Dr. Wiot reviewed the same and found no evidence of CWP. He found there were calcified lymph nodes in the right hilum and right mediastinum, which are not clinically significant. Most of the time they are due to an old histoplasmosis, which is a fugus disease found in the soil. It is ubiquitous. There was very mild atherosclerotic change in the thoracic aorta. Dr. Rosenberg found there was no evidence of CWP.

The last set of x-rays is dated February 23, 2010. Both Drs. Cohen and Rosenberg found that the film quality is a 2. Dr. Cohen found that the exam is positive for opacities of pneumoconiosis p/q in shape at a profusion of 1/0 in all zones while Dr. Rosenberg found that there was no evidence of CWP.

The Arbitrator found that Petitioner sustained CWP that is causally related to his exposure to coal dust. The Arbitrator found that the opinions of Drs. Cohen, Smith and Alexander were more persuasive than Drs. Wiot and Rosenberg. However, the Arbitrator did not provide a basis for accepting the one set of opinions over another. Where the parties depart company appears to be on the issue of whether or not the opacities must first develop in the upper zones prior to developing in the lower zones and which particular zones, if any, the opacities are found in. The former appears to hinge on the medical legitimacy of the Laney and Petsonk article/abstract and whether or not it was published as a recognizable peer review. The second issue is whether the B-readers results need to parallel one another or not or whether it is sufficient to find the x-ray to be positive or negative. Given what has been presented to the Commission, the Commission will not base its determination on which expert should be given more weight than another. With that said, the Commission turns the issue of whether there is a disablement per the Occupational definition as set forth in Section 1(d) and 1(e) of the Act.

Based on the above, the Commission finds that while Petitioner complied with §1(f) of the Act, Petitioner failed to prove his claim falls under §§1(d)-1(e) of the Occupational Diseases Act, failed to prove he sustained an occupational disease arising

out of and in the course of his employment or which has become aggravated and rendered disabling as a result of the exposure of his employment, and failed to prove there is a causal connection between his current condition of ill-being and the exposure on August 30, 2007. The evidence shows that Petitioner did not leave the mine because he was disabled. He testified he left the mine because it shut down. Petitioner claims his disability is shortness of breath on exertion. While Petitioner testified and told Dr. Cohen that he experienced shortness of breath 10 years before the mine closed, the medical records do not support the fact that he relayed the same to his treating doctor. While the treating records show numerous instances of sinusitis and bronchitis over the years, it is not until the March 8, 2013 and April 2, 2013 entries that Petitioner reports shortness of breath. Petitioner last worked in the mine due to the mine being shut down and not due to Petitioner becoming disabled as a result of his exposure. Petitioner testified had the mine not shut down he was planning on working in the mine and he had no retirement date in mind. After the mine shut down, Petitioner placed himself on a recall panel but limited himself to above ground only work with the understanding that he would not be recalled based on a lack of seniority. He said he did not want to work underground not because he was experiencing shortness of breath but because of a lack of seniority he would be given the worse job and he did not want that. Petitioner then took his retirement in November of 2007, some three months after the mine shut down. Post retirement, he continued on with his small engine repair business and acting as a road commissioner. Petitioner did not seek any medical treatment for approximately six years post retirement. He reported two instances of shortness of breath on the eve of his trial and in turn was referred to an a allergist for treatment who found a pulmonary level within the low normal/normal range that was improved through the use of a bronchondilator. Another year then went by prior to the trial where Petitioner did not seek any medical treatment. Given these facts the Commission finds that Petitioner was not disabled as defined by Section 1(e) of the Act and did not sustain an occupational disease resulting in a disablement as defined by Sections 1(d) of the Act.

IT IS THEREFORE ORDERED BY THE COMMISSION that since Petitioner failed to prove he sustained a disease arising out of and in the course of his employment or which has become aggravated and rendered disabling as a result of the exposure of the employment, his claim for compensation is hereby denied

14IWCC0944

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

DATED: NOV 0 6 2014

O: 9/24/14

MB/jm

43

Mario Basurto

David L. Gore

Stephen Mathis

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

Michael McBride,
Petitioner,

vs.

NO: 11 WC 43091
12 WC 18986

Central School District 301,
Respondent.

14IWCC0945

DECISION AND OPINION ON REVEW

In 11 WC 43091, Petitioner appeals the decision of Arbitrator Andros finding that Petitioner sustained an accidental injury arising out of and in the course of his employment on April 12, 2011. As a result, Petitioner is entitled to $26,304.05 in medical expenses. The Arbitrator found there is no causal relationship between the April 12, 2011 work accident and Petitioner's current condition of ill-being. As such, Petitioner is not entitled to prospective medical expenses or additional compensation/attorneys' fees. Respondent is entitled to a credit of $4,433.44. Additionally, there are no attorneys' fees are awarded to the prior attorney.

In 12 WC 18986, Petitioner appeals the decision of Arbitrator Andros finding that Petitioner sustained an accidental injury arising out of and in the course of his employment on April 17, 2012. As a result Petitioner was temporarily totally disabled from April 18, 2012 through October 19, 2012 for 25 weeks, is entitled to $16,293.06 in medical expenses, which are the medical expense through Dr. Zelby's July 16, 2012 evaluation. The Arbitrator found there is no causal relationship between the April 17, 2012 work accident and Petitioner's current condition of ill-being. Petitioner is not entitled to prospective medical expenses or additional compensation/attorneys' fees. Respondent is entitled to a credit of $11,744.98 for temporary total disability payments, $378.00 for payments under Section 8(j) of the Illinois Workers'

Compensation Act and $6,979.81 for medical expenses that were paid. There are no attorneys' fees awarded to the prior attorney.

The Issues on Review are whether there is a causal relationship between the April 12, 2011 and April 17, 2012 work accidents and Petitioner's present condition of ill-being, and if so, the amount of reasonable and necessary current and prospective medical expenses, the extent of Petitioner's temporary total disability, whether Petitioner is entitled to additional compensation and/or attorneys' fees under Sections 19(l), (k) and 16 of the Act. Lastly in regard to Claim No. 11 WC 43091 only, whether Petitioner's prior attorney is entitled to attorney's fees.

The Commission, after reviewing the entire record, reverses the Arbitrator's finding on causation and finds Petitioner's current condition of ill-being is causally related to the April 12, 2011 and April 17, 2012 work accidents. As a result, Petitioner was temporarily totally disabled from August 2, 2011 through December 5, 2011 and April 18, 2012 through May 19, 2013. The Commission finds Petitioner is entitled to the medical expenses set forth in Petitioner's PX1 and orders Respondent to pay for additionally reasonable and necessary prospective medical expenses. The Commission affirms the Arbitrator's denial of additional compensation/attorneys' fees. The Commission further finds that Petitioner's former attorney failed to prove he is entitled to attorneys' fees. Lastly, the Commission remands the claims to the Arbitrator pursuant Thomas v. Industrial Commission, 78 Ill. 2d 327, 399 N.E. 2d 1322 (1980), for the reasons set forth below.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

The Commission finds:

1. Petitioner, a 47 year old custodian, testified on April 12, 2011 he was mopping under desks in a figure eight format when he turned and felt a sharp pain in his upper left shoulder. It felt like something almost tore.

2. On April 14, 2011, Petitioner was seen at Provena St. Joseph Hospital's Occupational Health Services. Petitioner provided a history that while at work using a hand held swivel dust mop he experienced a sharp pain in his left shoulder. On examination, Petitioner's neck and thoracic spine were without any redness, swelling, deformity. His flexion and extension were intact. His rotation was limited to approximately 75 degrees on the right and 60 degrees on the left due to tightness in left shoulder area. His Spurling test was negative for symptoms in the left upper extremity. Petitioner was diagnosed with an acute strain and spasm to the left shoulder with left upper extremity radiculopathy. Petitioner was given a handout on sprains, prescribed medication, told to return to work and told to follow up in four days.

3. At the April 18, 2011 follow visit at Provena, physical therapy and medication were prescribed and Petitioner was told to return in one week. On April 25, 2011, it was noted

that Petitioner was slowly healing. On April 27, 2011. the diagnosis was a left shoulder strain with occasional left arm radiculopathy. On May 2, 2011, it was noted that Petitioner's shoulder pain has slightly lessened, but he continues to experience occasional tingling in the left hand and volar forearm which occurs sometimes at rest. He noted numbness, tingling and soreness in left shoulder which he reported is worse as the work week progresses but it improves over the weekend. He reported that he feels physical therapy is helping. At that time Petitioner's diagnosis was an acute strain and spasm of left shoulder which is improving along with left arm and hand radiculopathy which has not improved since last week. On May 9, 2011, Petitioner reported while his shoulder symptoms are minor now, his left arm symptoms are persistent. A left arm EMG/NCV was ordered and Petitioner was instructed to continue with physical therapy and to follow up in one week.

4. The May 11, 2011 left arm EMG/NCV demonstrated evidence of mild left median sensory neuropathy at the wrist suggestive of early left carpal tunnel syndrome. There was no evidence of left cervical radiculopathy or brachial plexopathy.

5. On May 16, 2011, Petitioner followed up at Provena where he was diagnosed with an acute strain and spasm in left shoulder and slowly healing, median neuropathy at wrist which remains symptomatic. He was referred to an orthopedic doctor and discharged from care and from physical therapy.

6. On May 26, 2011, Petitioner was seen at Fox Valley Orthopedics by Dr. Ketterling for an evaluation of his left upper extremity and neck pain. At that time he reported on April 12, 2011 he was mopping when he developed severe pain in neck radiating down along his shoulder, primarily to the elbow level, but he also experienced significant numbness and tingling down into his left hand. Currently, Petitioner reports he is now getting pain radiating over in right shoulder along with some tingling. On examination, Petitioner has tenderness and tightening down into the trapezius, left greater than right and mild limited extension. He reported that flexion and extension aggravated the pain in both shoulders. On examination, his pain is recreated with axial compression in the neck only. There was nothing radiating down either arm. He had minimum positive impingement signs. His left shoulder x-rays were unremarkable. His cervical x-rays demonstrated severe degenerative changes at the C5-6 level. Dr. Ketterling diagnosed Petitioner as having severe degenerative change at the C5-6 level and he stated that they needed to rule out left upper extremity radiculitis. He ordered a cervical MRI and restricted Petitioner to light duty.

7. The June 10, 2011 cervical MRI showed a C3-4 minimal posterior disc bulging, C4-5 mild diffuse posterior disc bulging, C5-6 disc degeneration with loss of disc height. A diffused posterior disc protrusion and spur formation with extension into the neural foraminal bilaterally causing some mild bilateral neural foraminal compromise. There was a slight indentation of the anterior left cord. A large anterolateral osteophyte formation was present and it measured 15 mm in size. At the C6-7 level there was a protrusion with a more

prominent and eccentric right lateral recess with disc herniation and associate spur formation indenting the anterior right cord and causing marked compromise of the right lateral recess and right neural foramina. There was minimum spur foramation in the left neural foraminal as well.

8. On June 14, 2011 Petitioner followed up at Fox Valley and he saw Dr. Atkins. He reported complaints of pain initially radiating from his neck to his shoulder after mopping on April 12th. By next day he had numbness, tingling and pain radiating from his arm down to his fingers. Over last two to three days the numbness and tingling have resolved. He continues to have pain from his neck to his shoulder, which he rates as 9 out of 10 on a 10 point scale. He reports it is worse with certain activities. He feels his arm is a little weak and uncoordinated. On examination he has good neck range of motion, full abduction of both shoulders and full elbow range of motion, and a positive Tinel sign at carpal tunnel on left. Dr. Atkins diagnosed improving carpal tunnel syndrome and cervical radiculopathy. Petitioner was treated with a cock-up splint, was told he could perform light duty tasks with no repetitive use of his left upper extremity. He was told to re-evaluate his condition in one month. Dr. Atkins opined that Petitioner has an element of a double-crush syndrome resulting in cervical pathology.

9. On June 16, 2011 Petitioner again saw Dr. Ketterling who noted that his symptoms seem to be exacerbated by activities that require him to look up. His physical evaluation is unchanged. He reviewed Petitioner's MRI and diagnosed C5-6 and C6-7 herniated discs with cervical stenosis. He limited Petitioner to light duty with limited overhead activity and no lifting greater than 20 pounds. He referred Petitioner to Dr. Siodlarz for a possible epidural steroid injection.

10. On August 2, 2011 Petitioner saw Dr. Siodlarz who noted that on examination Petitioner's cervical range of motion was limited on the left side with bending and rotation. He had greater than 50% reduction secondary to pain. He has muscle spasm in the scapula into the paraspinals at the C6-7 and C5-6 levels. The Spurring test reproduced pain that radiates to the medial border of the scapula into the lateral aspect of the shoulder. He diagnosed Petitioner as having bilateral upper extremity pain, left greater than right. He had disc osteophyte complex at C5-6 to the left and C6-7 to the right along with bilateral lower extremity radiculopathy. However, his May 11, 2011 EMG was negative for radiculopathy. Dr. Siodlarz opined that the EMG may have been done just a little too early at only four weeks post injury. He recommended a cervical epidural steroid injection, medication and took Petitioner off of work.

11. On August 15, 2011 Dr. Atkins opined that Petitioner may have some degree of carpal tunnel syndrome, but he thinks his main problem is cervical at this time and as such he does not recommend surgery for the carpal tunnel at this time.

12. On September 14, 2011 Petitioner was evaluated by Dr. Pomerance, a hand and upper extremity surgeon. He noted that Petitioner's clinical exam is suggestive of left sided cervical radiculopathy. He stated he does not treat or evaluate cervical spine or other spine conditions. As such, his best option would be to be evaluated and treated by a doctor with the expertise and training of cervical spine disorders. He lastly stated that since he does not treat or evaluate neck condition, he would not be in a position to make a statement regarding causation of Petitioner's current symptoms.

13. On September 28, 2011 Petitioner again saw Dr. Siodlarz who noted that Petitioner is rating his pain as a 7 out of a 10 on a 10 point scale. He has a cold, and has been sneezing/ coughing and this is increasing his pain. The pain radiates down to first three digits.

14. On October 3, 2011 Petitioner was evaluated by Dr. Zelby who noted that about one to two months after his April 12, 2011 injury Petitioner began developing pain at the bottom of his neck in the upper thoracic area. He had no pain radiating down the arm but has a little pain creeping into the top of the left deltoid region. Currently, he feels that his pain is better than after his injury and he feels it is tolerable. He gets tingling intermittently now in the dorsal aspect of the left forearm extending into the lateral three fingers of the left upper extremity. His most prominent and most bothersome pain is still the pain at the top of the left shoulder blade. He feels his symptoms are exacerbated by raising his arm above his head and putting his arm behind his back. There is no indication that Petitioner had any neck pain associated with his reported injury. His symptoms were exclusively related to his shoulder. While he has several diagnoses of left-sided radiculopathy, his EMG found no evidence of cervical radiculopathy on the left and his MRI described no lateral recess or foraminal stenosis that would result in radiculopathy on the left. His MRI also describes no acute abnormalities or any changes which suggest that his reported injury aggravated or accelerated the degenerative condition in his cervical spine. Although he continues to report symptoms in the left upper extremity there are no radicular findings in distribution and he also has no radicular findings on exam. Based on his evaluation of Petitioner and the review of the records, it appears that he developed left shoulder pain with some neurological-type symptoms that have no radiculopathy as a consequence of his work injury. His spine and nervous system require no treatment and no diagnostic studies. He also requires no absence from work or any work restrictions. I have no opinion as to what injury Petitioner might have sustained and what treatment he might require for his shoulder. As it relates to the spine and nervous system, Petitioner has sustained no injury, so he is at maximum medical improvement and he may work without any restrictions.

15. On November 2, 2011, Petitioner saw Dr. Freedberg at Suburban Orthopedics. Dr. Freedberg noted that Petitioner reports pain radiating to top and back of the shoulder. There is still tightness there. He reports his first three fingers feel different, tight and swollen. He reports he cannot grip for long periods of time and he has lost strength. He feels a shocking pain in shoulder with coughing/sneezing. Dr. Freedberg diagnosed Petitioner with left shoulder

impingement, cervical myalgia with degenerative disc disease at C5-6 and left cervical radiculopathy.

16. On November 4, 2011 Petitioner was evaluated by Dr. Bush-Joseph who noted that the patient's diagnosis is consistent with cervical radiculopathy. He notes a significant loss of range of motion of the cervical spine that is now improving as well as gradually improving neurological symptoms in the C5-6 nerve distribution. He opined that the patient's current condition seems to be a direct result of the April 12, 2011 work injury.

17. On November 22, 2011, Petitioner was seen at Chicago Pain and Orthopedic Institute by Dr. Morgan who noted that Petitioner reports on April 12, 2011 he was dusting between desks when he felt a sharp pain in his left upper shoulder and parascapular area pain with a tingling traveling down his left arm to the hand. On evaluation Petitioner's motion was limited and it caused axial neck pain. His sensation to light touch was reported to feel different in his left thumb, index and middle fingers when compared to right side. He had 4/5 weakness at left triceps but otherwise no focal weakness in upper extremity. His left shoulder impingement and cervical area are positive. He prescribed a cervical epidural injection which took place on November 29, 2011.

18. Petitioner was off of work from early August of 2011 to December 5, 2011. After Dr. Zelby's exam, Petitioner said he was notified that his workers' compensation benefits were going to be cut off based on Dr. Zelby's opinion. On November 30, 2011, Petitioner testified he asked to go back to full-duty work because his workers' compensation benefits were denied, he had no money coming in and he was about to lose his house. Petitioner went back to work on December 5, 2011.

19. On December 20, 2011 Petitioner followed up with Dr. Morgan who noted that Petitioner is 50% improvement. The tingling in his arms has resolved but he continues to experience upper parascapular area pain. He feels a cracking sensation in neck and he continues to experience left shoulder pain and pain with raising the left arm. He returned to work two weeks ago and he reports some increased pain since returning to work. Petitioner was given a second cervical injection on January 10, 2012.

20. On January 12, 2012, Petitioner again saw Dr. Morgan who commented that Petitioner did not experience any relief from the injection. He has developed pins and needles sensation with sharp shooting pain in his right arm. He reports right arm weakness. He is right-handed and is having difficulties performing work activities. He reports neck and arm pain on right side that is worse than the left side. Petitioner reports that his right-sided pain is at the same level of pain he has when he originally injured his left shoulder and neck. He is no longer experiencing sharp shooting pain or tingling in his right arm. The Petitioner reports he returned to work because of financial hardships. Dr. Morgan prescribed a medrol dose pack.

He ordered a new EMG. He discontinued Petitioner's medication and told him to recheck in two weeks.

21. On February 15, 2012 Petitioner followed up with Dr. Freedberg. Petitioner reported that he now feels worse. He reported that he had another injection which did not help and that Dr. Jain hit a nerve. After the injection, his right arm was completely numb and he had no use of it for two days. Now, he is having some pain radiating from the right shoulder down to the right arm. Dr. Morgan has ordered an EMG to see if any damage was done after the injection. His left side is about the same. He is still having problems at work because of weakness in both arms. Dr. Freedberg stated that he disagreed with the evaluator and he believes that there is a causal connection between Petitioner's work injury and his condition of ill-being.

22. On February 21, 2012, Petitioner followed up with Dr. Morgan who recommended that Petitioner obtain a new cervical MRI. On March 20, 2012, he noted that Petitioner's EMG and MRI requests were denied. Dr. Morgan referred Petitioner to a spinal consultant. On April 17, 2012, Dr. Morgan noted that things were status quo and he diagnosed Petitioner with cervical discogenic pain, cervical radiculopathy and cervical facet syndrome.

23. On April 17, 2012, Petitioner sustained a second work accident. Petitioner reported that he reached down to pick up some paper towels in the boys' locker room and hit his head on the bottom of the paper towel dispenser. He identified PX12, a photo of the paper towel dispenser which has a crack in it, and said that the crack was not there before he hit his head. His symptoms were in both shoulders and in the center of his neck. Specifically, the symptoms were where his neck meets the top of his shoulders. The Arbitrator commented let the record reflect that Petitioner is rubbing his fingers across the left and right over what I would call the top of the shoulder towards the deltoid on both sides. We are talking about the cervical spine area. Petitioner testified that prior to the second accident his left shoulder was still sore but he was not having any problems with his neck. He had had three injections in his neck and they did not help.

24. On April 17, 2012, Petitioner was seen at Provena St. Joseph Hospital where it was reported that Petitioner hit head on a towel dispenser. On examination Petitioner had redness at the top of the head and slight edema. The Petitioner also reported a history of neck problems. Currently, Petitioner has increased cervical pain with numbness radiating to the right arm. The cervical x-ray showed no evidence for cervical spine fracture. There was minimum grade I retrolisthesis noted at several levels above, which may be projectional. The doctor diagnosed relatively mild to moderate spondylotic changes.

25. On April 23, 2012 Petitioner followed up with Dr. Freedberg who noted that Petitioner bumped his head on a paper towel dispenser. After this Petitioner reported that he had pain is radiating down into his neck and shoulder and mid back along with him having a headache

on right side. He reported that prior to this recent injury he was considerably better and had been working full duty. Now he feels he is back down to zero. Dr. Freedberg diagnosed Petitioner as having cervical and thoracic strains/sprains and he took Petitioner off of work.

26. In a May 15, 2012 follow up visit with Dr. Morgan, the doctor noted that the recommended spinal consult has not been authorized to date. Petitioner suffered another work injury on April 17, 2012 and Petitioner is currently reporting a worsening of his cervical, thoracic and upper extremity pain since the accident. He is also complaining of a shock like pain in right arm when he turns his head. Dr. Morgan once again ordered an EMG, cervical MRI and referred Petitioner to a spinal consultant.

27. On May 24, 2012, Petitioner followed up with Dr. Freedberg and he reported that he does not feel any better since his last visit. Currently, he reports he is still having severe headaches. When he turns his head and looks down at the same time he feels like a shot of electricity is going down his right arm all the way to his fingertips and when he moves his head back to a certain spot the shock goes away. Petitioner reports the pain goes down his spine to the base of his scapula and into both shoulders.

28. The June 7, 2012 cervical MRI demonstrated spondylosis changes, multilevel spinal stenosis, most marked at C6-7 with a minimal indentation of the ventral aspect of the spinal cord associated with a disc osteophyte complex and multilevel neural foraminal stenosis. The June 18, 2012 EMG/NCV demonstrated bilateral C6-7 and left C5 cervical radiculopathy. There were also early signs of median sensory nerve action and potential demyelination noted. The evaluator noted that this finding is a strong indication for carpal tunnel syndrome which is in progress and it may need to be re-evaluated in six months if it does not resolve with physical therapy.

29. On July 24, 2012, Petitioner saw Dr. McNally who opined that the April 17, 2012 work injury did not cause the degenerative changes in the patient's cervical spine. However, the April 17, 2012 work injury aggravated and accelerated the pre-existing prior asymptomatic degenerative cervical spinal conditions causing them to be symptomatic and require treatment. Dr. McNally instructed Petitioner to continue to treat with Drs. Morgan and Jain for pain management. He asked Petitioner to consider a surgical decompression. He prescribed physical therapy, took Petitioner off of work and told him to follow up in six weeks.

30. On August 7, 2012 a third cervical steroid epidural injection was administered. On August 21, 2012, Petitioner followed up with Dr. Morgan. Petitioner reported he had increased right arm pain after the cervical injection. He reports that overall he is doing better since then but he still experiences somewhat more right ulnar forearm pain since the injection along with sensitivity to touch.

31. On September 11, 2012, Petitioner followed up with Dr. McNally who recommended Petitioner continue with Dr. Morgan for pain medical management and consider surgical decompression. He recommended Petitioner have a CT myelogram, discontinue physical therapy obtain an updated EMG and follow up after he received the test results.

32. On September 17, 2012, Petitioner was sent for a consultation with Dr. Marsiglia who indicated that the Petitioner has a worsening of his cervico-thoracic pain since his new injury. He had been managed medically on medication along with undergoing three epidural injections. Dr. McNally recommended he discontinue physical therapy as he is not obtaining any significant improvement. On examination, Petitioner has a positive facet loading maneuvers bilaterally in the cervical spine. There is a reproduction of pain at the cervico-thoracic junction with cervical facet loading. His Spurling's testing does not reproduce any pain radiating beyond the shoulder. The Petitioner has significant tenderness to palpation over the cervico-thoracic paraspinal muscles. He recommended that Petitioner continue with his medication, discontinue physical therapy, undergo a CT myelogram and EMG and follow up in four weeks.

33. The September 25, 20112 cervical myelogram demonstrated disc degeneration and spondylosis with reasonable filling of dural nerve root sleeves bilaterally. The September 25, 2012 cervical CT showed multilevel disc degeneration and spondylosis with multilevel disc bulging. It was noted that there was central spinal stenosis, which was most pronounced at C6-7. The September 26, 2012 EMG/NCV showed C6-7 demyelination affecting the ulnar compound muscle action potentials. This pathology is bilateral and seems more aggravated on the right side. It showed the patient was negative for CTS, polyneuropathy and diabetic neuropathy.

34. Petitioner's temporary total disability benefits were terminated after Dr. Zelby's October 10, 2012 evaluation.

35. On October 11, 2012, Petitioner followed up with Dr. McNally who noted that Petitioner continues to have neck and bilateral shoulder pain with radiculopathy since the April 17, 2012 injury. He had not had relief with muscle relaxers, narcotics and pain management. The April 17, 2012 work injury did not cause the degenerative changes in the patient's cervical spine. However, it did aggravate and accelerated the pre-existing prior asymptomatic degenerative cervical spinal conditions and cause them to become symptomatic and require treatment. The patient feels he has maximized his non-operative care and is interested in the surgery options we posed. The patient had opted to proceed with C5-6, C6-7 anterior cervical discectomy and fusion.

36. On October 15, 2012, Dr. Marsiglia recommended a cervical medial branch blocks at C4-C7.

37. On March 4, 2013 Petitioner underwent a surgery procedure consisting of a decompressive C5 to C6 anterior cervical diskectomy through the posterior longitudinal ligament with removal of posterior osteophytes and decompression of the neural elements, decompressive C6 to C7 anterior cervical diskectomy through the posterior longitudinal ligament with removal of posterior osteophytes and decompression of the neural elements, C5 to C6 and C6 to C7 anterior cervical spinal interbody fusion, C5 to C7 anterior cervical spinal instrumentation, insertion of structural allograft bone graft to the C5 to C6 intervertebral biomechanical space for spinal fusion, local autograft bone graft harvest and preparation for spinal fusion. His post surgical diagnosis was a cervical disk displacement, cervical spinal stenosis, cervical spondylosis and cervical disc degeneration.

38. On April 11, 2013, Petitioner saw Dr. Jain who noted that post surgery Petitioner has noticed significant improvement and his forearm pain is resolved.

39. On May 14, 2013 Petitioner followed up with Dr. McNally. Petitioner states he has some pain on the back of the neck and into both his shoulders. He thinks the shoulder pain is due to physical therapy. He states the neck pain continues but is not as bad as it was before the surgery. He mostly feels sore in the back of neck. He denies experiencing any numbness and tingling. He has spasms that come and go. He would like to return to work. He is doing very well. He has some residual soreness but he has been able to wean off of the medication. Dr. McNally prescribed an orthofix e-stimulator. He released Petitioner to return to work without any restrictions and instructed him to continue with his medication and to follow up in one month.

40. On May 20, 2013, Petitioner was seen at Provena St. Joseph Hospital's emergency room. His vehicle was involved in a minor motor vehicle accident in which his vehicle was rear-ended. Petitioner complained of neck pain. He denied neurological symptoms. He reported that he recently underwent neck surgery and this was his first day back at work. A cervical CT was performed and there was no acute pathology found. Petitioner was instructed to follow up with his primary care physician.

41. On May 21, 2013 Petitioner followed up with Dr. McNally. Petitioner reported he was on his way to work when his vehicle was rear-ended. He is currently getting constant lower neck pain, just above the shoulder blade area. He states it is also radiating to the back of the shoulders. It is greater on the right. There is no numbness or tingling. He would like to return to work but he will need a note for yesterday and today. Overall, he reports he is was doing very well and is very satisfied with post surgical progress. Unfortunately, he was involved in a rear end vehicle collision. Currently, he continues to wean from medication and he is anxious to return to work. Dr. McNally diagnosed him as having a cervical strain. He released Petitioner to return to work without any restrictions and instructed him to continue to wean himself off of the medication.

42. On June 18, 2013 Petitioner again followed up with Dr. McNally. At that time Petitioner reported his neck is still sore and the pain is going into both shoulders. He is also getting pain back in his right forearm. Petitioner reports he is now back at work and he says this may be the reason why he is starting to getting the right arm pain again. He said the right arm pain before the surgery went away. The job he is performing consists of working on the lights and this is causing him to experience neck and shoulder pain. His cervical x-rays show his hardware is in good position. He is now three months post surgery. He had been doing very well and was very satisfied with post surgical progress. Unfortunately, he was involved in rear end collision on May 20, 2013 but his symptoms have not progressed. However, he is having increased soreness following his return to work. Dr. McNally recommended that Petitioner continue using the orthofix e-stimulator, continue taking medication and follow up in three months for repeat cervical x-rays.

43. Petitioner testified that upon returning to work he was switched from working in the middle school to the high school. Currently, they are on summer shift and are performing more maintenance and cleaning jobs such as stripping and waxing floors, doing lights and ceiling tiles. While performing these tasks his neck and arm have been bothering him quite a bit. He is scheduled for a follow up appointment with Dr. McNally in the middle of September. When he saw Dr. McNally in June of 2013, he did not want Petitioner to be working. Petitioner testified has he has not followed this recommendation. He testified that the doctor did continue to release him with no restrictions. Currently, he is still having the same symptoms. It is starting to hurt again under his right forearm, which is a symptom he had prior to the surgery. He also has a constant pain in the back of his neck and into the shoulders like he had prior to the surgery.

44. Dr. Zelby, a board certified neurological surgeon, was deposed on May 13, 2013. He evaluated Petitioner a total of three times. He first evaluated Petitioner on October 3, 2011. At that time, Petitioner reported that on April 12, 2011 he was dry mopping a floor between school desks in a side-to-side motion and he felt a sharp pain along the top of the left shoulder blade. He reported the next day the pain was worse and he felt numbness and tingling in the entire left hand. He treated at the company clinic with nine sessions of physical therapy and medication which he felt helped his pain. About 1-2 months after his injury he began to develop pain at the bottom of his neck in the upper thoracic region. He had no pain radiating down the arm but had a little creeping pain into the top of the left deltoid region. At the time he evaluated Petitioner in October of 2011, the Petitioner reported that he felt that his pain was better than after his injury and he felt it was tolerable. He reported experiencing tingling intermittently in the dorsal aspect of the left forearm extending into the lateral three fingers of the left lower extremity. The most prominent and bothersome pain was the pain at the top of the left shoulder blade. He felt his symptoms were exacerbated by raising his arm above his head or putting his arm behind his back. He reported he had been a custodian for the last three years and described tasks between

medium and heavy physical labor. After his injury, he worked full duty until he had some restrictions placed on him during summer cleaning. He was taken off of work on August 2, 2011. After examining the Petitioner and reviewing the medical records, Dr. Zelby diagnosed shoulder pain. He opined that there was no indication that he had any neck problem associated with his reported injury and his symptoms were exclusively related to his shoulder. While he had several diagnoses of left-sided radiculopathy, his EMG found no evidence for cervical radiculopathy on the left and his MRI described no lateral recess or foraminal stenosis that would result in radiculopathy on the left. His MRI also described no acute abnormalities or any changes to suggest that his reported injury aggravated or accelerated the degenerative condition in his cervical spine. Although Petitioner continued to report symptoms in the left upper extremity there was no radiculopathy in distribution. Based on his evaluation of the Petitioner and review of the medical records, Dr. Zelby opined that Petitioner developed left shoulder pain with some neurologic-type symptoms that had no relationship to his cervical spine. He did not sustain any injury to his cervical spine or develop any radiculopathy as a consequence of his work injury. With regard to his spine and nervous system he did not require any treatment or diagnostic studies. He also did not need to be off of work. He was at maximum medical improvement. While, he had some pretty significant stenosis on the right, this is not causing any of the left-sided symptoms.

Dr. Zelby saw Petitioner again on July 16, 2012. Petitioner reported that on April 17, 2012 he stood up and hit his head on a paper towel dispenser. Petitioner reported that he developed pain on the area where he struck his head along with experiencing neck pain. A few days later he developed pain in the muscle above the right shoulder blade and pointed to his superior medial right trapezius region. He already had pain above the left shoulder blade and in the left shoulder but said it was the same as it had been since the April 2011 injury. He reported that his headache went away a few days after the April 2012 injury but he still had neck pain, bilateral trapezius pain and left shoulder pain. He felt his worse pain was in the right medial upper trapezius region. He had no symptoms extending into the upper extremities. He worked from December 5, 2011 to April 17, 2012 but he had not worked since then. After examining Petitioner and reviewing the medical records and diagnostic test, he diagnosed Petitioner with a trapezius strain. Dr. Zelby opined that neither of Petitioner's injuries aggravated, exacerbated, accelerated or even caused his cervical spondylosis to become symptomatic. He recommended Petitioner undergo 8-10 more visits with physical therapy and he opined that after that Petitioner would be at maximum medical improvement. He further opined that Petitioner did not have any surgical correctible problem. He had some neck pain but, in the absence of spinal cord compression, he expected a poor result from surgery. He noted that Petitioner had no radicular symptoms on exam. Although the EMG suggested multiple radiculopathies, there was no clinical correlation between eithe his symptoms, his exam or his diagnostic studies. While surgery could be performed he opined that it would give the patient no reasonable expectation for any long term meaningful relief.

Dr. Zelby evaluated Petitioner a third time on October 10, 2012. At that time Petitioner reported he still had a lot of neck and bilateral shoulder blade pain, which was greater on the right along with bilateral biceps pain. He had no pain radiating down the arms and the tingling in his hands that he had before. Based on the examination and a review of the medical record and diagnostic studies, Dr. Zelby testified he diagnosed Petitioner as having a trapezius strain. While Petitioner reported ongoing complaints that he ascribed to his work injury. Dr. Zelby testified that he found his diagnostic studies showed fairly mild degenerative changes without any acute abnormalities and without any neural impingement. He opined that Petitioner did not have any identifiable medical condition on his diagnostic studies that correlated with his radiographic findings, and there were certainly no indication to consider or pursue any surgical intervention. There was no reasonable expectation that any kind of surgical intervention would provide Petitioner with any subjective relief of his symptoms. Based on Petitioner's exam, his diagnostic studies, the treatment he received, he was qualified to perform the same work activities he had performed prior to April of 2012. He further opined that Petitioner did not require any further treatment for his spine or nervous system.

As a house keeping matter, Petitioner's attorney pointed out that there was a prior law firm retained that filed claim 11 WC 32356. Petitioner filed two more claims that are noted above in the case captioned. At the outset of the arbitration hearing, Petitioner's current attorney asked that the Arbitrator to accept an order to voluntarily dismiss the 11 WC 32356 claim. The motion was accepted by the Arbitrator. Next Petitioner's attorney indicated he is offering PX18, the prior attorney's fee petition. Petitioner had previously retained Attorney David Martay and he handled his file for a few months. Petitioner's current attorney sent Petitioner's prior attorney an e-mail regarding the hearing today. The prior attorney did not appear. Petitioner's current attorney then discussed what services the prior attorney had rendered and submitted the prior attorney's fee petition into evidence as Petitioner's PX 18. The Commission finds based on the evidence that Petitioner's prior attorney failed to prove up his entitlement to attorneys' fees.

The Commission noted that all of the doctors were in agreement that the April 12, 2011 accident resulted an injury to Petitioner's left shoulder. The dispute specifically centers around whether or not the April 12, 2011 work accident resulted in Petitioner's pre-existing degenerative two level cervical condition to become symptomatic and in need of treatment. From the April 17, 2011 through April 16, 2012,the day before the second accident, Petitioner's diagnoses ranged from upper extremity radiculopathy to median neuropathy at the wrist, C5-6 and C6-7 herniated disc with cervical stenosis, cervical myalgia with degenerative disc disease at C5-6, cervical discogenic pain and cervical facet syndrome. These diagnoses were in turn treated conservatively with medication, physical therapy, cock-up splint, cervical injections and Petitioner being taken off of work. Of these diagnoses, it appears that the cervical radiculopathy is most suspects and is left unproven by the EMG/NCV. The Arbitrator highlights the fact that he relied on Drs. Pomerance, Bush-Joseph and Zelby as a basis for his opinion. Taken in turn, the Commission notes that Dr. Pomerance is a hand and upper extremity surgeon who readily admits

that he does not have the expertise or training in the cervical area to evaluate and/or comment on the causation of Petitioner's condition. As such the Commission places no weight on his opinion. The Commission notes that Dr. Bush-Joseph both finds Petitioner's condition is consistent with cervical radiculopathy and further expresses a positive causation opinion in terms of whether the April 12, 2011 work accident relates to Petitioner's cervical condition. Lastly, Dr. Zelby finds that Petitioner's symptoms are exclusively related to his left shoulder. However, at a later point in his report Dr. Zelby notes that Petitioner developed left shoulder pain with "some neurological-type symptoms" that have no radiculopathy Give all of the above, the Commission finds that evidence supports the fact that Petitioner sustained a left shoulder strain as a result of the April 12, 2011 work accident and additionally Petitioner's pre-existing degenerative two level cervical condition became symptomatic and in need of conservative treatment after the work April 12, 2011 work accident.

After the April 17, 2012 second accident, Petitioner expresses additional and new subjective complaints in terms of his right cervical area as well as the prior symptomatic left side and additional objective testing was performed. Immediately after the April 17, 2012 work accident Petitioner complained of electrical shot type pain going down his right arm. The follow-up EMG shows for the first time shows C6-7 and left C5 cervical bilateral radiculopathy. At this juncture, Drs. McNally and Zelby express differing causation opinions. Dr. McNally finds that the April 17, 2012 accident aggravated and accelerated Petitioner's pre-existing prior asymptomatic degenerative cervical spinal condition causing the same to become symptomatic and in need of treatment while Dr. Zelby found that the objective testing was not supported by the clinical findings and as such there was no such aggravation, exacerbation or acceleration of Petitioner's cervical spondylosis. As a result of Dr. McNally's opinion, Petitioner is ultimately subjected to a two level cervical surgery. Further potentially complicated this case is the fact that immediately before Petitioner returns to work after the surgery, Petitioner's vehicle is rear-ended. Having reviewed the medical records surround this incident, the Commission finds the motor vehicle accident does not constitute an intervening accident that breaks the causation chain given the fact that the cervical fusions is shown to be still intact, Petitioner was at most diagnosed with a cervical strain and Dr. McNally released Petitioner to return to work two days later with no restrictions. Based on the chain of events, the Commission finds that, whether it be neurologically or orthopedically based, the April 17, 2012 work accident caused an otherwise asymptomatic pre-existing degenerative condition to become symptomatic and in need of treatment. As such, the Commission reverses the Arbitrator's opinion and finds Petitioner's cervical condition as well as his left shoulder condition is causally related to the April 12, 2011 and April 17, 2012 work accident.

Based on the above, the Commission modifies the Arbitrator's decision and finds Petitioner is entitled to all medical expenses incurred and orders Respondent to pay for all reasonable and necessary prospective medical expenses. Furthermore the Commission finds that based on the April 12, 2011 accident Petitioner was temporarily totally disabled from August 2,

2011 through December 5, 2011 and finds that based on the April 17, 2012 accident, Petitioner was temporarily totally disabled from April 18, 2012 through May 19, 2013.

While the Commission does not agree with Dr. Zelby's position, the Commission finds that Respondent was reasonable in relaying on the same as a basis to cut off temporary total disability and not authorize and/or pay for some of the medical treatment. As such the Commission finds Petitioner is not entitled to any additional compensation and/or attorneys' fees.

IT IS THEREFORE ORDERED BY THE COMMISSION that Claim No. 11 WC 43091, Respondent pay to Petitioner the sum of $324.71 per week for a period of 18 weeks, that being the period of temporary total incapacity for work under §8(b) of the Act, and that as provide 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 in Claim No. 12 WC 18986, pay to Petitioner the sum of $324.71 per week for a period of 56-4/7 weeks, that being the period of temporary total incapacity for work under §19(b) of the Act , and that as provide 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 medical expenses set forth in Petitioner's PX1 and orders Respondent to pay for additionally reasonable and necessary prospective medical expenses under §8(a) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Petitioner, is hereby not entitled to any additional compensation and/or attorneys fees under §19(l), §19(k) or §16 of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Petitioner's former attorney's petition for attorneys' fees, is hereby denied.

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

14IWCC0945

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: NOV 0 6 2014

O: 10/2/14

MB/jm

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Mario Basurto

David L. Gore

Stephen Mathis

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

Clinton Taylor,
Petitioner,

vs.

NO: 12 WC 43325

Mt. Vernon Police Department,
Respondent.

14IWCC0946

DECISION AND OPINION ON REVIEW

Respondent appeals the decision of Arbitrator Lee finding Petitioner sustained an accidental injury arising out of and in the course of his employment on October 16, 2012. As a result Petitioner was temporarily totally disabled from November 27, 2013 (sic) through March 25, 2013 minus a credit of 7.20 weeks for a total of 9.66 weeks under Section 8(b) of the Illinois Workers' Compensation Act, is entitled to the medical expenses contained in Petitioner's group exhibit and permanently lost 15/20% (sic) of the use of his right leg under Section 8(e) of the Act. The Issues on Review are whether Petitioner sustained an accidental injury on October 16, 2012, whether there is a causal connection between the alleged October 16, 2012 work accident and Petitioner's present condition of ill-being, and if so, the amount of necessary medical expenses and the nature and extent of Petitioner's permanent disability. The Commission, upon reviewing the entire record, reverses the Arbitrator's decision and finds while Petitioner proved he sustained an accidental injury on October 16, 2012, he failed to prove a causal connection exists between the alleged October 16, 2012 work accident and Petitioner's present condition of ill-being, for the reasons set forth below.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

The Commission finds:

1. Petitioner, a 36 year old police sergeant, testified that on October 16, 2012, he was arresting a subject who was resisting arrest and trying to flee. He forced the subject to the ground. Petitioner testified that his own knees struck the asphalt/concrete parking lot many times during the altercation. Petitioner identified an incident report and a court finding in which the subject was found guilty of resisting a peace officer. Petitioner testified that prior to October 16, 2012 he did not have any right knee injuries, treatment or claims. Following the altercation, he experienced soreness in his knees and arms. He thought he was going to get better, but he said obviously he had a severe injury he did not know about.

2. Petitioner testified that a few days after the altercation he was working on his commode at his own personal residence. After working on it, his knees started swelling and this caused pain. At the December 20, 2013 Arbitration hearing, Petitioner demonstrated his actions on the day he fixed the commode. He was down on both knees, was flexed forward with his head tilted in an upward manner. During this job he was up and down three to four times for no more than ten to twenty seconds at a time. He was kneeling on a carpeted floor and believes he was wearing jeans at the time. Petitioner testified that prior to performing this job his knee was giving him problems. It continued to bother him and he sought treatment from Dr. Mall.

3. Ryan McKee testified he is a corporal for Respondent's police department. He was present on October of last year when the incident occurred in which Petitioner was required to restrain an individual. They were at the Alternative School responding to a fight call. They handled the initial fight. Then they had a run-in with another student. Petitioner tried to restrain another student while the student was resisting arrest. Petitioner took the student to the ground and they both fell to the concrete. Petitioner's knees were on the concrete. He probably restrained the suspect for 15-20 seconds. Ryan McKee testified he is married to Amanda McKee and she is a nurse practitioner. To the best of his knowledge, the police report is accurate. He is not aware of any problems Petitioner had with his right knee before the incident in October.

4. Both Petitioner and Officer McKee agreed that as police officers they had special training in documenting events and police reports. They agreed that accurate reporting is important to their profession and that, for the most part, the histories taken closer to the event are more accurate than the histories taken at a later date. Petitioner testified he initially thought that the knee pain would go away. He has gotten hurt many times on the job in the last fourteen years and he thought he would get better as he had in the past. Officer McKee testified he did not document any event where Petitioner fell on his knee. He does not have an explanation as to why he did not put down that Petitioner struck his knees on the asphalt/concrete.

5. Petitioner identified an October 16, 2012 incident report he completed. He reported that as Corporal McKee and I were leaving the alternative school a student was standing just outside the door and he was blocking the door from being opening. I walked up to the student and told him to step back inside while I grabbing his arm to escort him back into

the school. The student immediately tensed up and tried to resist while jerking around aggressively. I had to take him to the ground. Once on the ground the student continued to resist and he would not put his hands behind his back. Corporal McKee helped me handcuff the student. After this incident was over I had pain in my left forearm and hand. I had red marks with a small scratch and a small amount of blood on my forearm. Petitioner noted that his injuries were photographed and attached to the report. The Commission notes that no photographs were submitted into the arbitration transcript.

6. Petitioner testified that Nurse McKee is a family friend. She came to the house a few times. During these visits he would complain about his knee.

7. On November 16, 2012, exactly a month after the October 16, 2012 altercation, Petitioner completed an accident report. He reported that on October 16, 2012 he was attempting to arrest a subject. The subject resisted arrest and he had to take the subject to the ground and fight with him on the ground. He reported he tore the patrellar (sic) tendon in his right knee. The Commission notes Petitioner listed a diagnosis prior to seeking medical treatment.

8. On November 19, 2012, Petitioner was seen at Orthopedic of Southern Illinois by Nurse Practitioner Amanda McKee. Mrs. McKee noted that Petitioner's chief complaint was right knee pain. He rated the pain as being a 3 out of a 10 point scales and he reported that he has been experiencing the pain over the past two weeks. Initially he reported that he did not experience any injury or trauma. He next reported he has been wrestling round with a co-worker and he was unsure if that caused the injury. He also reported he was doing work on his knees while replacing a toilet and that may also be causing pain. He was unable to straighten the leg all the way. She diagnosed him as having acute right knee pain, patellar tendinitis or a patellar tendon or quadriceps rupture. She also noted that a meniscus tear needed to be ruled out and she ordered a right knee MRI.

9. The November 19, 2012 right knee MRI showed Petitioner had a partial tear of the proximal aspect of the patellar tendon, beginning at its origin from the patella with peritendinous fluid and edema. The tear measures up to 6 mm AP and 8 mm medial-lateral just distal to the patella. There is also pre-existing patellar tendinosis with mild to moderate tendon thickening, deep infrapatellar bursitis, moderate knee joint effusion but no evidence of a meniscus tear.

10. On November 20, 2012 Petitioner followed up at Orthopedic of Southern Illinois and this time he saw Dr. Freehill. The doctor noted that Petitioner reports having experienced right knee pain dating back to October 16, 2012. He works as a police officer and he was involved in an altercation at work where he was wrestling a perpetrator down to the ground. Apparently when he wrestled the guy down to the ground, he landed directly on his right anterior knee. He was also kneeling to handcuff the guy. He did not have immediate pain but he noted he was sore in the anterior right knee. A couple of days later he was replacing something on the toilet and he has increased pain and swelling about the anterior knee. He did not turn this into the workers' compensation department. He reports he has been limping for the last month. After reviewing the right knee MRI, Dr. Freehill

diagnosed a right knee partial patellar tendon tear. He noted that it is a small area and he recommended conservative management consisting of a hinged knee brace, physical therapy, and pain medication. He noted Petitioner can perform his regular work but he should be careful if his knee buckled. He was told to return in one month.

11. On November 21, 2012, Petitioner starting receiving physical therapy at Mulvaney Rehabilitation Services. There he reported that he had injured his right knee on October 16, 2012 when he got into an altercation with someone that he was trying to apprehend.

12. On November 26, 2012 Petitioner completed an accident report in which he listed the date of accident as October 16, 2012. He noted that he did not immediately report the incident to supervisor because he did not know at the time that he was seriously injured. He reported he attempted to arrest a subject who was resisting arrest. He had to take the subject to the ground and while on ground the subject continued to resist. Corporal McKee assisted him and they were able to get the subject into handcuffs. The ground was concrete. His left forearm and hand were injured in the fight but they have since healed.

13. On November 26, 2012 a supervisor's accident investigation report was completed by Captain Hudson. The date of the incident was listed as October 16, 2012. It was noted that there was a combative arrestee. Officers were called to a fight. The initial incident was under control. Sergeant Taylor and Corporal McKee stayed behind to maintain the peace. Then a 16 year old male student created a disturbance. Sergeant Taylor was escorting the student back into the school to keep the peace. The unruly student physically resisted. Sergeant Taylor used muscling techniques to control the student and to take the student to the concrete, which is what caused Sergeant Taylor's injury. Corporal Ryan McKee witnessed the event. Captain Hudson also memorialized the same in a memo to Chief Mendenall on the same day.

14. On December 5, 2012 Petitioner completed a new patient intake form for Regional Orthopedics Clinic. He listed October 16, 2012 as the date of the incident. He noted that the injury was work related and occurred while arresting a suspect and falling to the ground. On December 6, 23012 Petitioner completed an Application for Adjustment of Claim in which he listed the date of accident as October 16, 2012 and stated he injured his right knee/leg while arresting a combative subject.

15. On December 12, 2012.Petitioner started treating at Regional Orthopedics with Dr. Mall. The doctor noted that Petitioner was working as police officer when he was involved in an altercation on October 16, 2012 in which she (sic) had to wrestle a 15 year old and hand cuff him. After the altercation, Petitioner noticed several lacerations, scrapes on his arm as well as some soreness in his arms and legs and in various parts of his body. As these injuries became less relevant, he began noticing right knee pain. He believes several co-workers noticed him limping. Since then he has been having swelling in the knee and this prompted him to see an orthopedic doctor. Dr. Mall opined that based on the fact that patient had had no prior knee pain and assuming the history he provided is factually correct, and I have no reason to believe it is not correct, he believes that Petitioner's symptoms are causally related to his injury that occurred on October 16,

2012. He further stated that Petitioner's delay in reporting this is likely secondary to the multiple injuries that he suffered at that time and this simply became more sore as Petitioner became more active following the injury. It also became more relevant and more apparent as his other injuries cleared up. Since this did not affect the entire patellar tendon, it is reasonable that he did not have significant deficits initially as the remainder of the patellar tendon was functioning. Therefore, this is less a functional problem than a pain related problem. The doctor recommended Petitioner undergo surgery consisting of a knee arthroscopy and patellar insertion debridement through the scope, patellar tendon trephination, and a small open debridement and reattachment of the patellar tendon defect centrally.

16. On January 3, 2013, Petitioner underwent surgery. The post operative diagnosed was a right knee patellar tendon tear and right knee patellar tendonitis.

17. On March 25, 2013, Dr. Mall remarked Petitioner is doing great and at this point he believes it is safe for Petitioner to proceed with a four week trial return to work. He noted that if Petitioner does well with this then we will proceed to find Petitioner has reached maximum medical improvement. On April 24, 2013, Dr. Mall released Petitioner to full duty and found that he had reached maximum medical improvement.

18. On November 20, 2013, Dr. Mall was deposed. He testified he is an orthopedic surgeon who has sports medicine fellowship training. The operative findings matched the MRI and the clinical results. Dr. Mall was asked whether the act of kneeling for a period of 5-10 minutes on a concrete surface would likely cause the defect that was seen surgically and he answered it would not have caused the defect. Dr. Mall opined that the MRI demonstrated pretty clearly that there is some acute inflammation in the knee, that there was a defect in the patellar tendon associated with that and that his clinical symptoms correlated exactly with where that defect was located .So clearly in my opinion his symptoms were directly related to that defect in the patellar tendon. Based on my discussion with the Petitioner, he was not having any knee problems before this. He does not have any reason to think that Petitioner was lying to him when he reported that his injury occurred when he was attempting to handcuff and take down this 15 year old suspect and he developed knee pain as a result of this incident. He mentioned that he had some scratches and other problems that could have easily been more painful for him at the initial point and as those started to resolve the knee pain became more and more evident to him. Although he did state that he had knee pain immediately after the injury as well, it may not have been as much of a problem for him until the other things sort of resolved and started to heal themselves. If one has a complete patellar tendon rupture, then they would not be able to function immediately after an injury. However, Petitioner had at most a tear of 25% of the tendon. So clearly, there were plenty of tendon fibers that would allow the patient to have the ability to extend his knee and would not present like a typical acute patellar tendon rupture. The patient would have had pain related to that area and pain with certain activities. Petitioner reported that he limped occasionally and that some of his other fellow officers were able to pick up on that, which I would expect potentially was worse as the pain got worse. Petitioner has done fantastic since the surgery. Once he got his full knee strength back, he did great. He went back to full duty

work. He was last seen on April 24, 2013 at which time he had reached maximum medical improvement. Dr. Mall testified that it would not be unreasonable after having knee surgery to have a little bit of discomfort when running, especially if Petitioner has even a mild amount of quadriceps weakness which might exacerbate the knee. The alleged event at work was on October 16, 2012 and Petitioner first sought treatment on November 19th from Nurse McKee. He is not sure if he ever saw her notes. He does not recall recording in his notes that Petitioner was working on a toilet but he does remember having that conversation with him. Specifically, he said he has some pain when kneeling for a short time. He has never heard of someone having a patellar tendon injury from kneeling even for ten to twenty hours. He opined that kneeling can aggravate a lot of knee conditions and it can probably aggravate a patellar tendon rupture. There are lots of things that made Petitioner's knees symptomatic. It was not just kneeling.

19. Dr. Nogalski, a board certified orthopedic surgeon, was deposed on September 30, 2013. He evaluated Petitioner on April 3, 2013. Dr. Nogalski testified that contemporaneous histories are better than histories that are obtained after the fact. In the contemporaneous medical records there was no history like the present history. After a few days, a story can change. In this case, we are getting reports based upon people's statement that were made a month later. So not only is there an issue about timing but there is also an issue about revision, based on the discussion between people so that there is even another source of error or potential inaccuracies. Dr. Nogalski opined that police men are some of the best/most accurate historians because it is incumbent up on them to report an accurate history that is contemporaneous with the event since their reports are often relied upon with respect to criminal prosecution and tort issues. They know very well that they need to be detailed and complete. Petitioner indicated he was involved in an altercation while working as a police officer. He arrested a 15 year old student. He was trying to restrict the student and he was slammed down to the ground. He recalls having pain in his knee. He took some pictures of his arm which was scratched up and this resulted in aggravated battery charge. Right after that happened he stated he had some soreness. He told me that he was more occupied with the scratches on his arm then his knee. Although he believed his knee was sore. Three to four days later, he had to kneel down to change some seals around his toilet bowl. After that, he noticed his knee swelled up and he started having problems walking and getting in and out of the car. He went to see a nurse practitioner who is the wife of one of his co-workers. His first report was to Nurse McKee. In her notes there was a chief complaint of right knee pain which he rated as a 3 out of 10 on a 10 point scale for the past two week. He reported there was no injury or trauma. He also reported that he has been wrestling a co-worker and he was unsure of what caused the injury. He further reported he was doing work on his knee while replacing a toilet and that this may also be causing pain. Dr Nogalski opined that Petitioner's condition was not related to his employment. He does not believe his employment caused, aggravated or accelerated the right knee condition that ultimately required surgery. First of all, if someone tears their tendon they know they have torn it because they cannot put weight on it and walk on it. They cannot perform straight leg raising as Petitioner did with Nurse McKee. This condition is going to be one where you know it is there from the beginning. Here, Petitioner did not have the symptoms around the time of the claimed injury. He even volunteered to Nurse McKee that there were several possibilities as to how this

occurred. A month's time elapsed prior to there being a specific complaint of pain formally given to a medical provider. It appears he was scratched from the incident but he did not have any clear, contemporaneous statements that that he struck his knee or injured his knee specifically at the time of the claimed October 16, 2012 altercation.

20. Petitioner testified that Dr. Mall placed him at maximum medical improvement on April 24, 2013. He released him back to work three weeks prior to his final release date to see if his knee was up to it. He has not seen Dr. Mall or any other medical professionals for his knee since April 24, 2013. He was released back to full duty because his job would not allow for restrictions. Currently, he has a lack of strength in his right knee. He feels it when he is bending and squatting down and standing up. After walking for a half an hour, his knee gets sore. Occasionally, he takes over-the-counter Aleve for his knee pain. When he squats down sometimes it is harder to stand up or he has to shift his position a little bit to stand. He resigned from Respondent's employment on October 14, 2013. Currently he is working as a part-time detective for another police department. He also owns his own hunting and fishing guide business and he owns a concealed carry business.

The Commission finds that Petitioner's contemporaneous records are not consistent with one another and they do not support Petitioner's claim that he injured his right knee in the October 16, 2012 altercation. The most contemporaneous report is the October 16, 2012 incident report which is made on the day of the event. The incident report contains an extreme amount of detail regarding the altercation. Among other things, it addressed the physical condition of the Petitioner post altercation with references/photos taken of Petitioner's injured arm/hand and scratches, but it makes absolutely no reference to and had no photos whatsoever of Petitioner's right knee. One whole month elapses before a second report is made. The second report is the Form 45, which is dated approximately one month later and which again addresses the altercation, but oddly enough it contains a diagnosis of a torn patrellar (sic) tendon in Petitioner's right knee prior to Petitioner seeking any medical care. Petitioner does speak about being familiar with Nurse McKee, who is the wife of fellow Officer Ryan McKee. He says she came by the house a few times during which he complained of his right knee. Interestingly enough, when he sees Nurse McKee in a formal medical setting three days after he completes the Form 45 report he does not mention the altercation but instead talks about wrestling with a co-worker and being on his knees while fixing a toilet. He dates the onset of the knee pain only two weeks before and he indicates that it is without injury or trauma. All of the medical records subsequent to right knee MRI correspond to the altercation. Petitioner claims that he did not know his right knee was that bad. He thought it was going to get better. Otherwise, he would have mentioned it earlier.

While it is true that Dr. Mall provides a positive causation opinion regarding Petitioner's right knee and the altercation, his opinion is only as good as the foundation upon which it based upon. Dr. Mall relied on Petitioner's history that he developed right knee pain following the altercation. He speculates that the only after the pain dissipated from the scratches and other problems that the knee pain became more evident to Petitioner. Dr. Mall also testified he is not sure if he ever saw Nurse McKee's notes. Based on the medical records, the Commission finds that the evidence does not support

14IWCC0946

Dr. Mall's opinion. Conversely, while Dr. Nogalski may have overstated the fact that Petitioner would be immediately incapacitated with such a tear, he makes a valid point that the contemporaneous records should be weighed heavier than those further removed. As noted above, the Commission does not find that the Petitioner's contemporaneous records are consistent with one another and they do not support Petitioner's claim that he injured his right knee in the October 16, 2012 altercation. Given the totality of the evidence, the Commission places more weight on Dr. Nogalski's causation opinion than Dr. Mall's causation opinion and finds Petitioner failed to prove his right knee condition arose out of and in the course of the October 16, 2012 altercation. Notably, Petitioner's extremely detailed incident report authored the day of the incident and the contemporaneous medical report given to Nurse McKee do not support Petitioner's claim that his right knee condition resulted from a work accident on October 16, 2012.

IT IS THEREFORE ORDERED BY THE COMMISSION that since Petitioner failed to prove a causal relationship exists between the accident of October 16, 2012 and Petitioner's current condition of ill-being, his claim for compensation is denied.

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

DATED: NOV 0 6 2014

O: 9/25/14

MB/jm

43

Mario Basurto

David L. Gore

Stephen Mathis

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

Ruben Camacho,
Petitioner,

vs.

NO: 13 WC 31607

14IWCC0947

Vesuvius USA Corp.,
Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of accident 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, with the exception of what is noted below.

The Commission strikes the language contained in the Arbitrator's decision in which she states that the basis of her causation opinion is in part resulting from the opinions of the treating doctor and otherwise affirms the Arbitrator's decision.

IT IS THEREFORE ORDERED BY THE COMMISSION that, with the exception noted above, the Decision of the Arbitrator filed April 24, 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.

14IWCC0947

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $990.00. 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: NOV 0 6 2014

Mario Basurto

MB/jm

O: 10/2/14

David L. Gore

43

Stephen Mathis

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

CAMACHO, RUBEN A
Employee/Petitioner

Case# **13WC031607**

14IWCC0947

VESUVIUS USA CORP
Employer/Respondent

On 4/24/2014, 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:

0146 CRONIN PETERS & COOK
KENNETH D PETERS
221 N LASALLE ST SUITE 1454
CHICAGO, IL 60601

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

14IWCC0947

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 19(B) ARBITRATION DECISION PURSUANT TO SECTION 19(F)

RUBEN A. CAMACHO
Employee/Petitioner

v.

VESUVIUS USA CORP.
Employer/Respondent

Case # 13 WC 31607

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 **JESSICA A. HEGARTY**, Arbitrator of the Commission, in the city of **CHICAGO**, on **2/11/14**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

14IWCC0947

FINDINGS

On **6/11/13**, 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 **$33,280**; the average weekly wage was **$640.00**.

On the date of accident, Petitioner was **47** years of age, ***married*** with **1** dependent children.

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

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

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

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

ORDER

Respondent shall pay reasonable and necessary medical services, pursuant to the medical fee schedule, of $890.00 to Southland Orthopaedics, as provided in Sections 8(a) and 8.2 of the Act.

The Arbitrator further orders the Respondent to authorize and pay for the arthroscopic surgical procedure to the Petitioner's right knee as prescribed by Ram Aribindi, M.D.

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

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

Signature of Arbitrator

4/24/14
Date

APR 24 2014

14IWCC0947

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

RUBEN A. CAMACHO,	)	
	)	
Petitioner,	)	
	)	
vs.	)	**No. 13 WC 31607**
	)	
VESUVIUS USA CORP.	)	
	)	
Respondent.		

ADDENDUM TO ARBITRATION DECISION
STATEMENT OF FACTS

Petitioner is a forty-seven (47) year old laborer who has worked for Respondent for thirteen (13) years. Petitioner works in the "Pack Ups" department, a job that requires him to inspect "small shapes" of cement that are loaded onto wooden pallets and moved by forklift. On a normal day Petitioner climbs on and off a forklift thirty-five times a day.

On June 11, 2013, Petitioner was getting off a forklift. He swung his legs over to the side of the forklift and then slid down to the ground and noticed pain in his right knee. Petitioner identified a photograph of the forklift truck (PX 1) testifying the truck has a seat in the center with two steps on the side of the truck. Petitioner estimated the distance from the side of the forklift to the ground to be about four (4) to five (5) feet. Petitioner did not use the steps to get off the truck. Petitioner reported the accident to his supervisor, Jack Lee, shortly after it happened. Mr. Lee told Petitioner to see the Safety Director who advised Petitioner to seek medical attention at Advocate Occupational Health in Hazel Crest (hereinafter "Advocate"). Petitioner identified Mr. Lee who was in court.

The June 11, 2013, Advocate medical records document Petitioner was "getting off a forklift, felt sharp pain in my R knee." The examination documented pain to palpation. X-rays showed degenerative changes in the knee and internal derangement of the knee. Petitioner was released with restrictions not to lift more than 20 lbs, not to work at heights as well as no squatting or

kneeling. A knee brace was recommended. (PX 2) Petitioner returned to work and Respondent accommodated the restrictions recommended by the medical provider.

On June 21, 2013, a right knee MRI revealed an oblique tear extending to the inferior articular surface within the body and posterior horn of the medial meniscus sparing the meniscal root, mild arthritis of the medial and patella femoral compartments, possible "jumper's knee" and bipartite patella variant. Petitioner was referred to Ram Aribindi, M.D., an orthopedic surgeon. (PX 3)

On July 8, 2013, Dr. Aribindi noted Petitioner "injured the right knee while getting off a forklift while at work on June 11, 2013." The doctor noted right knee pain and assessed a tear of the right medial meniscus. A right knee arthrocope was prescribed. The doctor indicated he would proceed upon approval from the workers' compensation carrier. (PX 3) Petitioner retuned to Dr. Aribindi on July 22, 2013 and August 5, 2013. On both occasions, Dr. Aribindi continued to recommend the arthroscopic surgery pending the workers' compensation carrier's approval. On August 5, 2013, Dr. Aribindi recommended light duties with limited walking and no climbing ladders. (PX 3)

On August 15, 2013, Petitioner was examined by Stephen Weiss, M.D., pursuant to Respondent's Section 12 request. The doctor noted that the Petitioner experienced pain in his knee as he swung his right leg while dismounting a forklift. The doctor noted the forklift was two feet high. The doctor noted that Petitioner felt pain in his right knee before his foot hit the ground. Dr. Weiss' report contains the opinion that getting off a forklift could not cause or significantly aggravate the right knee to such a point that would necessitate surgery. In Dr. Weiss' opinion, Petitioner experienced pain while simply swinging his leg to the side which is not a weight bearing, torquing motion and from a physical perspective this motion would not produce a traumatic meniscal tear nor would such a motion be sufficient to accelerate an underlying condition. Dr. Weiss opined that Petitioner did not sustain a traumatic injury and instead simply experienced a manifestation of a pre-existing medial meniscus tear. Dr. Weiss did agree that arthroscopy is warranted.

Petitioner denied telling Dr. Weiss that the pain in his right knee started before he hit the ground.

Petitioner testified that he never had experienced that type of pain in his right knee before. Petitioner testified to ongoing right knee pain as well as right sided limping. He testified that he continues to work for Respondent but refrains from climbing ladders. Petitioner testified that he wishes to undergo the surgical procedure prescribed by Dr. Aribindi.

OPINION AND ORDER

Accident and Causal Relationship

Petitioner's testimony was that he injured his right knee on June 11, 2013 while getting off a forklift that he was using to move cement parts. Petitioner identified the forklift shown in Petitioner's Exhibit Number 1 as the forklift he was using that day. Petitioner testified that he swung his legs to the right and then slid of the side of the forklift onto the ground. He stated he felt pain in his right knee when he hit the ground. The Arbitrator observed Petitioner during his testimony and found him to be credible. The medical records from June 11, 2013 and July 8, 2013 note that Petitioner was injured while getting off a forklift on June 11, 2013.

The Arbitrator finds Petitioner did sustain an accident that arose out of and in the course of his employment on June 11, 2013.

A causal connection may be established by a chain of events including employee's ability to perform manual duties prior to the date of accident and decreased ability to perform them immediately following that date. Zion Benton Township High School Dist. 126 vs. Industrial Commission, 242 Ill. App. 3d 109, 182 Ill. Dec. 440, 609 N.E. 2d 974, 1993.

Petitioner testified he had been employed by Respondent in a physically demanding job that required him to get on and off a forklift approximately thirty-five times a day. It is unrebutted that Petitioner was able to perform his job without difficulty until June 11, 2013.

Petitioner testified that on June 11, 2013, he injured his right knee while getting off a forklift. He testified that he felt the pain in his right knee when he landed on the ground. Petitioner sought medical care the same day at a clinic recommended by his employer. The clinic records document that Petitioner's accident occurred that same day while he was getting off a forklift. The clinic diagnosed an internal derangement of the knee and placed restrictions on Petitioner's work activities. Following an MRI that revealed a torn medical meniscus, the clinic referred Petitioner to Ram Aribindi, M.D. an orthopedic surgeon.

The orthopedic doctor's records contain a history consistent with Petitioner's testimony with respect to the cause of his right knee injury on June 11, 2013. Dr. Aribindi recommended arthroscopic surgery to repair the torn meniscus and sought approval from Respondent's workers compensation carrier.

The Arbitrator finds that Petitioner has presented sufficient evidence to establish a causal connection between the present condition of ill-being of his right knee and the accidental injuries he sustained on June 11, 2013 by both the chain of events established by the evidence and the opinion of his treating doctor. The Arbitrator finds the opinions of the treating doctor and the chain of events more persuasive on the issue of causal connection than the opinion of Respondent's Section 12 examiner. After reviewing the photograph of the forklift, and listening to Petitioner's testimony, as to how he dismounted the forklift, the Arbitrator finds Petitioner's version of events to be credible.

The Arbitrator therefore finds a causal connection between Petitioner's present condition of ill-being and the injuries sustained on June 11, 2013.

Medical Expenses

The Petitioner introduced into evidence Petitioner's Exhibit Number 4 which is an itemized bill from Dr. Aribindi's office showing a balance of $890.00. This bill documents charges for office visits and consultations with Dr. Aribindi. The Arbitrator finds these charges to be for reasonable and necessary medical services and directs the Respondent to pay these bills pursuant to the applicable statutory fee schedule.

Prospective Medical

Petitioner's treating orthopedic surgeon, Ram Aribindi, M.D., has recommended Petitioner undergo arthroscopic surgery to his right knee. Steven Weiss, M.D., Respondent's Section 12 examiner concurs with that recommendation.

The Arbitrator finds the prospective medical treatment in the form of a right knee arthroscopic surgical procedure to be reasonable and necessary and orders Respondent to authorize and pay for this procedure and the resulting post surgical treatment.

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

Mark Hall,

Petitioner,

14IWCC0948

vs.

NO: 13WC 13147

Illinois Department of Transportation,

Respondent,

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Respondent, herein and notice given to all parties, the Commission, after considering the issues of accident, medical expenses, 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 4, 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.

14IWCC0948

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

DATED: NOV 06 2014
MJB/bm
o-09/30/14
052

Michael J. Brennan

Thomas J. Tyrrell

Dissent

I respectfully dissent from the Majority's decision. The Petitioner failed to present medical opinion evidence that his work duties caused or contributed to the repetitive injury alleged. I would reverse this decision.

Kevin W. Lamborn

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

HALL, MARK
Employee/Petitioner

Case# **13WC013147**

ILLINOIS DEPARTMENT OF TRANSPORTATION
Employer/Respondent

14IWCC0948

On 4/4/2014, 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:

0250 HOWERTON DORRIS & STONE
STEVE STONE
300 W MAIN ST
MARION, IL 62959

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

0558 ASSISTANT ATTORNEY GENERAL
NICOLE WERNER
601 S UNIVERSITY AVE SUITE 102
CARBONDALE, IL 62901

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

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

APR 4 2014

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

STATE OF ILLINOIS)
)SS.
COUNTY OF WILLIAMSON)

14I 00948

☐ Injured 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

MARK HALL
Employee/Petitioner

v.

ILLINOIS DEPARTMENT OF TRANSPORTATION
Employer/Respondent

Case # 13 WC 13147

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 **Ed Lee**, Arbitrator of the Commission, in the city of **Herrin**, on **February 5, 2014**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS 14IWCC0948

On **12/20/2010**, 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 $50,904.50; the average weekly wage was $978.93.

On the date of accident, Petitioner was **51** years of age, ***married*** with **1** dependent children.

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

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

ORDER

Respondent shall pay reasonable and necessary medical services of $7,336.13, as provided in Sections 8(a) and 8.2 of the Act, with due credit for group or workers' compensation payments previously made.

Respondent shall pay Petitioner permanent partial disability benefits of $587.36/week for **20.05** weeks, because the injuries sustained caused the **10** % loss of the **hand**, as provided in Section 8(e) of the Act.

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

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

Edward Lee 3/21/14

Signature of Arbitrator Date

APR 4- 2014

Mark Hall
vs.
Illinois Department of Transportation

No. 13-WC-13147

Attachment to Decision of Arbitrator

Mark Hall was diagnosed with deQuervain's syndrome in his left hand. (See generally Petitioner's 1 & 2) The treatment for his deQuervain's was reasonable and necessary. (See Petitioner's 1 and Page 16 of Petitioner's 2) Surgery resolved the deQuervain's syndrome, but petitioner continues to have soreness and loss of grip strength, particularly if he is called upon to use his hand frequently or participate in heavier labor activities.

The central issue is whether work caused or contributed to cause him to suffer deQuervain's syndrome. While the Illinois Department of Transportation honored the claim and approved the medical treatment, it now disputes accident, causation, and nature and extent of the disability.

Mark Hall first experienced symptoms in his hand in December of 2010. It started out as something akin to a strain, but ultimately, his joint would lock up on him, and his efforts to release the joint caused significant pain and dysfunction. (Tr. pp. 31-33.)

He reported the problem to his supervisor on December 21, 2010. He saw a doctor for the first time on December 29, 2010. His history to the doctor of an onset three weeks prior is consistent with his testimony and report of injury. He related to the doctor that he had no recall of a specific injury, but did relate that he was a concrete tester, and that he does a lot of repetitive

"rodding" with his left hand when checking concrete. His doctor gave him Volteran gel, a splint and Motrin.

Mr. Hall followed up with his doctor in January with worsening symptoms, reporting that the Volteran gel did not help. The splint did not help. His doctor sent him to an orthopedic surgeon, who tried therapy and injections before recommending surgery. (Petitioner's 1, Red Tabs 5 and 6 detail the medical treatment)

Mark Hall worked for the Illinois Department of Transportation as a tester of concrete for years before December of 2010. Petitioner's exhibits 5-14 are photographs of the equipment he utilized on a daily and weekly basis to test concrete. As a tester of concrete, he would conduct air testing, slump testing, strength testing, and would grade concrete. The number of times he would be called upon to do each test per day and week varied, but the work is undoubtedly "hand intensive." (Tr. pp. 10-30.) Respondent's section 12 examiner admitted as much:

Q: And you would agree that there are some elements of his work are hand intensive?

A: Yes (Petitioner's 2 at page 25.)

Petitioner detailed the tests he performed. The air test alone is "hand intensive." To do the air test, he uses a scoop to gather wet concrete, pours wet concrete into a steel cylinder, "rods," that is, thrusts a steel rod down through wet concrete seventy five times, pounds the cylinder with a rubber mallet, seals the concrete into the cylinder by symmetrically tightening down

large wing nuts with his left and right hands, manipulating valves, and then introduces air to sample the concrete. He at times did this 4-5 times a day, but at times did as much as 30 times a day, and this was just one test, and does not account for clean up. (Tr. pp.10-30)

According to respondent's section 12 physician, there are two ways to get deQuervain's: repetitive use or some kind of trauma. (Petitioner's 2 at page 17 lines 12-18)

There is no evidence of blunt trauma or fall, and respondent's section 12 doctor admitted as much. (See lines 18-20 at page 26 of Petitioner's 2)

So petitioner's condition is the result of hand intensive activity.

Respondent's Section 12 admitted that petitioner's work was hand intensive:

Q: There is at least – he does have – based on all that you've reviewed, there is some part of his day that is hand intensive at work?

A: Yes (See lines 12-15 at page 26 of Petitioner's 2)

Indeed, respondent's section 12 physician admitted that 99% of hand intensive activity away from work combined with as little as 1% of hand intensive active at work could cause deQuervain's. (See line 17 at page 25 to line 11 at page 26 of Petitioner's 2)

While respondent's section 12 doctor opined that there was not enough hand intensive activity in petitioner's work day to cause deQuervain's syndrome, he conceded that a combination of non work and work activity likely did cause petitioner's deQuaervain's syndrome.

Q: So the most likely cause is a hand intensive activity exclusively at work or a combination of the two?

A: That's the most likely explanation. (See lines 21-24 of page 26 of Petitioner's 2)

Petitioner produced respondent's section 12 report and deposition in his case; therefore, the evidence of causal connection provided by respondent's section 12 physician compliments all the other evidence, namely, that petitioner had hand intensive activity at work sufficient to contribute to deQuervain's syndrome. Accident and causal connection is established.

Nature and extent of injury is 10% of a hand. Petitioner continues to experience pain and dysfunction (loss of grip strength) when laboring. He voluntarily sought a lateral move to avoid the strain on his hand from the work described in his testimony. This was not disputed.

Medical. Respondent to pay the bills outlined in Petitioner's 1, pursuant to the fee schedule and subject to any credit owed.

STATE OF ILLINOIS)
) SS.
COUNTY OF WILL)

☐ 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

SHIRLEY DOSHER,

Petitioner,

14IWCC0949

vs.

NO: 10 WC 19613

GRAND PRAIRIE TRANSPORTATION,

Respondent.

DECISION AND OPINION ON REVIEW

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

To the extent the Commission modifies the Decision of the Arbitrator, it only vacates the awarding of benefits under Section 8(e) for injuries claimed to Petitioner's left knee and right hand as it finds no causal connection was shown that related the April 21, 2010, accident to any injury to either body part. The Commission, moreover, finds there is no evidence of either body part being injured as a result of the April 21, 2010, accident.

In reviewing the evidentiary record, the Commission finds Petitioner testified to falling and hitting an unspecified arm and then seeking treatment for her symptomatic lower cervical and upper thoracic spine. She later testified that, when the accident occurred, her knee, fist and upper and middle back hurt. She did not, however, specify which knee or fist was hurting as a result of the accident. She then testified to experiencing tingling and numbness in the fingers of her right hand in the month following the accident. In reviewing the medical records, it becomes apparent that, if Petitioner sustained injuries to her left knee and right hand as a result of the April 21, 2010, accident the physicians who examined and treated Petitioner failed to find any

evidence of this.

Petitioner fell on April 21, 2010, and was seen two days later, on April 23, 2010, at Pirie Chiropractic & Elite Rehabilitation Institute ("Pirie Chiropractic"). At that time, she provided a history of falling forward and landing onto both her left knee and left wrist. The records indicate Petitioner had a history of osteoarthritis in her left knee, and the examination of Petitioner's left knee found positive for knee pain but did not indicate her left knee experienced an acute trauma. The record of Petitioner's April 23, 2010, visit did not document any abrasions, cuts or bruises being found on Petitioner's left knee. This is in contrast to the findings of her left wrist showing multiple scratches, bruises and, specifically, an open cut consistent with a fall onto a hard surface. The Commission takes note that Dr. Anthony Pirie, the examining physician, did not make the same or a similar comment with respect to Petitioner's claimed injury to her left knee. The Commission also takes note that Petitioner did not complain of any pain or dysfunction concerning her right hand or wrist to Dr. Pirie.

Petitioner was seen at Pirie Chiropractic over approximately sixty-six visits between April 26, 2010, and June 21, 2011, for treatment involving her knees bilaterally, neck, shoulders and low back. Concurrent with this treatment, Petitioner was also seen by Dr. Samir Sharma of the Pain & Spine Institute. Upon initially presenting to him on May 11, 2010, Petitioner completed an intake form in which stated that she fell onto her knees and body on April 7, 2010. In that same form, she complained of numbness, tingling and a pins-and-needles sensation in her right hand. Despite these complaints, Dr. Sharma made no mention of either over the eight office visits in which he saw and examined Petitioner, not even within the context of detailing Petitioner's then-current complaints. The Commission, after reviewing his records, recognizes his attention was focused on treating Petitioner's complaints involving her back, but finds it unlikely that he would not have made at least passing reference to complaints of left knee and/or dysfunction in her right wrist if she, in fact, voiced such complaints particularly as she was actively undergoing treatment for left knee at the same time she was being seen by him.

Pursuant to a referral by Dr. Sharma, Petitioner presented to Dr. George DePhillips for a neurosurgical consultation on October 6, 2010. Though Petitioner's history or complaints did not reference any left knee or right wrist pain, Dr. DePhillips examined her upper and lower extremities and found no positive findings.

Five days later, on October 11, 2010, Petitioner underwent a State-mandated physical as is required for school bus drivers. The findings were the same as was found by Dr. DePhillips. Petitioner's upper and lower extremities were normal or within normal limits.

The Commission, based on the totality of evidence, finds nothing in the evidentiary record to support Petitioner's claim that either her left knee or right wrist complaints were causally connected to the accident of April 21, 2010, most notably a physician's opinion stating as such or any record of either body part coming into contact with the ground or being subjected to any trauma that would have caused them to become symptomatic due to her fall. Accordingly, the Commission vacates the permanent disability awards meant to compensate Petitioner for injuries to her left knee and right wrist and affirms and all other aspects of the Decision of the Arbitrator.

14IWCC0949

IT IS THEREFORE ORDERED BY THE COMMISSION that the permanent partial disability awards concerning Petitioner's left knee and right hand are vacated.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $245.33 per week for a period of 37.5 weeks, as provided in §8(d)2 of the Act, for the reason that the injuries sustained caused the 7½% loss of the person as a whole.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent is liable to pay Petitioner the fee schedule-adjusted amount with respect to medical expenses associated with Petitioner's cervical spine condition.

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 $9,300.00. 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: NOV 0 6 2014
KWL/mav
O: 09/08/14
42

Kevin W. Lamborn

Thomas J. Tyrrell

Michael J. Brennan

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

14IWCC0949

DOSHER, SHIRLEY
Employee/Petitioner

Case# **10WC019613**

GRAND PRAIRIE TRANSPORTATION
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:

1315 DWORKIN AND MACIARIELLO
THOMAS GAYLE
134 N LASALLE ST SUITE 1515
CHICAGO, IL 60602

0208 GALLIANNI DOELL & COZZI LTD
ROBERT J COZZI
20 N CLARK ST SUITE 825
CHICAGO, IL 60602

STATE OF ILLINOIS)
)SS.
COUNTY OF WILL)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION 14IWCC0949

SHIRLEY DOSHER
Employee/Petitioner

v.

GRAND PRAIRIE TRANSPORTATION
Employer/Respondent

Case # 10 WC 19613

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 **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 _____

14IWCC0949

FINDINGS

On **4/21/10**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$13,448.24**; the average weekly wage was **$258.62**.

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 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

Respondent shall pay Petitioner permanent partial disability benefits of $245.33/week for 48 weeks, because the injuries sustained caused the 7-1/2% loss of the person as a whole (37.5 weeks) as provided in Section 8(d)2 of the Act; 2.5% loss of the left leg (5.375 weeks) and 2.5% loss of the right hand (5.125 weeks) as provided in Section 8(e) of the Act.

Respondent is liable to pay to Petitioner the fee schedule adjusted amount with respect to medical expenses associated with Petitioner's left knee contusion, right wrist contusion, cervical spine condition.

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

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

12/27/13
Date

ICArbDec p. 2

DEC 30 2013

FINDINGS OF FACT:

On April 21, 2010, Petitioner was employed by Respondent as a bus driver. Petitioner testified that the job required her to drive a bus route as well as driving charter bus trips scheduled by Respondent. Petitioner testified that she did not work at a fixed job site and her duties required her to travel to various locations throughout the Respondent's service area. While on assigned charter trips Petitioner was not given scheduled breaks and was on duty for the entire charter trip.

On April 21, 2010, Petitioner testified that Respondent assigned her to drive a charter trip that required her to pick up handicapped passengers at a nursing home and take them to lunch at Lone Star Restaurant. Petitioner stated that upon arriving at restaurant with her passengers, she stopped the bus at the front entrance and assisted the passengers off the bus by operating the wheelchair ramp and assisting with wheelchairs and walkers. Petitioner provided that once the passengers were unloaded, she parked the bus in the parking lot and walked back to the front entrance of the restaurant. Upon reaching the front entrance of the restaurant she spoke with nursing assistants who were escorting the passengers into the restaurant. She then returned to the bus to retrieve her travel drink mug with the intention of going inside the restaurant to fill it with water. She returned to the entrance of the restaurant; spoke with the nursing assistants; turned to go into the restaurant; and tripped on uneven concrete. [Petitioner submitted pictures of surface which purports show a defined raise of approximately 1 to 1-1/2 inch in one slab of concrete when compared to the adjacent slab. (PX 8)] Petitioner testified that she fell forward noticing pain in her knees, wrists, upper neck and back pain.

Petitioner testified that in the ensuing days her symptoms got worse. On April 23, 2010, Petitioner sought medical attention with Dr. Pirie of Pirie Chiropractic. Petitioner presented with complaints of neck, back, left knee, and right wrist pain. The recorded history includes that she fell in parking lot on uneven surface, fell forward landed on left knee and left wrist. Petitioner indicated that her pain progressively worsened including back and neck pain 8/10. (PX 1) Petitioner testified that the fall was on the sidewalk at the entrance to the restaurant as opposed to falling in a parking lot. An examination revealed multiple scratches and bruises on the left wrist and hand with generalized edema. Her cervical range of motion was about 80% normal with pain with forced flexion. Shoulder depression was positive for moderate bilateral arm pain in C5/6 dermatones. At the left wrist there was pain with pressure over carpal bones pisiform and there was a positive McMurrays test of the left knee. Petitioner was assessed with cervicalgia, lumbago and wrist and knee pain secondary to fall. The treatment plan consisted of 4weeks of chiropractic care and physical therapy. (PX 1) Petitioner continued to work for Respondent.

On May 3, 2010, Dr. Pirie referred Petitioner to a pain management specialist for ongoing pain complaints. (PX 1) Also, Dr. Pirie's recommended Petitioner undergo a MRI of the cervical spine which when carried out on May 4, 2010 revealed disk bulges, endplate spurring and facet arthritis causing mild asymmetric stenosis of the left neural foramen at C3/4 C4/5 and C5/6. (PX 4)

On May 11, 2010, Petitioner presented to Dr. Sharma at the Pain and Spine Institute for pain management. (PX 3) Dr. Sharma recorded a history of fall on uneven sidewalk. Dr. Sherma noted Petitioner complained of low back pain primarily in the upper, mid and lower lumbar spine. The doctor also noted complaints of neck pain with location of discomfort being posterior and both sides of the neck. Petitioner provided that it radiated to the upper back, intrascapular area, subscapular region, shoulders, arms and forearms

bilaterally. Dr. Sharma assessed low back pain, lumbar radiculopathy, upper back pain, cervical radiculopathy and neck pain. Medication was prescribed. (PX 3)

Pursuant to Dr. Pirie's recommendation, Petitioner underwent x-rays of the right wrist and left knee at Provena June 14, 2010. X-rays of the left knee were unremarkable except for mild narrowing and minimal degenerative changes in the medial compartment. (PX 5) The Arbitrator notes PX 5 shows a billing for a left wrist x-ray. However, there is no report depicting the results.

On July 23, 2010, Petitioner returned to Dr. Sharma who noted Petitioner complaints were low back pain, lumbar radiculopathy, upper back pain, cervical radiculopathy and neck pain. Dr. Sharma recommended facet diagnostic medial branch blocks at C4-C7. (PX 3)

Petitioner underwent the first cervical blocks on August 9, 2010. In follow up on August 31, 2010, Dr. Sharma noted that the branch blocks provided no relief and referred Petitioner to a neurosurgeon for consultation. (PX 3)

Petitioner was seen by Dr. Dephillips on October 6, 2010. Dr. Dephillips recorded a history that Petitioner tripped on uneven sidewalk and fell forward thrown on the ground with her head jerked backward to avoid striking the cement. Since then she suffered neck pain and bilateral shoulder pain and shooting pain into the right arm to the elbow. Pain was 7/10 worst at the neck and left shoulder. The doctor noted the cervical branch block provided initial relief but the pain returned the next day to the same severity. Also noted was the MRI of the cervical spine revealed degeneration with bulges at C3/4 C4/5 C5/6. Dr. Dephillips differential diagnosis was cervical sprain, facet pain, discogenic pain from exacerbation of degenerative disc disease and neurologic impingement. Dr. DePhillips recommended a second diagnostic medial nerve branch block C3-C7. He noted that Petitioner continued to work but that driving aggravates her pain. (PX 2)

On October 8, 2010, Petitioner underwent an Illinois Department of Transportation medical examination. Petitioner provided the examination was to maintain her bus driving license. As part and parcel to the examination, Petitioner was required to complete a questionnaire. The first page of the questionnaire reveals that the question of whether she has had "[a]ny illness or injury in the last 5 years" is not check either way. The other boxes are checked "no," including any reference to a "spinal injury" or "chronic low back pain." Dr. James Niemeyer performed an examination and found no abnormality, deformities, limitation of motion, tenderness of the spine and no loss of impairment of the extremities. The doctor certified that Petitioner met the necessary standards and provided medical clearance for her commercial driver's license. (RX 1)

On October 27, 2013, Petitioner returned to Dr. DePhillips. The doctor noted Petitioner continued to suffer neck pain which she rated at 7 to 8 on a scale of 1-10. The pain radiated into the right shoulder and arm to the elbow. Petitioner also reported numbness to her right hand. Dr. DePhillips continued to recommend the second branch block. Also discussed was radiofrequency rhizotomy if the block provided relief. I (PX 2).

On December 13, 2010, Dr. Sharma performed the second cervical branch block. (PX 3) Petitioner continued chiropractic care with Pirie Chiropractic. At her December 14, 2010 visit, she reported soreness but was able to move head/neck easier. (PX 1)

On December 23, 2010, Petitioner followed up with Dr. DePhillips and it was noted that the branch block reduced her symptoms for 24 hours but the symptoms returned. Her pain was noted at 6/10 associated with headaches and interscapular pain but no shooting pain; however, she had numb tingling to the second, third, and fourth digits of right hand. Dr. DePhillips recommended cervical epidural steroid injections. (PX 2)

On January 19, 2011, Petitioner saw Dr. Sharma. The doctor noted Petitioner presented with unchanged upper back, neck pain and cervical radiculopathy. Dr. Sharma performed a C6/7 epidural steroid injection. (PX 3)

On February 9, 2011, Dr. Sharma noted ongoing upper back pain and cervical radiculopathy with neck pain. Also noted was that following the first epidural steroid injection Petitioner had 75% relief of symptoms. Dr. Sharma provided the second prescribed cervical epidural steroid injection. (PX 3)

Petitioner returned to Dr. DePhillips on February 24, 2011. The doctor noted that the epidural steroid injections provided relief for a few weeks. She continued to experience neck pain radiating into the left shoulder which was aggravated with left lateral bending. Dr. DePhillips wanted to confer with Dr. Sherma before recommending additional treatment modalities. (PX 2)

Petitioner continued chiropractic care with Pirie Chiropractic and on March 1, 2011 it was noted that progress was good. (PX 1)

On March 2, 2011, Petitioner saw Dr. DePhillips. Dr. Sherma was also present at the visit. Dr. DePhillips noted Petitioner continued with ongoing symptoms. The doctor recommended radiofrequency ablation bilaterally. (PX 2) Petitioner did not wish to proceed with the procedure.

Petitioner returned to Pirie Chiropractic on March 8, 2011, April 26, 2011 and May 5, 2011. Records noted ongoing improvement. (PX 1)

On May 11, 2011, Petitioner was seen by Dr. Sharma. The doctor noted that the epidural had provided 90% relief of symptoms. Petitioner was released from care on PRN basis. (PX 3)

Petitioner testified that the effects of the epidural steroid injections continued to improve her condition and she felt the full improvement was a month or more after the second injection. Petitioner had her final chiropractic visit June 28, 2011 and has not sought additional medical care for this accident.

Petitioner testified that she did not injure her lumbar spine and that some of the treatment and care was paid by her husband's her health insurance. Petitioner testified that she still experience neck and upper back pain as well as tingling in the right hand.

With respect to (C) Did an accident occur that arose out of and in the course of employment of Petitioner's employment by Respondent, the Arbitrator finds as follows:

Having considered the credible evidence and testimony, the Arbitrator concludes that Petitioner sustained an accidental injury that arose out of and in the course of her employment by Respondent.

The Arbitrator notes the long standing traveling employee doctrine in Illinois Workers' Compensation as well as the recent appellate court decision in Mlynarczyk v. IWCC 2013 ILApp3d 120411WC (hereinafter Mlynarczyk) affirming said doctrine.

The first assessment is whether Petitioner is a traveling employee. (id). In determining whether Petitioner is a traveling employee the Court determines whether claimant did not work at a fixed job site and whether her duties required her to travel to various locations throughout the area. (id).

Upon determining that Petitioner is a traveling employee it must be determined whether the accident arose out of and in the course of her employment. (id). The Appellate Court ruled that as a traveling employee the exposure to the hazards of the streets, is by definition, greater quantitatively than that of the general public as long as her conduct at the time of the injury was reasonable and foreseeable to the employer. (id). Thus the test of whether the traveling employee's injury arose out of and in the course of employment is the reasonableness of the conduct in which she was engaged at the time of the injury and whether the conduct might have been anticipated or foreseen by the employer. (id).

In Mlynarczyk, Petitioner's job was to go from site to site to meet cleaning crews, she did not have a fixed job site, and her job required her to travel around Respondent's service area. (Id). In Mlynarczyk the accident occurred after Petitioner had completed an assignment, had gone home for a meal, and was leaving her home. (Id). The Appellate Court found that she was a traveling employee and that her conduct at the time of accident, descending stairs, was reasonable and foreseeable by Respondent. (id). The Court awarded claimant benefits under the Act. (Mlynarczyk).

In the instant case, Petitioner is a traveling employee. Petitioner has no fixed job site and her job requires travel throughout Respondent's service area. At the time of accident, Petitioner was on a charter bus trip assignment and that during this assignment she was at all times "on the clock" and was not provided with any scheduled breaks.

Given the conclusion that Petitioner is a traveling employee, the assessment is whether Petitioner was engaged in reasonable conduct at the time of accident and whether this conduct might have been anticipated or foreseen by the employer. The Arbitrator concludes that Petitioner's conduct of walking to the entrance of the restaurant where her charter passengers were having lunch was entirely reasonable. That talking with the passengers' nursing assistants near the entrance is entirely reasonable. It is further reasonable that Petitioner would retrieve a travel mug from the bus and return to the restaurant to fill said mug. At the time Petitioner fell she was walking on the sidewalk at the restaurant entrance to get ice for her mug and tripped on an uneven surface. This behavior is entirely reasonable on its own. The reasonableness of this behavior is further supported by the fact that Respondent provided no scheduled break during this charter trip. Petitioner testified credibly to each of these facts and Respondent presented no evidence to the contrary.

The final assessment of whether the conduct of the employee is anticipated by or foreseen by the employer is similarly determined. An employer of a traveling bus driver who assigns an employee to drive a charter bus trip with passengers to a restaurant during lunch time with no scheduled breaks for the employee must reasonably anticipate and foresee that the employee may walk to the entrance of the restaurant for a beverage cup of ice.

The Arbitrator concludes that Petitioner's accident arose out of and in the course of her employment with Respondent.

With respect to (F) Is Petitioner's condition of ill-being causally connected to the injury, the Arbitrator finds as follows:

Having reviewed the credible testimony and evidence, the Arbitrator concludes that Petitioner's condition of ill-being is causally connected to this injury. In support of said conclusion the Arbitrator notes the following:

Petitioner testified that she did not have similar symptoms prior to the accident. Petitioner sustained a traumatic fall from standing position to ground landing on knees and hands with jerking of her neck to catch herself from hitting her face on the concrete. Petitioner testified that following this fall she had knee, hand, upper back, and neck pain. This testimony was credible and supported by the medical records.

Petitioner initially presented with back pain with radicular symptoms, neck pain with radicular symptoms, left knee pain, and right wrist pain. Subsequently, based on the medical records, it appears that the knee pain and wrist pain substantially resolved. The cervical spine radicular symptoms with neck pain were indicated as the most severe of her conditions.

Care for Petitioner's neck and cervical spine condition was with Dr. Sharma and Dr. George Dephillips M.D.,S.C Neurological Surgery. Dr. DePhillips reviewed the cervical spine MRI scan and reported that Petitioner had disc degeneration primarily at C3/4, C4/5, and C5/6 with disc bulging and associated disc osteophyte complexes. In his October 6, 2010 report, Dr. Dephillips offered the differential diagnosis of cervical sprain, neck pain, discogentic pain from exacerbation of degenerative disc disease, and neurologic impingement. Respondent presented no medical opinion to dispute the diagnosis or causal connection.

The Arbitrator concludes that based on the credible testimony and evidence this accident caused a left knee contusion, right wrist contusion, and an aggravation of a pre-existing degenerative cervical spine condition causing cervical radicular symptoms. The Arbitrator notes Petitioner testified that she did not injure her lower back in the accident.

With respect to (J) Were the medical services that were provided to Petitioner reasonable and necessary. Has Respondent paid all appropriate charges for all reasonable and necessary medical services, the Arbitrator finds as follows:

Having reviewed the credible testimony and evidence the Arbitrator concludes that Respondent has not paid all related necessary medical expenses and is liable for payment of same.

Petitioner testified and the medical records reflect that the diagnostic testing and conservative treatment that she received was overall effective in improving her condition of ill-being. Petitioner underwent chiropractic care from, April 23, 2010 to June 28, 2011. The medical records indicate regular improvement in her conditions.

Petitioner underwent two cervical branch blocks prescribed by her medical doctor and while these blocks ultimately did not resolve the condition there is no evidence that this was unreasonable conservative medical care.

Petitioner underwent two cervical epidural steroid injections prescribed by her medical doctor and there is ample evidence that these injections provided substantial and lasting relief culminating in a release from further medical care.

Respondent presented no evidence or testimony disputing the reasonableness and necessity of the medical care provided.

The Arbitrator notes Petitioner testified that she did not injure her low back in the accident. Some of the bills offered does not separate the charges to the low back from those associated to the neck and other related parts. As such, the Arbitrator concludes that Respondent is liable to pay to Petitioner the fee schedule adjusted amount with respect to medical expenses associated with Petitioner's left knee contusion, right wrist contusion, cervical spine condition. Respondent shall to pay to Petitioner reimbursement for the amount paid by her husband's group health insurance plan for payments to Pirie Chiropractic. Amounts paid by the husband's group health insurance plan to providers after July 7, 2010 are not related to this claim.

With respect to (L) What is the nature and extent of the injury, the Arbitrator finds as follows:

Petitioner sustained a compensable accident that resulted in a left knee contusion, right wrist contusion, and an aggravation of a pre-existing degenerative cervical spine condition causing cervical radicular symptoms. Petitioner underwent conservative treatment that included chiropractic care, physical therapy, two cervical branch blocks and two cervical epidural steroid injections. The conservative care culminated in substantial and lasting relief. Petitioner testified that she still experience neck and upper back pain as well as tingling in the right hand.

The Arbitrator concludes that Petitioner sustained a partial permanent disability of 2.5% loss of use of the left leg, 2.5% loss of use of the right hand, and 7-1/2% loss of use of the person as a whole.

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 Von Thaden,

Petitioner,

14IWCC0950

vs.

NO: 10 WC 8392

All Out Print Communications,

Respondent.

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed December 5, 2013 is hereby affirmed and adopted.

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

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: NOV 0 6 2014
KWL/vf
O-9/9/14
42

Thomas J. Tyrrell

Michael J. Brennan

DISSENT

I respectfully dissent from the Majority's decision. Given the paucity of testimony concerning Petitioner's activities, and the lack of objective medical evidence supporting his record I am not persuaded that Petitioner's right rotator cuff tear resulted from the overuse of his right upper extremity as a result of compensating for his previously injured left shoulder. I would find the rotator cuff tear in the right shoulder is not causally related to Petitioner's December 18, 2009 injury to this left shoulder.

Kevin W. Lamborn

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

14IWCC0950

VON THADEN, ROBERT
Employee/Petitioner

Case# **10WC008392**

ALL OUT PRINT COMMUNICATIONS
Employer/Respondent

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:

2208 CAPRON & AVGERINOS PC
DANIEL F CAPRON
55 W MONROE ST SUITE 900
CHICAGO, IL 60603

2837 LAW OFFICES OF JOSEPH A MARCINIAK
BRENT HALBLEIB
2 N LASALLE ST SUITE 2510
CHICAGO, IL 60602

STATE OF ILLINOIS)
)SS.
COUNTY OF COOK)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

14IWCC0950

Robert Von Thaden
Employee/Petitioner

v.

All Out Print Communications
Employer/Respondent

Case # 10 WC 08392

Consolidated cases: _____

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Carolyn Doherty**, Arbitrator of the Commission, in the city of **Chicago**, on **November 12, 2013**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On the date of accident, **December 18, 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 **$41,600.00**; the average weekly wage was **$800.00**.

On the date of accident, Petitioner was **38** 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 **$46,704.47**.

ORDER

Respondent shall authorize and pay for the surgery to Petitioner's right shoulder and the attendant care as prescribed by Dr. Silver pursuant to Sections 8 and 8.2 of the Act.

Respondent shall pay Petitioner's reasonable and necessary medical expenses incurred in connection with the care and treatment of the causally related right shoulder pursuant to Sections 8 and 8.2 of the Act and shall pay any medical expenses incurred in connection to the left shoulder injury which remain outstanding pursuant to Sections 8 and 8.2 of the Act. PX 6. Respondent shall receive credit for amounts 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.

Carolyn Doherty
Signature of Arbitrator

12/5/13
Date

ICArbDec19(b)

DEC 5 – 2013

14IWCC0950

FINDINGS OF FACT

The matter appears before this Arbitrator on Petitioner's 19(b)/8(a) Petition. By way of background, the Arbitrator notes that Petitioner injured his left shoulder while working for the respondent on December 18, 2009. That accident gave rise to a left shoulder surgery and a recommendation by the treating orthopedic surgeon, Dr. Ronald Silver, for a second left shoulder surgery. Respondent disputed the need for a second shoulder surgery. As a result, the matter was heard pursuant to Section 19(b) of the Act on March 9, 2012.

The Arbitrator issued a decision on May 4, 2012, and determined that Respondent was to pay for the second left shoulder surgery. Respondent filed a petition for review. In a Decision dated January 10, 2013, the Commission affirmed and adopted the Decision of the Arbitrator. On February 15, 2013, Petitioner underwent surgery to his left shoulder consisting of an arthroscopic subacromial decompression, lysis of adhesions, distal clavicle resection, synovectomy and debridement. (PX 1, p. 15) Petitioner remains under the care of Dr. Silver for his left shoulder. He is receiving physical therapy and TTD benefits.

During the pendency of the review petition on the Arbitrator's Decision concerning the second left shoulder surgery, Petitioner began to experience pain in his right shoulder. Petitioner associated these right shoulder symptoms with the overuse of his right shoulder as a result of the injury to his left shoulder. The issue currently before the Arbitrator is whether Petitioner's right shoulder condition is causally related to the original left shoulder injury by way of aggravation or overuse. Petitioner filed an 8(a) Petition requesting a finding of causal connection for the right shoulder condition and an award of the recommended right shoulder treatment.

At trial before the Arbitrator on 11/12/13, Petitioner testified that while waiting for his left shoulder surgery, he began to gradually develop pain in his opposite right shoulder which he associated with overuse. Specifically, Petitioner testified that between March 2012 and January 2013, his left shoulder remained painful while waiting for the surgery so Petitioner overused his right shoulder during this 10 month period. Petitioner testified that he would perform all daily tasks including light housework, cleaning and vacuuming with his dominant right arm because his injured left arm was of little utility to him.

Subsequent to the issuance of the first Arbitrator Decision in May 2012, Petitioner continued to wait for his left shoulder surgery and continued to treat with Dr. Silver. PX 1. On June 26, 2012, Dr. Silver indicated that "because of the long delay in treatment of (the petitioner's) left shoulder, his right shoulder has begun to become progressively more and more painful due to the overuse he had to put on it over the past years." Dr. Silver diagnosed rotator cuff impingement "due to overcompensation overuse due to his work injury regarding his left shoulder and his delay in treatment." (PX 1, p. 8) A cortisone injection to the right shoulder provided only temporary relief. (PX 1, p. 7)

On August 24, 2012, Dr. Silver noted that both of the petitioner's shoulders were "doing poorly" with reduced range of motion. An MRI of the right shoulder was prescribed. (PX 1, p. 6)

Petitioner underwent an MRI of his right shoulder on September 17, 2012. It revealed rotator cuff tendonopathy with a full-thickness tear in the distal fibers of the supraspinatus tendon. (PX 1, p. 9-10) On September 21, 2012, Dr. Silver reiterated that this full thickness rotator cuff tear was due to "the overuse he placed on the right shoulder due to the left shoulder injury..." PX 1, p. 5. Dr. Silver recommended right shoulder surgery in the form of a rotator cuff repair. PX 1, p. 5. Since that time, Petitioner has remained under the care of Dr. Silver but has been able to treat only for the originally-injured left shoulder (PX 1, 2) Dr. Silver has periodically requested authorization to proceed with the right shoulder surgery. (PX 1, p. 2-5; PX 2, p. 6-8)

On August 26, 2013, Petitioner was examined Respondent's request pursuant to Section 12 of the Act by Dr. Anthony Romeo. Dr. Romeo did not review the right shoulder MRI but did review the report. Based on the exam and on the MRI report, Dr. Romeo agreed that Petitioner has a torn right rotator cuff which requires surgery. He concluded, however, that this right shoulder condition is not causally connected to the original work accident because "he had no specific injury to correlate with his previous job to indicate that his right shoulder is a work-related injury." In further support of his opinion, Dr. Romeo stated that "Based on the medical records provided and the patient's discussion of his work related injury, there is no recorded link of causation of the patient's current right shoulder condition to his work-related injury on 12/18/2009." (RX 1)

Petitioner testified at trial that he had no history of accident, injury or treatment to his right shoulder prior to the Section 19(b) hearing on March 9, 2012. He also testified that he has had no accidents to either shoulder since the time of that hearing.

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 in his right shoulder causally related to the injury? K. Is Petitioner entitled to prospective medical care?

The Arbitrator finds that Petitioner's testimony regarding the gradual onset of right shoulder pain while overusing the right shoulder during treatment for his left shoulder is credible, unrebutted and supported by the treating medical records. Dr. Silver has repeatedly and pointedly causally related Petitioner's torn right rotator cuff to the overcompensation associated with the left shoulder injury. Dr. Silver recommends surgical repair of the right shoulder. The Arbitrator notes that Dr. Romeo agrees with both the diagnosis and the recommended treatment but opines no causal relationship based on a lack of a specific injury or a "recorded link" to the original accident and injury. The Arbitrator notes that Dr. Romeo does not specifically address or rebut the issue of "overuse" of the right shoulder due to the left shoulder injury. Accordingly, the Arbitrator assigns greater weight to the opinion of Dr. Silver and finds that Petitioner's current condition of ill-being in his right shoulder is causally connected to the original injury. Based on the finding of causal connection, the Arbitrator further finds that Petitioner is entitled to the surgery recommended for the right shoulder by Dr. Silver and that Respondent shall authorize and pay for that surgery and the attendant care pursuant to Section 8(a) of the Act.

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

Based on the Arbitrator's findings on the issue of causal connection for Petitioner's right shoulder, the Arbitrator further finds that Respondent shall pay Petitioner's reasonable and necessary medical expenses incurred in the care and treatment of the right shoulder pursuant to Sections 8 and 8.2 of the Act. Respondent shall receive credit for amounts paid. The Arbitrator further finds, per the agreement of the parties at trial, that Respondent shall pay any medical expenses incurred in connection to the left shoulder injury which remain outstanding pursuant to Sections 8 and 8.2 of the Act. PX 6. Respondent shall receive credit for amounts paid.

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Chris Matthews,

Petitioner,

vs.

NO: 12 WC 21926

14IWCC0951

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, causal connection, medical expenses 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 successfully showed that he sustained accidental injuries arising out of the course and scope of his employment with Respondent.

Petitioner testified that on May 23, 2012, he was performing preventative maintenance on his double tandem tractor with a trailer with three tandem axles. On that date his truck was low of fuel, so he took it to the fuel house to fuel up for the trip. It was a very windy day and his side door was open as he was fueling the truck with his right hand. His left hand was resting on the truck where he steps up and the wind pushed the door closed smashing his left hand. (Transcript Pgs. 8-12)

He first received treatment at Rush University Medical Center on May 26, 2012, and gave an alleged history of his left hand being swollen with pain for three days after catching a heavy object at work. He allegedly gave a further history that that the mechanism of the injury was a direct blow and the object fell onto his left hand when he tried to prevent it from falling.

The Medical Center took X-rays of his left hand and he was sent to see Dr. Wysocki at Midwest Orthopedics. (Petitioner Exhibit 3)

When the Petitioner went to Midwest, he gave Dr. Wysocki a history of having a car door close on his left hand on May 23, 2012. Petitioner was advised that he had a mildly comminuted fracture without displacement or angulation of fifth metacarpal neck. He was treated by Dr. Wysocki through June 22, 2012. On that date, Petitioner complained of a pain rating of one out of ten. Dr. Wysocki found he was improving with respect to pain and range of motion. The x-rays revealed adequate interval healing with callus formation of the essentially non-displaced fifth metacarpal neck fracture. (Petitioner Exhibit 2)

Petitioner testified that when he went to the emergency room at Rush Medical Center, he gave a consistent history with the history contained on the x-ray report. He further testified that he had no control over what the nurse wrote down and that it could "possibly" be a mistake as to what she wrote down. (Transcript Pg. 43)

The Commission finds the testimony of the Petitioner credible and that he sustained accidental injuries arising out of and in the course of his employment with the Respondent.

The Petitioner testified that he notices he does not have the strength in his left hand that he once had. It is a "little weaker than normal." He further testified that the little finger will not flatten out and he is unable to grip like he used to before the accident.

The Commission finds that Petitioner's employment is a heavy duty type of job. The Petitioner was forty seven years old on the date of the injury. There is not any effect on the Petitioner's future earning capacity as a result of this injury.

However, based on Petitioner's current complaints, as well as Dr. Wysocki's x-ray and physical findings, Petitioner has sustained a loss of use of the left hand to the extent of 7.5%.

The Arbitrator's decision is reversed.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $695.78 per week for a period of 15.375 weeks, as provided in §8 (e) of the Act, for the reason that the injuries sustained caused the loss of use of the left hand to the extent of 7.5%

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $3,816.13 for medical expenses under §8(a) of the Act and §8-2.

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

14IWCC0951

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

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $14,600.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: NOV 07 2014

Charles J. DeVriendt

Daniel R. Donohoo

Ruth W. White

HSF
O: 9/10/14
049

STATE OF ILLINOIS)
) SS.
COUNTY OF)
WILLIAMSON

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Jamie Head,

Petitioner,

vs.

NO: 07 WC 23764
12 IWCC 78
2013 IL App(5th)120543WC-U

White County Coal,

Respondent.

14IWCC0952

DECISION ON REMAND FROM THE APPELLATE COURT

This matter comes before the Commission on the Appellate Court's remand of the Commission's decision which was issued on January 20, 2012. In that decision the Commission found that Petitioner was entitled to temporary total disability from October 14, 2006 through November 10, 2009. The Commission also questioned the validity of Petitioner's job search for alternate employment although it agreed that Petitioner could not return to work at his original job with the Respondent.

The Appellate Court remanded this matter back to the Commission for further findings regarding the Vocational Rehabilitation expert's credibility regarding the Petitioner's skills and limitation. In so doing the Commission must also comment on the credibility of the Petitioner.

When the vocational rehabilitation counselor, Delores Gonzalez, evaluated the Petitioner, he told her that he couldn't sit for more than an hour and a half. He informed her that he could not walk for more than two hours or his leg would swell. He told her he was unable to lift more than 20-25 pounds while walking and that he experienced right leg pain if he bent and right knee pain if he knelt. He told her that he had great difficulty trying to climb stairs and had to hold the

14IWCC0952

railing for support. He could drive for about an hour and a half but then he would need to get out of the car and stretch and walk around before returning to his car. He tried to help around the house but had trouble bending, kneeling and carrying. (Petitioner Exhibit 3 Pgs. 12-13)

Ms. Gonzalez saw no potential for employment with his prior employers given the nature of Petitioners complaints and the restrictions placed upon him by Dr. Houle and McFadden. She found that he is limited in the amount of standing he can do and also with the amount of sitting he can handle. She also found that climbing, crawling and squatting activities are not appropriate for Petitioner. Thus she focused her job search on sedentary and light duty with the ability to stand and sit at will. (Petitioner Exhibit 3 Pgs. 17-20)

Petitioner had told her that he weighed 235 pounds at the time of his accident. That was proved untrue by the medical records following the date of loss. He did not tell her about such activities he undertook such as deer hunting and climbing into a deer stand. Ms. Gonzalez admitted that climbing into a deer stand could be inconsistent with what he told her about climbing stairs. (Petitioner Exhibit 3 Pgs. 43-44) Ms. Gonzalez determined there was no stable job market for Petitioner without accommodations. (Petitioner Exhibit 3 Pgs. 15-17)

The surveillance DVD offered by Respondent (Respondent Exhibit 1) shows the Petitioner riding an ATV over rough terrain at fast speeds. It shows him hunting and jumping off the back of a truck. Petitioner claims he can do all of those things when his leg is not swollen and that the problems come when he stands for more than an hour and a half. He limits his hunting to two or three hours. (Transcript Pgs. 66-69)

Petitioner testified that Dr. Houle has seen his leg after he has been standing for two hours. (Transcript Pgs. 70-71) Dr. Houle in his first deposition testified that his restrictions were no standing for more than two hours and squatting, climbing and crawling would be impossible for him. It must be noted that nothing was mentioned to Dr. Houle regarding Petitioner's deer hunting activities. (Petitioner Exhibit 1 Pgs. 41-42) In his second deposition Dr. Houle testified that he established the two hour limit based on what Petitioner told him in regard to his ability to stand. (Petitioner Exhibit 2 Pg. 22-23) The Doctor admitted that he never saw Petitioner in the kind of test where he would stand on it for two hours and they would measure his leg. He recommended Petitioner to have an FCE but it was never done. (Petitioner Exhibit 2 Pgs. 40-43) He also testified that there is no test to measure the competency of Petitioner's veins because the veins are not arterial and that on January 15, 2010, Petitioner mentioned nothing to him about hunting, fishing or riding ATV's. (Petitioner Exhibit 2 Pg. 44-47)

Dr. Houle admitted that if Petitioner had an FCE which had him on his feet for over two hours and he does not have swelling his opinion would change. (Petitioner Exhibit 2 Pg. 53) It has only been the swelling that was an issue with Petitioner's leg. (Petitioner Exhibit 2 Pgs. 60-61)

Dr. McFadden testified that Petitioner told him that when he stands for over 2 hours his leg would swell to an enormous size. An FCE that required Petitioner to stand for more than two hours would have been very valuable. They could put Petitioner through something to make an objective determination as to his swelling. (Respondent Exhibit 3 Pgs. 10-12)

When Dr. McFadden viewed the DVD he never saw the Petitioner limping. He saw the Petitioner riding an ATV in a field. He admitted that going over an uneven terrain where you have to keep so you are not thrown up and down is "kind of aggressive for someone who's having, you know, pain in their right leg, especially their calf...that should hurt." (Respondent Exhibit 3 Pgs. 39-45) Dr. McFadden indicated that his recommendation on September 3, 2010, was that Petitioner have an FCE due to the lack of objective corroboration of the Petitioner's significant swelling. (Respondent Exhibit 3 Pgs. 46-51)

An FCE was performed on October 13, 2010. (Petitioner Exhibit 11) In that FCE there was no testing in regard to how long the Petitioner could stand without significant swelling in his leg. There is a mention that the longest duration Petitioner could stand without a seated rest period was 41 minutes. However, there is no mention throughout the report of the Petitioner's leg swelling after 2 hours of standing.

The Commission finds that Delores Gonzalez's opinions regarding the Petitioner's capability to work or the job's he may be incapable of working are not persuasive. The history Ms. Gonzalez received from the Petitioner was not a valid history of his complaints. The Petitioner never told her about his hunting for two to three hours. Nowhere does he mention that he deer hunts or that he climbs into the deer stand. He never tells her that he drives a four-wheeler over rough terrain at a fast speed. Instead, all he tells her was that he had great difficulty trying to climb stairs and had to hold the railing for support. He could drive for about an hour and a half but then he would need to get out of the car and stretch and walk around before returning to his car. He tried to help around the house but had trouble bending, kneeling and carrying. She admitted that climbing into a deer stand could be inconsistent with what he told her about climbing stairs.

In the case of **In re Joseph S.**, 339 Ill. App. 3d 599, 607, 791 N.E.2d 80, 87, 274 Ill. Dec. 284 (2003) "Expert opinions must be supported by facts and are only as valid as the facts underlying them." It is the province of the Commission to determine the credibility of witnesses and the weight to be accorded their testimony. **O'Dette v. Industrial Comm'n,** 79 Ill. 2d 249, 253, 403 N.E.2d 221, 223-24, 38 Ill. Dec. 133 (1980).

The Commission therefore finds the testimony of Ms. Gonzales regarding the amount of money the Petitioner can make after his injury to be of little weight and credibility..

14IWCC0952

The Commission attaches its prior decision regarding this claim and incorporates the findings of fact and law contained therein.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $602.16 per week for a period of 160 3/7 weeks, that being the period of temporary total incapacity for work under §8(b) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $541.96 per week for a period of 87.5 weeks, as provided in §8(d) (2) of the Act, for the reason that the injuries sustained caused the permanent loss of use of 17.5% to the person as a whole

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $1,962.58 for medical expenses under §8(a) of the Act.

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

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

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $49,600.00. 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: NOV 07 2014

Charles J. DeVriendt

Daniel R. Donohoo

Ruth W. White

HSF
R: 9/9/14
049

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

MOHAMMED NOMAN,

Petitioner,

vs.

NO: 10 WC 28519

14IWCC0953

ROBERT J. SCHMITZER & BRADLEY A. MINER, Individually and as members of Eagle Eye Surveillance Chicago, LLC, EAGLE EYE SURVEILLANCE CHICAGO, LLC, E-J INDUSTRIES, and ILLINOIS INJURED WORKER BENEFIT FUND,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein, and notice given to all parties, the Commission, after considering the issues of whether E-J Industries was a statutory employer, extent of temporary total disability (TTD), the nature and extent of the injury, and penalties and attorney fees, and being advised of the facts and law, reverses the Decision of the Arbitrator and finds that E-J Industries was the statutory employer of Petitioner. The Commission otherwise affirms and adopts the Arbitrator's awards of TTD (with clerical modification), medical expenses and permanency, but finds that they should properly be awarded against E-J Industries as the statutory employer, relieving the Injured Worker's Benefit Fund from liability. The Commission also affirms the Arbitrator's denial of penalties and attorney fees. The reasons for these findings are stated below.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

The Petitioner, a low voltage technician, worked for Respondent Eagle Eye Surveillance (hereinafter, "Eagle Eye") for two days (March 25 and 26, 2010) prior to the March 29, 2010

accident date. On that date he was performing a permanent surveillance camera installation at the facility of E-J Industries (hereinafter, "E-J"). This involved running cable through walls and using various hand and power tools. While doing so, he fell approximately 12 feet through a platform onto concrete, resulting in significant injury to his right hand. After being taken to Mt. Sinai Hospital, he contacted Eagle Eye's lead partner Schmitzer seeking insurance information, and was told that the company did not carry insurance, and that everything was to be done in Petitioner's name.

E-J's business involved the manufacture of restaurant furniture. Petitioner testified that the facility contained all sorts of hand and power tools in effectuating this purpose. He also said the building itself ran the approximate length of a Chicago city block.

Medical records reflect Petitioner suffered open posterior dislocation of the right second, third and fourth metacarpophalangeal joints. He underwent emergency surgery on March 29, 2010 with Dr. Kaymakealan, which involved open reduction of the right volar plate in the hand with internal fixation, as well as A1 pulley release of the second flexor tendon. He underwent physical therapy at ATI from April 19 through August 4, 2010. Dr. Kaymakealan released him to light duty on May 27, 2010, but Petitioner indicated his calls to Eagle Eye required him to leave a message, and the calls were not returned. Petitioner testified he obtained employment with Lincoln Electronics from May 31 to June 7, 2010, but was let go when he couldn't keep up with the work due to his injury. He obtained a job with Homerun Tech on August 24, 2010 while still restricted to light duty. The job was similar to his job with Eagle Eye, the installation of low voltage camera and home theater installations, and he continued to work in that position at the time he testified.

On October 28, 2010 Petitioner was referred to work conditioning by Dr. Kaymakealan, but he didn't attend because he was not receiving workers compensation benefits. He testified to ongoing headaches and dizziness, reduced right hand strength, and right shoulder pain with the use of power and vibratory tools. He testified to an inability to full extend his fingers, and to a loss of finger flexion and grip strength.

Respondent E-J's Jason Weitzman, testified on the company's behalf. He indicated it was a family business started by his grandfather, and since the grandfather's death a year prior to hearing, the company was reorganizing, leaving him without a current formal title, although the plan was for him to become vice president of the company. His father, Keith, was his supervisor and the owner of the company. Weitzman testified that E-J's business involved manufacture of restaurant furniture, including millwork of bars and cabinets.

E-J hired Eagle Eye to install surveillance cameras. Weitzman testified he was in charge of the project, and that the installation was for E-J's purposes only. He hired Eagle Eye based on their expertise and job bid. He testified that he was present at E-J's facility when Petitioner was injured, and that Eagle Eye "more or less" walked off the job afterwards, resulting in Weitzman hiring another company to finish the installation job.

Per Weitzman's testimony, the building housing E-J also leases space, including a Chicago city mental health facility. The building contained addresses from 1201 South Campbell on the north to 1275 South Campbell on the south. He indicated there were 8 separate spaces in the building, which looks like a single structure from the outside, which were separated by cinder blocks on the inside. All except the mental health facility were accessible via a central hallway. The mental health facility was blocked off by a door which was closed at all times. After testifying at the initial hearing that Eagle Eye owned the building at issue, Weitzman testified at a later date that his grandfather, Leonard, had been the owner, and at some point transferred the ownership interest into a trust to which Leonard himself was the beneficiary.

A lease agreement between Leonard Weitzman and the City of Chicago (Respondent's Exhibit 11) reflects Leonard Weitzman as the sole beneficiary of Metro Bank Trust Number 1806, and that the property at 1201 South Campbell was leased to the city from March 1, 2008 through February 28, 2015. As of 2013, pursuant to a 2012 tax bill (Respondent's Exhibit 12), Leonard and his wife Estelle remained owners of record of the property at 1227 South Campbell. The bill was addressed to the Weitzmans at 1275 South Campbell.

Neither Robert Schmitzer nor Bradley Miner were called to testify by any party to this case. As the attorney for these men and Eagle Eye had previously withdrawn, no one appeared at the hearing before the Arbitrator on their behalf. Petitioner's Exhibit A included copies of notifications sent certified mail to Schmitzer and Miner, with Schmitzer failing to pick his up, and Miner refusing delivery.

Petitioner had previously filed a Motion for Request for Preliminary Hearing Pursuant to Section 4(d) of the Act, and hearing was held on April 19, 2011. At that time, only Eagle Eye, Schmitzer and Miner were party Respondents. Pursuant to the motion, the Commission issued a March 8, 2012 order finding the following: 1) Petitioner and Respondents were operating under the Illinois Workers' Compensation Act at the time of the Petitioner's accident; 2) Petitioner and Respondents had an employer/employee relationship at the time of Petitioner's work accident; 3) Petitioner sustained accidental injuries that arose out of and in the course of his employment with Respondents on March 29, 2010; 4) Respondents did not have workers compensation insurance coverage that covered Petitioner on March 29, 2010; and, 5) Respondents knowingly failed to have such workers compensation coverage which covered Petitioner on March 29, 2010. It was noted that Respondents Schmitzer and Miner had signed an affidavit affirming that they knowingly did not have a workers' compensation insurance policy in place for employees of Eagle Eye on March 29, 2010. (See the Commission Order in Petitioner's Exhibit B).

The Commission finds that, based on a preponderance of the evidence, the Weitzman family owned the E-J facility, as well as the building and multiple spaces within that housed it, and leased at least a portion of the building to the City of Chicago.

The Arbitrator relied on a Commission case, McCarthy v. Diversified Fleet & Arrow Truck Sales, 01 IIC 793 (2001), in finding that E-J was not a statutory employer. Petitioner argues that the statutory employer issue is controlled by Fefferman, Cropmate and Graphic Group. (Fefferman v. Industrial Commission, 71 Ill.2d 325, 375 N.E.2d 1277, 16 Ill.Dec. 935 (1978); Cropmate Co. v. Industrial Commission, 313 Ill.App.3d 290, 728 N.E.2d 841, 245 Ill.Dec. 759 (2000); Graphic Group & KLW, Inc. v. Industrial Commission, 167 Ill.App.3d 1041, 522 N.E.2d 128, 118 Ill.Dec. 673 (1988)).

Initially, it should be noted that the concept of the statutory employer is defined in Section 1(a)(3) of the Act, which references Sections 3(1) and 3(2).

Section 1(a)3 states:

> "Any one engaging in any business or enterprise referred to in subsections 1 and 2 of Section 3 of this Act who undertakes to do any work enumerated therein, is liable to pay compensation to his own immediate employees in accordance with the provisions of this Act, and in addition thereto if he directly or indirectly engages any contractor whether principal or sub-contractor to do any such work, he is liable to pay compensation to the employees of any such contractor or sub-contractor unless such contractor or sub-contractor has insured, in any company or association authorized under the laws of this State to insure the liability to pay compensation under this Act, or guaranteed his liability to pay such compensation. . . ."

Section 3 requires that the Act apply to all employers and all their employees who are engaged in any department of various enumerated enterprises or businesses which are declared to be extra hazardous. Two of these enumerated enterprises or businesses are described in Sections 3(1) and 3(2). Sections 3(1) and 3(2) apply to:

1. The erection, maintaining, removing, remodeling, altering or demolishing of any structure.
2. Construction, excavating or electrical work."

The Fefferman, Graphic Group, Cropmate and Pulliam cases all support the theory that use of a building, even for storage purposes, constitutes "maintaining" a structure within the purview of Section 3(1) of the Act.

In Fefferman, a general merchandiser stored goods within a building on its property. Fefferman retained Dixon Wrecking to demolish the building, and in doing so one of Dixon's employees fell and was injured. Dixon was uninsured. The court determined that Fefferman was the statutory employer, finding: "where one maintains buildings or structures for profit, whether that profit be as compensation for his services or by way of rentals received, and such maintenance requires a substantial portion of his time and attention, he must be said to be engaged in the business of maintaining a structure within the meaning of the Act." The

Fefferman court stated: "In short, for a building owner who has elected not to be subject to the Act, to be liable for the injuries of an employee of an uninsured contractor under the Act, that owner must be engaged in an extra hazardous business or enterprise. Maintenance of a structure is one such business." Fefferman at 329, 1279, 937.

In Graphic Group, a graphic design company hired Dorsch to perform plastering and painting work in its offices on the 32nd floor of a Chicago high-rise. The court noted it was not indicated whether the company owned or leased the office space, "or even if they were going to use it themselves." Dorsch hired the claimant and others to perform the work, and while doing so the claimant was injured. Graphic Group argued that it did not "maintain" a structure within the meaning of the Act. Finding Graphic Group to be a statutory employer, and citing Fefferman, the court indicated that the company's ownership of the offices was not determinative of whether the offices were a capital asset to the company. The court found that Graphic Group was maintaining a structure within Section 3(2) because the inference was that the offices "centralized and made more efficient the operation of its business", and as such indirectly contributed to the revenue received from the business.

In Cropmate, the company manufactured, sold and applied pesticides and insecticides. The EPA required it to erect a chemical containment building. They hired Pinkerton for the project, and in the process of construction, one of Pinkerton's employees was seriously injured. Pinkerton did not have workers compensation insurance coverage. The Commission found that Cropmate owned the building in question, that its construction was required by environmental regulations, and that the building was thus a necessary and essential enterprise from which Cropmate derived substantial income. Cropmate attempted to distinguish the Fefferman decision, arguing Fefferman had maintained a structure "by virtue of the nature of the storage business." The court held that nothing indicated Fefferman's business was "storage", but rather that the building involved in that case had been used to store mercantile goods that were for sale. The court stated that "the determining factor in Fefferman was not the nature of the business, but the fact that the structure contributed to the revenue Fefferman derived from his business."

Based on the Fefferman, Graphic Group and Cropmate cases, we believe that E-J Industries is the Petitioner's statutory employer. The Petitioner was performing work which involved going through walls of the structure that E-J was housed in. Weitzman's testimony clearly indicated that E-J used the building for multiple purposes in performing its business. The purpose of the surveillance installation was to further the business of E-J. It is difficult for the Commission to see how this case differs in any significant way from the precedential cases in terms of the determination that E-J fell within the purview of Sections 1(a)3, 3(1) and 3(2) of the Act.

The Arbitrator noted that Jason Weitzman testified that E-J did not own the building, but rather that it was owned by Leonard Weitzman as a trust beneficiary, and that E-J did not derive any revenue from ownership of the building. He found that E-J was not in the business of installing security cameras, or in any of the businesses enumerated in Section 3(1) or 3(2). As

such, he denied the claim. Petitioner, noting McCarthy reached the right result, argued it is distinguishable, as the claimant in that case was repairing a truck, while Petitioner here was injured while permanently installing cameras into the building itself, both exterior and interior.

In Graphic Group, the court specifically notes that ownership of the building, in and of itself, does not determine whether the building is a capital asset of the prospective statutory employer. All that must be determined is that this employer *derive income from the building, even if it does so indirectly.* Given that E-J clearly uses the building for multiple aspects of its business, from building to storage to offices, it is hard to see how it can be argued that it did not directly derive income from the building.

The work being done by the Petitioner was to the structure itself, and was to be permanent. While it is not "construction or demolition" within the common meaning of the word, the Commission fails to see how it would be considered anything different than the painting and plastering performed in the Pulliam case. Pulliam v. Industrial Commission, 43 Ill.2d 364, 253 N.E.2d 448 (1969). In that case, a funeral home owner had one of his employees, who was normally a driver and aide, performing painting when business was slow. The Fefferman court noted that the clear rationale of the Pulliam case was that "the building was a capital asset which had a noticeable or conspicuous impact on the generation of revenue from his business to the owner of the building." Fefferman at 329-330, 937. The court also stated that Pulliam had effectively overruled a line of cases which had held that maintaining a building as an incident to the business is not the same as maintaining a structure under the Act.

Here, it's clear that there was modification of the structure itself in order to install cameras and TVs. We believe the case at bar is more analogous to Pulliam and its progeny than McCarthy. Additionally, McCarthy is a Commission case which, per the Act, provides us with no precedential value. That this is the key case E-J is relying on supports the fact that current Illinois case law supports a different outcome in this case than the decision on arbitration.

The Commission clarifies the TTD award. While the period of TTD awarded by the Arbitrator was correct, the number of specified weeks this period covers, 19-6/7 weeks, is incorrect and should be 20-1/7 weeks. This modification is reflected in our orders, below.

It is an unfortunate circumstance in this case that the Petitioner has clearly shown he sustained injuries arising out or and in the course of his employment on March 29, 2010, but was unable to obtain contemporaneous benefits due to a lack of insurance with his employer Eagle Eye, and a dispute by E-J over whether it was a statutory employer of Petitioner. While we have found in favor of Petitioner on this issue, we also believe that the defense raised by E-J was not unreasonable or vexatious. As such, we cannot award penalties and attorney fees pursuant to Sections 19(k) and 16 of the Act. Further, because there was good and just cause for E-J to deny paying benefits pending the outcome of this case, we also decline to award penalties under Section 19(l). Thus, we affirm the Arbitrator's denial of these penalties and fees.

14IWCC0953

IT IS THEREFORE ORDERED BY THE COMMISSION that the decision of the Arbitrator is reversed, and that the Petitioner proved by a preponderance of the evidence that E-J Industries was his statutory employer on March 2, 2010 pursuant to Sections 1(a)3, 3(1) and 3(2) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $400.00 per week for a period of 20-1/7 weeks (March 29, 2010 through May 31, 2010 and June 8, 2010 through August 23, 2010), that being the period of temporary total incapacity for work under §8(b) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $360.00 per week for a period of 54 weeks, as provided in §§8(e)3, 8(e)4 and 8(e)5 of the Act, for the reason that the injuries sustained caused the loss of use of 50% of the right index finger, 50% of the right middle finger, and 50% of the right ring finger.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $43,656.90 for medical expenses under §8(a) of the Act, subject to the fee schedule contained in §8.2 of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that 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 $71,200.00. 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: NOV 0 7 2014
TJT: pvc
o 09/09/14
51

Thomas J. Tyrrell

Michael J. Brennan

Kevin W. Lamborn

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

NOMAN, MOHAMMED
Employee/Petitioner

Case# **10WC028519**

EAGLE EYE SURVEILLANCE CHICAGO LLC; E-J INDUSTRIES INC; & THE IL ST TREAS EX-OFFICIO CUSTODIAN OF THE INJURED WORKERS' BENEFIT FUND
Employer/Respondent

14IWCC0953

On 4/16/2013, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.09% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

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SUITE 1410
CHICAGO, IL 60601

2837 LAW OFFICES OFTHADDEUS GUSTAFSON
JOSEPH MARCINIAK
2 N LASALLE ST SUITE 2510
CHICAGO, IL 60602

0766 HENNESSY & ROACH PC
BRIAN DRISCOLL
140 S DEARBORN 7TH FL
CHICAGO, IL 60603

5120 ASSISTANT ATTORNEY GENERAL
DAVID PAEK
100 W RANDOLPH ST 13TH FL
CHICAGO, IL 60601

STATE OF ILLINOIS)
)SS.
COUNTY OF Cook)

14IWCC0953

☒ Injured 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

Mohammed Noman
Employee/Petitioner

Case # **10** WC **28519**

v.

Eagle Eye Surveillance Chicago, LLC; E-J Industries, Inc.; and the Illinois State Treasurer, as *ex-officio* Custodian of the Injured Workers' Benefit Fund
Employer/Respondent

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **David Kane**, Arbitrator of the Commission, in the city of **Chicago**, on **3/21/2013**. 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. ☒ What temporary benefits are in dispute?
☒ TPD ☐ Maintenance ☒ TTD
L. ☒ What is the nature and extent of the injury?
M. ☐ Should penalties or fees be imposed upon Respondent?
N. ☐ Is Respondent due any credit?
O. ☐ Other

FINDINGS

On **3/29/2010**, 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 **$31,200**; the average weekly wage was **$600**.

On the date of accident, Petitioner was **27** 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

Pursuant to Section 8(b) of the Act, Respondent shall pay Petitioner temporary total disability benefits of $400/week for 19-6/7 weeks, commencing from 3/29/10 through 5/31/10 and 6/8/10 through 8/23/10, as provided in Section 8(b) of the Act.

The Respondent shall pay reasonable and necessary medical services of $43,656.90 and subject to the medical fee schedule of Section 8.2 of the Act.

The physical injuries sustained caused a permanent partial disability to the extent of 50% loss of use of the right index finger (21.5 weeks), 50% loss of use of the right middle finger (19 weeks), and 50% loss of use of the right ring finger (13.5 weeks). The Respondent shall pay the Petitioner permanent partial disability benefits of $19,440, based on the PPD rate of $360/week for a period of 54 weeks ($360 x 54 weeks = $19,440), as provided in Section 8(e) of the Act.

The Illinois State Treasurer, as *ex-officio* custodian of the Injured Workers' Benefit Fund, was named as a co-Respondent in this matter. The Treasurer was represented by the Illinois Attorney General. This award is hereby entered against the Fund to the extent permitted and allowed under §4(d) of the Act. In the event of the failure of the Respondent-Employer to pay the benefits due and owing the Petitioner, the Respondent-Employer shall reimburse the Injured Workers' Benefit Fund for any compensation obligations of the Respondent-Employer that are paid to the Petitioner from the Injured Workers' Benefit Fund.

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

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

David A. Kane
Signature of Arbitrator

April 16, 2013
Date

APR 16 2013

STATE OF ILLINOIS)
)
COUNTY OF LaSalle)

14IWCC0953

ILLINOIS WORKERS' COMPENSATION COMMISSION

ARBITRATION DECISION

Mohammed Noman
Employee/Petitioner

Case # **10** WC **28519**

v.

Eagle Eye Surveillance Chicago, LLC; E-J Industries, Inc.; and the Illinois State Treasurer, as *ex-officio* Custodian of the Injured Workers' Benefit Fund,
Employers/Respondents

RESPONDENT'S PROPOSED FINDINGS OF FACT AND CONCLUSIONS OF LAW

I. FINDINGS OF FACT

This action was pursued under the Workers' Compensation Act by the Petitioner and sought relief from the Respondent-Employer Eagle Eye Surveillance Chicago, LLC ("Eagle Eye"), E-J Industries, Inc. ("E-J Industries"), a co-Respondent on whose premises the Petitioner was injured, and the Injured Workers' Benefit Fund (the "IWBF"). On March 29, 2010, the alleged date of Petitioner's work-related accident, Eagle Eye did not maintain workers' compensation insurance. On February 21, 2013, a hearing was held before Arbitrator David Kane in Chicago, Illinois. The Petitioner gave notice of the hearing to Eagle Eye by U.S. certified mail. [Pet. Ex.'s A, A1, A2.] Eagle Eye was not represented by an attorney and

did not appear at the arbitration proceedings. E-J Industries was represented and did participate in the arbitration proceedings. The Illinois Attorney General filed an appearance on behalf of the Illinois State Treasurer, as *ex-officio* custodian of the IWBF and participated in the arbitration proceedings. The proceedings were thereafter continued to March 21, 2013 for some additional witness testimony and exhibits were admitted into evidence and proofs were closed on that date.

Mohammed Noman (the "Petitioner") was born on October 21, 1982. [Pet. Ex. 1.] On March 29, 2010, the date of the work-related accident, the Petitioner was 27 years old and single with no dependent children. [Arb. Ex. 1 and 2.] Petitioner testified that he first started working for Eagle Eye on March 25, 2010 (four days prior to Petitioner's work-related accident). Petitioner testified that Eagle Eye sold and installed electronic surveillance systems which were mounted on ceilings and on the interior and exterior walls of buildings. Petitioner testified that when Eagle Eye hired him, it agreed to pay him $15/hour and that he would work 40 hours per week as a low voltage technician. As part of his job, Petitioner would have to install cameras and wires and use tools including but not limited to a hammer, power drill, and screw drivers. Petitioner testified that he is right handed. Petitioner never received a paycheck from Eagle Eye nor has Petitioner received any workers' compensation benefits from Eagle Eye to date.

The Petitioner testified that on March 29, 2010, he was using power tools to install security cameras on the premises where E-J Industries was operated and located at 1275 S. Campbell Ave., Chicago, Illinois. Petitioner was directed to go to E-J Industries by Robert Schmitzer, a member of Eagle Eye ("Schmitzer"). Petitioner testified that while at E-J Industries, Petitioner went up a ladder to get to a platform to install some

cameras. After getting on to the platform it collapsed causing Petitioner to fall approximately 12 feet. Petitioner fell on his right hand which resulted in several broken bones sticking out of Petitioner's right hand. Petitioner testified that his right hand was bleeding profusely. Petitioner testified he immediately informed Schmitzer of the accident and of his injury; Petitioner also informed Eagle Eye's shop foreman, Wally, who was on E-J Industries' premises at the time of the accident.

E-J Industries called Jason Weitzman, an employee, to testify on its behalf. Weitzman confirmed that E-J Industries is located at 1275 S. Campbell Ave. in Chicago, Illinois and is in the business of manufacturing and selling furniture and seating intended for the use of restaurants, clubs, and hotels. On the date of the accident, Petitioner testified that Keith Weitzman, E-J Industries' president, was on the premises and was made aware of Petitioner's injury.

The Petitioner testified that on March 29, 2010, the Chicago Fire Department took Petitioner to the emergency room at Mount Sinai Hospital. [Pet. Ex. 1.] That same day Petitioner had emergency surgery to treat an open dislocation of the second, third and fourth metacarpal-phalangeal joints on his right hand. The surgery was performed by Dr. Orhan Kaymakcalan and consisted of an open reduction of the second, third and fourth metacarpal-phalangeal joint open dislocation; A1 pulley release of second flexor tendon; volar plate repair of the second, third and fourth metacarpal-phalangeal joint; K-wire fixation of the second, third and fourth metacarpal-phalangeal joint in 90 degree flexion; and skin closure. [Pet. Ex. 1.] Petitioner was discharged from Mount Sinai Hospital on March 30, 2010. [Pet. Ex. 2.] On or before May 11, 2010, Petitioner had fixation pins removed from Petitioner's metacarpal-phalangeal joints. [Pet. Ex. 1.] From

April 25, 2010 to August 4, 2010, Petitioner had approximately 30 sessions of physical therapy at ATI Physical Therapy. [Pet. Ex.'s 3, 6.]

Dr. Orhan Kaymakcalan released Petitioner to return to work light duty as of May 28, 2010 with no heavy use of the right hand and no lifting over 5 pounds. [Pet. Ex. 1.] During subsequent visits to Dr. Kaymakcalan, the doctor gave Petitioner other restrictions including no use of vibrating machinery and no heavy use on August 16, 2010, and no heavy lifting or drilling on October 28, 2010. [Pet. Ex. 1.]

Petitioner testified that due to his injury, he was off work from between March 29, 2010 and May 31, 2010. The Petitioner testified that he returned to work and started a new job at Lincoln Electronics from June 1, 2010 to June 7, 2010 after Dr. Kaymakcalan released Petitioner to return to work light duty. However, Petitioner testified that Lincoln Electronics terminated him because they were not satisfied with his job performance primarily because he was not doing his work fast enough. Petitioner testified that he was then off work from June 8, 2010 to August 23, 2010. On August 24, 2010, Petitioner started working at Homerun Tech, a company that installs home theaters and Petitioner continues to work at Homerun Tech to date. Petitioner currently earns more from Homerun Tech than he earned as an employee of Eagle Eye.

The Petitioner testified that following his right hand surgery, he has recovered for the most part but he still feels pain in his right hand for which he takes over the counter Tylenol several times a week. The Petitioner testified that he is no longer able to fully open his right hand by extending his fingers and that he can no longer fully clench his hand into a fist. Petitioner testified that when he tries to clench his hand into a fist there is a ½ inch space in between his fingers and his right palm. The Petitioner

testified that he is not currently receiving any treatment for his right hand and has no plans to seek further or additional medical treatment at this time.

The Petitioner did not submit any documentary evidence to sufficiently establish that his average weekly wage on the date of the March 29, 2010 accident was $600. However, Petitioner testified that Eagle Eye agreed to pay Petitioner $15/hour and that Petitioner and Eagle Eye agreed that Petitioner would work 40 hours per week. In light of Petitioner's testimony and the lack of any testimonial or other evidence submitted by Respondents rebutting Petitioner's testimony, Petitioner has sufficiently established an average weekly wage of $600.

Petitioner's counsel offered Petitioner's Exhibits 1-10 into evidence at trial. All of the Petitioner's exhibits were admitted into evidence subject to limited objections.

II. CONCLUSIONS OF LAW

Pursuant to the Section 4(d) Order entered on March 8, 2012, which is incorporated herein by reference, the Illinois Workers' Compensation Commission determined that Eagle Eye was operating under the Act on March 29, 2010. It was further determined that Eagle Eye and Petitioner had a employer-employee relationship and that Petitioner sustained an accidental injury on March 29, 2010 that arose out of and in the course of his employment with Eagle Eye. The Commission also found that Eagle Eye did not have workers' compensation insurance at the time of the March 29, 2010 accident.

a. The medical services provided to the Petitioner were reasonable and necessary, and the Respondent has

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

The Arbitrator finds that the Respondent shall pay the outstanding balance of $43,656.90 for reasonable and necessary medical services provided to the Petitioner, and subject to the medical fee schedule of Section 8.2 of the Act.

b. What is the Nature and Extent of Petitioner's Injury?

The Petitioner testified that he has returned to work full duty as of August 24, 2010 and he has some lingering pain and certain extending and gripping issues in his right fingers. The Petitioner has sufficiently established permanency resulting from his injury as to his right index, middle and ring fingers. The treating medical records clearly demonstrate that the Petitioner sought and received medical treatment as to these three right fingers. The Petitioner has the burden of proof on all issues and has proved that he sustained a 50% loss of use of the right index finger (21.5 weeks), 50% loss of use of the right middle finger (19 weeks), and 50% loss of use of the right ring finger (13.5 weeks) pursuant to Section 8(e) of the Act, and is therefore awarded a total 54 weeks of PPD at a rate of $360, totaling $19,440.

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

JUAN CRUZ,

Petitioner,

vs.

NO: 09 WC 09428

GM METAL, INC.,

Respondent.

14IWCC0954

DECISION AND OPINION ON REVIEW

Timely Petitions for Review having been filed by the Petitioner and Respondent herein and notice given to all parties, the Commission, after considering the issues of causation, temporary total disability, prospective medical and permanency, and being advised of the facts and law, modifies the Decision of the Arbitrator as stated below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

The Arbitrator determined that the Petitioner sustained the permanent loss of 37.5% of the man as a whole under Section 8(d)(2) of the Act. The Commission believes that this award should be reduced to 25% of the man as a whole.

We agree with the factual findings and reasoning of the Arbitrator with regard to all other issues presented at arbitration. With regard to permanency, on February 25, 2010 the Petitioner underwent left-sided partial hemilaminectomy, foraminotomy, decompression, partial medial facetectomy and excision of a herniated disc at L5. The need for the surgery was questioned by Respondent's Section 12 examiner, Dr. Walsh. Petitioner had significant ongoing complaints following surgery. While an initial EMG on March 26, 2009 was read by Dr. Kaye as positive for L5 radiculopathy, retesting on July 24, 2010 was completely normal.

When reexamined by Dr. Walsh on September 30, 2010, Petitioner had subjective complaints which were out of proportion to his objective abnormalities. He noted specific

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complaints by the Petitioner that could not be explained. A functional capacity evaluation performed on April 27, 2011 was noted to be invalid based on inconsistencies with grip dynamometer testing, heart rate variations, weights achieved and selectivity of pain reports/behaviors. Based on the invalidity, the therapist who performed the testing indicated there was no way to know what Petitioner's true abilities were. We note with interest the opinion of Dr. Walsh on February 20, 2011 that a fusion surgery proposed by Dr. Malek, at L4/5 and possibly to include L5/S1, was not reasonable or necessary, given there was no clear evidence of mechanical instability at the proposed surgical site, and that Dr. Malek's determination that there was such instability was significantly based on Petitioner's subjective complaints. There was an indication in this same Dr. Walsh report that Petitioner had been released by Dr. Malek to unrestricted duty, and that he agreed with this release. The Commission finds that all of the noted evidence supports an award of 25% of the man as a whole.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $299.67 per week for a period of 125 weeks, as provided in §8(d)(2) of the Act, for the reason that the injuries sustained caused the permanent loss of 25% of the man as a whole.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $10,279.59 for medical expenses under §8(a) of the Act, subject to the fee schedule pursuant to §8.2 of the Act.

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

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

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $47,800.00. 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: NOV 0 7 2014
TJT: pvc
o 09/09/14
51

Thomas J. Tyrrell

Michael J. Brennan

Kevin W. Lamborn

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

CRUZ, JUAN
Employee/Petitioner

Case# **09WC009428**

GM METAL INC
Employer/Respondent

14IWCC0954

On 3/22/2013, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.11% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

1747 STEVEN J SEIDMAN LAW OFFICE
TWO FIRST NATIONAL PLAZA
20 S CLARK ST SUITE 700
CHICAGO, IL 60603

0507 RUSIN MACIOROWSKI & FRIEDMAN LTD
MICHAEL A MOORE
10 S RIVERSIDE PLZ SUITE 1530
CHICAGO, IL 60606

STATE OF ILLINOIS)
)SS.
COUNTY OF DUPAGE)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Juan Cruz
Employee/Petitioner

Case # 09 WC 9428

v.
GM Metal, Inc.
Employer/Respondent

Consolidated cases:

14IWCC0954

An *Application for Adjustment 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 Kurt Carlson, Arbitrator of the Commission, in the city of Wheaton, on 1/17/13. 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

On 02/03/09, 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.

In the year preceding the injury, Petitioner earned $18,330.00; the average weekly wage was $352.50.

On the date of accident, Petitioner was 37 years of age, Married, with 2 children under 18.

Petitioner has received all reasonable and necessary medical services.

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

ORDER

14IWCC0954

Temporary Total Disability

The Arbitrator makes no award for TTD benefits as petitioner failed to meet his burden or proving by the preponderance of the credible evidence that he was temporarily totally disabled for the period sought from December 9, 2010, through March 27, 2011.

Medical benefits

Respondent shall pay reasonable and necessary medical services of $7,961.59 to Advanced Health Medical Group, as provided in Sections 8(a) and 8.2 of the Act.

Respondent shall pay reasonable and necessary medical services, pursuant to the medical fee schedule, of $1,500.00 to Archer Open MRI and of $818.00 to AMIC, as provided in Sections 8(a) and 8.2 of the Act.

Permanent Partial Disability: Person as a whole

Respondent shall pay Petitioner permanent partial disability benefits of $299.67/week for 187.5 weeks, because the injuries sustained caused the 37.5% 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 of at the rate set forth on the *Notice of Decision of Arbitrator* shall accrue from the date listed below to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

Signature of arbitrator

03.21.13
Date

MAR 22 2013

FINDINGS OF FACT AND CONCLUSIONS OF LAW

I. FINDINGS OF FACT

This case involves an undisputed accident that occurred on February 3, 2009, while petitioner was working for respondent. The parties stipulated at trial that respondent has paid all medical bills pursuant to the Fee Schedule and the Act for treatment incurred for petitioner's injuries resulting from the work accident other than the unpaid medical bills petitioner admitted into evidence at trial. The parties stipulated at trial that respondent has paid petitioner all TTD benefits that were due and owing to petitioner for the period from the February 3, 2009, accident through December 8, 2010, for a total of $23,074.39 in TTD benefits. The parties stipulated at trial that petitioner is seeking an award of TTD benefits for the period from December 9, 2010, through March 27, 2011.

The attorneys for the parties signed a Request For Hearing form that was admitted into evidence at Arbitrator's Exhibit #1. The Arbitrator notes that Arbitrator's Exhibit #1 is consistent with the above stipulations made by the parties at trial.

Petitioner is the only witness who testified in person at trial. Sean Salehi, M.D. and Kevin Walsh, M.D. testified via their reports which were admitted into evidence at trial without objection.

The Arbitrator notes that on December 17, 2012, petitioner's attorney sent letters via certified and regular mail to all of petitioner's medical care providers whose unpaid medical bills petitioner was seeking to be awarded by the Arbitrator at the January 17, 2013, hearing[1]. The Arbitrator notes that these letters informed these medical care providers of the January 17, 2013, hearing and of the fact that the issues of whether their bills were fair, reasonable, and causally connected to petitioner's work accident would be determined at the January 17, 2013, hearing

and that, consequently, the January 17, 2013, hearing would determine whether their medical bills would be awarded in this case. The Arbitrator also notes that all of these medical care providers were invited to appear at the January 17, 2013, to testify in support of an award of their medical bills, but that none of these medical care providers elected to so appear and testify.

The petitioner testified via a Spanish interpreter. Petitioner testified that on February 3, 2009, while working for respondent he was bent down lifting siding weighing about 20 to 30 pounds off of a truck onto a weight machine when he felt back pain and an electric shock sensation moving down his left leg. He testified that he treated with various medical care providers after the accident but that Dr. Michael Malek was his primary doctor for his work injuries. He testified that he also treated with Dr. Khan, who works out of Dr. Malek's office.

Petitioner testified that he underwent physical therapy at Advanced Health Medical Group ("AHMG") ordered by Dr. Malek from February 28, 2009, through January 20, 2011. He testified that AHMG charged about $68,128.00 for that physical therapy, of which respondent paid about $46,000.00.

Petitioner testified that on March 4, 2009, he underwent an EMG that was performed by Dr. Khan and that later he underwent another EMG that was performed by Dr. Kaye.

Petitioner testified that in mid-2009 he underwent an ESI in his lumbar spine performed by Dr. Hussain that was ordered by Dr. Khan.

Petitioner testified that he underwent a Section 12 examination with Dr. Salehi on May 16, 2009, and that afterwards he continued to receive conservative treatment from his doctors.

Petitioner testified that he underwent a CAT scan on June 4, 2009, and that afterwards he continued to receive conservative treatment from his doctors.

Petitioner testified that on February 25, 2010, he underwent an operation at Hind General Hospital in Indiana and that respondent paid for these charges, which totalled about $24,680.00. He testified that Dr. Malek performed this surgery, which was a left L4-L5 partial hemilaminectomy. He testified that after this surgery Dr. Malek ordered and he underwent additional physical therapy.

Petitioner testified that he had slight improvement after his February 25, 2010, surgery but that his back still hurt afterwards and that his back was "not much better" after surgery.

Petitioner testified that on September 7, 2010, Dr. Malek told him that he needed to undergo a discogram. Petitioner testified that he underwent the discogram that day because Dr. Malek told him to. He testified that he was charged $36,803.00 for this discogram and that respondent paid $4,723.00 of this bill.

Petitioner testified that after this discogram he continued to see Dr. Malek on and off. He testified that Dr. Malek eventually recommended that he undergo lumbar fusion surgery. Petitioner testified that he told Dr. Malek that he did not want to undergo a lumbar fusion surgery because he did not want to end up worse after a fusion surgery and that there was no guarantee that he would be better after a fusion surgery. Petitioner testified that Dr. Malek had petitioner continue his treatment with Dr. Malek even though he told Dr. Malek that he did not want to undergo lumbar fusion surgery. Petitioner testified at trial that he never wants to have a lumbar fusion surgery.

Petitioner testified that every time he saw the doctors in this case, including Dr. Salehi and Dr. Walsh, he told them about all of the problems he was having that he believed were caused by this work accident. He testified that he answered all of the questions of all of these doctors, including Dr. Salehi and Dr. Walsh, to the best of his memory. He testified that he

moved his body to the best of his ability whenever any of these doctors, including Dr. Salehi and Dr. Walsh, asked him to.

Petitioner testified that currently he experiences daily back pain. He testified that his back hurts a lot while he is walking. He testified that sometime he can not get up after he has been sitting for awhile. He testified that his whole left leg down to and including his left foot gets weak. He testified that now his left leg is smaller than his right leg.

Petitioner testified that he does not take prescription pain medication and that he has not done so since March 2011, when Dr. Malek stopped prescribing it for him. He testified that he does not take over the counter pain medication on a daily basis and instead takes it only when he can not tolerate the pain. He testified that in March 2011 Dr. Malek also stopped prescribing physical therapy for him.

While petitioner testified that he was seeking TTD benefits for the period from December 9, 2010, through March 27, 2011, the Arbitrator notes that petitioner did not testify that he was unable to work during that time period, not did petitioner testify that he did not work during that time period.

Petitioner testified that about 2 months prior to trial he began working as a taxi driver full time. He did not testify that his work injuries adversely affected his ability to work as a taxi driver. The Arbitrator notes that working as a taxi driver involves a lot of sitting.

Significantly, petitioner testified that he is pretty much the same now as he was when he first began treatment for his work injuries. He testified that the surgery did not really help him. He testified that the physical therapy did not really help him. He testified that he received no significant improvement from all of the treatment provided by or ordered by Dr. Malek. He testified that the treatment he received for his work injuries only improved him "a little bit."

Medical records from Advanced Health Medical Group, Grand Avenue Surgery Center, Hind General Hospital, American MRI, Archer Open MRI, Right Care Surgery Center, AMIC, ATI Physical Therapy, and Dr. Vladimir Kaye were admitted into evidence by Petitioner.

Petitioner also admitted into evidence: (1) a $36,803.00 bill with an unpaid balance of $32,080.00 from Grand Avenue Surgery Center for a September 7, 2010, discogram; (2) a $68,128.51 bill with an unpaid balance of $22,760.75 from Advanced Health Medical Group for services rendered from February 28, 2009, through January 20, 2011; (3) a $1,500.00 unpaid bill from Archer Open MRI for an abdominal CT scan performed on December 3, 2009; (4) an $818.00 bill from AMIC for services rendered; and (5) an unpaid $2,537.82 bill from ATI Physical Therapy for services rendered.

Respondent admitted into evidence Dr. Sean Salehi's May 16, 2009, report, reports of Dr. Kevin Walsh dates November 8, 2009, September 30, 2010, November 28, 2010, and February 20, 2011, and a payments log evidencing that respondent paid petitioner $23,074.59 in TTD benefits for the period from March 19, 2009, through December 8, 2010. Respondent also admitted into evidence a document from the American Academy of Orthopedic Surgeons regarding bill coding for spinal injections.

The medical records admitted into evidence provide the following medical information: On February 28, 2009, petitioner saw Dr. Ray Khan of AHMG and gave a history that on February 3, 2009, he was unloading metal siding when he felt a sharp burning sensation in his low back that travelled down his left leg. He reported that he notified his supervisor, who did not help him. He reported that he went to his own massage therapist for low back massages for the next few weeks hoping that his pain would resolve. He reported that he continued to work in pain, which had now become unbearable. He described his lower back pain as a sharp 7-9/10

intensity pain that travels down his left leg and also into his abdominal region. He stated that the abdominal region pain felt like a strain or a possible hernia. He stated that he feels weakness and a burning sensation with any walking, bending or squatting. He gave a history of a low back injury in 2003 that resolved itself after a brief course of therapy. He denied any other injuries. Examination revealed that he was 5'7" tall and weighed 215 pounds. Flexion was 16 inches with pain. Extension was 10 degrees with pain. Right and left rotation was 15/10 degrees with pain. Right and left lateral bending was 15/20 degrees with pain. A grade II-III myospasm was noted in the lumbar paraspinal musculature, left greater than right. Straight leg raising ("SLR") test was noted to be positive at 45 degrees, but it was not noted whether this was on the left, on the right, or bilaterally. Dr. Khan diagnosed petitioner with a lumbo-sacral strain/sprain with a possible intervertebral disc bulge with radiculopathy on the left, as well as a possible abdominal hernia. Additional diagnoses were stress, anxiety, and depression secondary to these injuries, as well as insomnia and headaches. Dr. Khan opined that petitioner's "signs and symptoms are consistent with the history of repetitive heavy lifting required by the patient's employment at GM Metal." Petitioner had related that he worked for GM Metal for the last two years as a loading and unloading packer of sheet metal and other kinds of metals weighing up to 400 pounds. Dr. Khan took petitioner off work for 14 days, ordered a lumbar spine MRI, a course of physical therapy and chiropractice manipulation, prescribed analgesics, anti-inflammatories, muscle relaxers, and a sedative for insomnia.

On March 4, 2009, a lumbar spine MRI was performed on petitioner at American MRI in Elmhurst, Illinois, was interpreted by the chiropractice radiologist as revealing: (1) a left subarticular protrusion, 5 mm in size, comprising the inner margin of the left foramen at L4-L5; (2) a 3 mm central protrusion with an annular tear at L2-L3; and (3) a 1 mm bulge at L5-S1.

On March 5, 2009, petitioner saw Dr. Khan, who ordered an EMG.NCV and an abdominal CT. After examining petitioner he provided an "Outcome Based Practice-Computer Analysis" (hereinafter "OBPCA") regarding range of motion, muscle strength, pain evaluation, and grip strength. Dr. Khan's diagnosis was multiple herniated discs of the lumbar spine and he kept him off work for 2 weeks.

On March 19, 2009, petitioner saw Dr. Khan complaining of pain radiating down to his left leg. Dr, Khan interpreted the MRI as showing a herniated disc with a tear at L4-L5 and L5-S1. He noted a positive SLR test, but did not note at what degree it was positive or whether it was on the left, on the right, or bilaterally. Dr. Khan's assessment was lumbosacral strain/sprain with herniated disc and radiculopathy. Dr. Khan "doubt[ed] he will be able to return to any type of meaningful work for at least another 12 weeks" and kept him off work for 4 weeks.

On March 26, 2009, petitioner saw Vladimir Kaye, M.D., a physiatrist who works with AHMG, for an EMG/NCV. He complained of "back pain numbness tingling pain weakness radiating to the lower extremities." Dr. Kaye's impression was an acute L5 radiculopathy on the left.

The Arbitrator finds that the physical therapy and chiropractic care performed at AHMG was often overlapping. Petitioner received physical therapy in 2009 on 4/14, 4/20, 4/23, 4/28, 5/5, 5/7, 5/12, 5/19, 5/21, 5/26, 5/28, 6/2, 6/9, 6/11, 6/23, 6/25, 7/7, 7/9, 7/23, 8/11, and on 10/08; in 2009 petitioner received chiropractic care on 4/8, 6/17, 6/19, 7/3, 7/15, and on 8/14.

On April 16, 2009, petitioner saw Dr. Khan and related that his right-sided pain was nearly gone but was still going to the mid-foot region, and that he still had pain radiating down to the left leg. Dr. Khan interpreted the EMG/NCV as being "consistent with his pain not going to his toe or heel, but to the top of the foot and mid-foot." He also complained of left hip pain,

which Dr. Khan opined could be part of an L2-L3 injury which he described as improving overall. Examination revealed tenderness to palpation with bulge on the right side of the paraumbilical region, which Dr. Kaye opined was consistent with a small (less than 2 cm) umbilical hernia. Dr. Khan wrote another OBPCA based on his examination. He referred petitioner to Mohammed Hussain, M.D. of AHMG for 3 lumbar epidural injections for pain management. Dr. Khan released him to light duty with no bending, squatting, or lifting over 10 pounds.

On April 16, 2009, Dr. Hussain saw petitioner for a consultation but he did not administer an injection at that time.

On April 30, 2009, petitioner saw Dr. Khan and related that his pain was 6-7/10. Examination revealed tenderness to palpation, muscle spasm, and decreased ROM in the lumbar spine with left-sided radiculopathy. Dr Khan recommended physical therapy 3x/week for 4 weeks and 2 more injections. Dr. Khan was hopeful that he would return to work within 12 weeks and kept him off work for 5 weeks.

On May 8, 2009, petitioner had his first epidural injection with Dr. Hussain at L5-S1.

On May 14, 2009, petitioner saw Dr. Khan complaining of pain in his low back down to his leg.

On May 16, 2009, petitioner underwent a Section 12 examination at respondent's request with Sean Salehi, M.D. Dr. Salehi recommended that petitioner receive two epidural steroid injections. He interpreted the MRI as showing a left L4-L5 herniated disc with central and significant left lateral recess stenosis with an annular tear that was consistent with the described mechanism of injury. He indicated that if the epidurals did not alleviate the symptoms petitioner

should undergo work conditioning, and if he was still symptomatic, he should undergo a microdiscectomy at L4-L5.

On May 27, 2009, Dr. Hussain saw petitioner for a second consultation but he again did not administer an injection. Petitioner reported 30-40% pain relief after the first injection. The Arbitrator is skeptical of the need for this consultation as apparently no injection was performed.

On June 4, 2009, petitioner saw Dr. Khan complaining of pain in his low back, weakness in his leg, some numbness in his groin, and some pain in his right testicular region. Dr. Khan's assessment was a full tear at L2-L3, a 5 mm left subarticular protrusion at L4-L5, with disc bulge, herniation, and radiculopathy. Dr. Khan wrote another OBPCA based on his examination, continued physical therapy, and kept him off work for 4 weeks.

On June 8, 2009, petitioner had his second epidural injection with Dr. Hussain at L5-S1.

On June 30, 2009, petitioner saw Dr. Khan complaining of 8/10 pain in his low back. Dr. Khan's assessment was lumbo-sacral intervertebral disc syndrome with radiculopathy. Dr. Khan wrote another OBPCA based on his examination, continued physical therapy, and kept him off work for 4 weeks.

On July 1, 2009, petitioner had his third epidural injection with Dr. Hussain at L4-L5.

On July 30, 2009, petitioner saw Dr. Khan complaining of low back pain with radiation into both legs, left greater than right. He related that the injections helped minimally. Dr. Khan's assessment was lumbo-sacral intervertebral disc syndrome with radiculopathy. Dr. Khan wrote another OBPCA based on his examination, continued physical therapy, kept him off work for 4 weeks, and referred him to Michel A. Malek, M.D. for a surgical consultation.

On September 15, 2009, petitioner was seen by Dr. Malek. He described his job with respondent for the last two years as that of a laborer loading and unloading metal sheets, taking

20 to 30 pound aluminum pieces off of pallets and putting them on a scale. He related that on February 3, 2009, as he bent down to pick up a piece of metal from the ground he felt a pain in his back and burning down his left lower extremity al the way down to the side of the left leg and into the top of the foot, and that he reported the incident to his supervisor, Greg Dejlitko. He related that he has been off work since February 28, 2009, due to his back pain, which radiates down both lower extremities, primarily on the left side, all the way down associated with tingling on both side and weakness and numbness on the left side, with the low back pain worse than the leg pain. He stated that the first injection helped him slightly but the other two did not help and that his condition had improved slightly. He stated that there was no history of a previous similar episode or similar injury. He did give a history of a neck injury from the 2006 motor vehicle accident from which he had no sequela. Examination found a positive SLR test bilaterally, but no degree is listed. Patrick's maneuver was negative. After reviewing the MRI and EMG/NCV test results, Dr. Malek's impression was bilateral lumbar radiculopathy worse on the left side with the preponderance of back pain primarily related to the L4-L5 pathology. Dr. Malek felt that conservative treatment had been exhausted and recommended a lumbar discography at the L2 to S1 levels followed by a post-discogram CT.

On September 28, 2009, petitioner returned to Dr. Malek complaining of the same symptoms. He recommended continued physical therapy and the discogram.

On October 1, 2009, petitioner returned to Dr. Khan, who stated that he had two big herniated discs, one torn fully jelly out. He concurred with Dr. Malek's recommendation for a discogram and stated that he was a likely candidate for a spinal fusion. He continued physical therapy and kept him off work for 4 weeks.

On October 4, 2009, petitioner underwent a discogram from the L1-l22 through the L5-S1 levels with Dr. Malek. Dr. Malek determined that the discogram identified the L4-L5 and the L5-S1 levels as the primary pain generator without contribution from L1-L2, L2-L3, of L3-L4. Dr. Malek opined that the discogram was valid.

On October 4, 2009, a post-discogram CT was performed by Uday Narahari, M.D., at Medical Imaging Center in Hoffman Estates. Dr. Narahari's impressions were: (1) a broad based midline/left parasagittal disc protrusion into the canal at L2-L3 that flatted the ventral sac and was superimposed on the small caliber canal to cause a moderate to severe central canal stenosis with left lateral recess stenosis; (2) a thin annular tear in the posterior midline of the L3-L4 disc with focal extension of contrast into the outer margin of the annulus, and a diffuse disc bulge and mild facet/ligamentum flavum hypertrophy was superimposed on the small caliber canal to cause a moderate to severe central canal stenosis; (3) degeneration of the L4-L5 disc that extended to the outer margins of the annulus posteriorly and posterolaterally to the right of the midline and a diffuse disc bulge with a small broad based midline/left parasagittal protruding component into the canal that was superimposed on the small caliber canal to cause a fairly severe central canal stenosis; (4) diffuse degeneration of the L5-S1 disc extending to the outer margins of the annulus posterolaterally on the right and left, and a fairly mild diffuse disc bulge and mild facet/ligamentum flavum hypertrophy superimposed on the small caliber canal to cause a mild to moderate central canal stenosis.

On October 26, 2009, petitioner returned to Dr. Malek, who recommended an L4-S1 fusion but only if his symptoms are interfering with his daily life to where he could not live with it. Dr. Malek indicated, however, that the lumbar discography and post CT study was positive at L4-L5 and L5-S1 consistent with the MRI, EMG, and petitioner's subjective complaints. He

therefore has indicated that petitioner has the option of undergoing a fusion at L4-L5-S1 if he could not live with the pain, and if he could live with the pain, undergo a four week course of work conditioning to be followed by a functional capacity evaluation to determine his work capabilities.

On October 29, 2009, petitioner returned to Dr. Khan complaining of 6/10 pain without activities. He was still ambulating with a cane. Dr. Khan felt that petitioner could return to work with restrictions of a largely office-based job with sitting but no bending, squatting or climbing. He prescribed a functional cross brace. Dr. Malek felt petitioner was 40% better as a result of the injections. He continued "office-based acupuncture" once a week.

On October 31, 2009, petitioner received acupuncture from chiropractor Mary Dietz at AHMG.

On November 5, 2009, Kevin Walsh, M.D., performed an IME of petitioner. Dr. Walsh's examination revealed no atrophy, strength 5/5, reflexes equal, and a negative SLR test. Dr. Walsh interpreted the MRI as showing a left L4-L5 protrusion 5 mm in size compromising the left nerve neural foramen. Dr. Walsh indicated, however, that the current examination revealed no evidence of an active radiculopathy and that it would have resolved. Dr. Walsh opined that petitioner was capable of returning to regular duty work and was not in need of any additional care.

On November 9, 2009, petitioner returned to Dr. Malek, who stated that petitioner was "pretty incapacitated by the pain and his symptoms are to the point where he is not willing or capable of living with them."

On November 9, 2009, Dr. Malek wrote a letter to Kevin Nespitt of AIG outlining petitioner's history and treatment and the reasons for same. He explained why he recommended

a fusion and stated that he was concerned that a delay in authorizing the surgery, "especially in view of his atrophy," could affect his outcome from this surgery. He opined that petitioner "already had neurological deficit in the form of his atrophy of the left lower extremity." The Arbitrator notes that Dr. Malek's note that petitioner had atrophy of the left lower extremity was contradicted by your November 5, 2009, examination findings.

On November 12, 2009, petitioner returned to Dr. Khan complaining of severe stomach pain. Dr. Khan continued therapy and returned petitioner to work on sedentary duty for 5 weeks..

On November 13, 2009, respondent terminated petitioner's TTD benefits and medical benefits based upon Dr. Walsh's report regarding his November 5, 2009, IME of petitioner.

On November 17, 2009, petitioner received acupuncture from Dr. Dietz at AHMG.

On November 17, 2009, petitioner was seen by Zain Vally Mahomed, M.D. of AHMG for abdominal pain.

On November 23, 2009, petitioner returned to Dr. Malek complaining of continued problems, primarily back pain but also left lower extremity pain. Dr. Malek stated that Dr. Walsh' November 5, 2009, report findings regarding the following were untrue: (1) petitioner did not have any objective findings to support his complaints; (2) the MRI scan showed a left L4-L5 disc herniation; (3) petitioner had no symptoms below his knee and therefore had no evidence of active radiculopathy; and (4) it appeared that the left L5 radiculopathy described in the EMG study appeared to have resolved.

In his November 23, 2009, office note Dr. Malek stated that: (1) petitioner told Dr. Malek that Dr. Walsh spent 3-4 minutes with petitioner; (2) it seemed "impossible" that Dr. Walsh could have taken a history and examined petitioner as described in his report; (3) Dr. Walsh did not measure or weigh petitioner; (4) Dr. Walsh did not measure his range of motion; (5) Dr.

Walsh did not performed a reflex sympathetic dystrophy test or a neurovascular examination. The Arbitrator notes that petitioner did not testify as to any of the foregoing at trial.

On November 24, 2009, petitioner received acupuncture from Dr. Dietz at AHMG.

On December 17, 2009, petitioner returned to Dr. Khan, who noted that petitioner was using a cane to ambulate and that he "clearly cannot work currently." Dr. Khan continued therapy and stated that he could return to work only at sedentary duty for 5 weeks.

On December 22, 2009, petitioner returned to Dr. Mahomed in follow up for his abdominal complaints.

On January 21, 2010, petitioner returned to Dr. Khan. He reported having 3 injections after which there was some improvement in the back but he still had pain radiating down to the leg. He related that he was using a cane to ambulate full time as he had difficulty walking. Dr. Khan continued therapy and took him off work for 4 weeks.

On February 10, 2010, Dr. Malek dictated a note in petitioner's chart regarding Dr. Salehi's May 16, 2009, IME report. Dr. Malek noted that Dr. Salehi recommended a left L4-L5 microdiscectomy for injuries suffered in our accident, which Dr. Malek described as being "not an unreasonable treatment." Dr. Malek then noted that he would perform a left L4-L5 microdiscectomy on petitioner.

On February 25, 2010, Dr. Malek performed a left L4-L5 partial hemilaminectomy, foraminotomy, lateral recess decompression, nerve decompression, foraminotomy, partial medial facetectomy, and excision of herniated disc at Hind General Hospital.

On March 8, 2010, petitioner returned to Dr. Malek, who noted that he was "pleased with the way [petitioner] has done" post-surgically. Petitioner reported that his radicular symptoms had resolved, although he still has some back in the back and into his hip. Dr. Malek removed

his staples, dressed his wound, and instructed petitioner to return in 1 month, at which point Dr. Malek expected to begin physical therapy.

On March 4, 2010, petitioner returned to Dr. Khan complaining of 6/10 pain post-surgery. Dr. Khan kept petitioner off work for 4 weeks.

On April 1, 2010, petitioner returned to Dr. Khan, who ordered physical therapy 3 times a week for 4 weeks, home-based therapy, stretching, and medication. He kept petitioner off work for 4 weeks and instructed petitioner to return in 4 weeks.

On April 12, 2010, petitioner returned to Dr. Malek, who noted that petitioner "had recovered well from" his microdiscectomy but had left leg atrophy, especially in the calf area. Petitioner related that the pain has persisted primarily in the back and still some down the leg. Straight leg raising did not reproduce radicular symptoms but did produce back pain. Dr. Malek opined that it was more likely than not that petitioner would need a fusion surgery. Dr. Malek ordered physical therapy and kept him off work.

On April 15, 2010, petitioner returned to Dr. Khan complaining of abdominal pain. A CT scan was ordered. Dr. Khan kept petitioner off work for 4 weeks.

On May 10, 2010, petitioner returned to Dr. Malek complaining of persistent symptoms "at a level he is not willing or capable of living with." Dr. Malek kept petitioner off work. Dr. Malek ordered 6 more weeks of physical therapy to be followed by 4 weeks of a conditioning program followed by a functional capacity evaluation. Dr. Malek stated that "[I]f symptoms worsen, then he needs to have lumbar fusion."

On May 13, 2010, petitioner returned to Dr. Khan complaining of 7/10 pain and relating slow improvement. Dr. Khan continued therapy, kept petitioner off work for 4 weeks, and instructed petitioner to return in 4 weeks.

On June 14, 2010, petitioner returned to Dr. Malek complaining of persistent pain. Dr. Malek ordered 4 weeks of a conditioning program and told him to return in 4 weeks.

On July 13, 2010, petitioner returned to Dr. Khan, who noted that Dr. Malek wanted to perform another operation but that petitioner did not.

On July 12, 2010, petitioner returned to Dr. Malek complaining of persistent axial pain. Dr. Malek recommended 2 more weeks of the conditioning program after which, if there was no improvement, Dr. Malek would discuss with petitioner whether to have a lumbar fusion surgery or whether to have a functional capacity evaluation and place petitioner at MMI.

On July 13, 2010, petitioner returned to AHMG and was kept off work for 5 weeks.

On August 19, 2010, petitioner returned to AHMG and was kept off work for 4 weeks.

On August 23, 2010, petitioner returned to Dr. Malek complaining of persistent worsening low back pain. Dr. Malek recommended a lumbar discography at the L4-L5, L5-S1 with post CT. Dr. Malek noted that a repeat EMG/NCV performed on July 28, 2010, showed no evidence of lumbar radiculopathy, and that his physical examination did not show focal deficit. Dr. Malek ordered a repeat EMG/NCV and a repeat lumbar spine MRI.. Dr. Malek kept petitioner off work.

On September 7, 2010, petitioner underwent a repeat lumbar discogram, this time performed by Dr. Malek.

On September 13, 2010, petitioner returned to Dr. Malek, who recommended that petitioner undergo a fusion at L4-L5 fusion and possibly also at L5-S1.

On September 21, 2010, petitioner returned to AHMG and was kept off work for 5 weeks.

On September 22, 2010, petitioner was seen by a chiropractor who noted that petitioner complained of low back pain and tightness but that he was improving with his work hardening exercises. He reported that he still had right leg weakness following surgery. The chiropractor assessed him as status post lumbar diskectomy and recommended continued work hardening.

On September 30, 2010, petitioner underwent a repeat Section 12 examination with Dr. Walsh who, after reviewing the treatment records generated since his prior examination, opined in his report in pertinent part as follows: (1) petitioner continues to report subjective complaints out of proportion to objective abnormalities; (2) petitioner has a normal EMG study and no evidence of radiculopathy, yet he demonstrates serve limitation in motion; (3) petitioner's diagnosis is status post-excision of herniated disk, lumbar microdiskectomy; (4) petitioner did not develop mechanical instability as a result of the work injury; (5) there is no clear evidence that petitioner developed mechanical instability as a result of the lumbar microdiskectomy; (6) further surgical intervention proposed by Dr. Malek is not causally related to the work injury; (7) petitioner is at maximum medical improvement with regards to the work injury; (8) there is no clear evidence that petitioner sustained a herniated disc on February 3, 2009; (9) there is no causal relationship between petitioner's current symptoms and his work injury; (10) no additional medical or surgical intervention is needed or advised for petitioner; (11) petitioner requires no permanent work restrictions as a result of the work accident; and (12) petitioner can return to work without restrictions, based on the review of his medical records and his physical examination. In his report Dr. Walsh asked to review the post-operative MRI scan, post-operative discogram, and the post-discogram CT scan.

On November 28, 2010, Dr. Walsh prepared a supplemental report after he reviewed petitioner's March 4, 2009, lumbar MRI films, his October 4, 2009, CT discogram, and the

September 22, 2010, notes of the chiropractor. In his report Dr. Walsh stated that reviewing these materials did not change any of his previously expressed opinions in this case, that March 4, 2009, MRI films clearly showed pre-existing degenerative changes that were not caused by, aggravated by, and accelerated by petitioner's work accident.

On January 20, 2011, petitioner last received therapy for his injuries from Dr. Malek's practice group, Advanced Health Medical Group.

On January 24, 2011, a lumbar spine MRI ordered by Dr. Malek was performed at American MRI.

On May 9, 2011, petitioner was last seen by Dr. Malek.

On February 20, 2011, Dr. Walsh prepared a supplemental report after he reviewed additional records. In his report Dr. Walsh did not change any of his previous opinions. Dr. Walsh again opined that the accident did not cause petitioner's degenerative changes or his spinal stenosis in his lumbar spine, and that petitioner required no current work restrictions.

In his February 20, 2011, report Dr. Walsh noted that Dr. Malek recommended a posterior spinal fusion of L4-L5 and possibly L5-S1. Dr. Walsh opined that he does not believe that Dr. Malek's proposed fusion surgery is reasonable, necessary, or causally related to his work accident because petitioner's medical records fail to clearly demonstrate that petitioner has mechanical instability at L4-L5 and at L5-S1. The Arbitrator agrees.

In his February 20, 2011, report Dr. Walsh noted that Dr. Malek returned petitioner to work without restrictions and see how he did based upon Dr. Walsh's recommendation. Dr. Walsh noted that per Dr. Malek petitioner returned to work in December 2010 "because of a dire financial situation and need to earn money to pay the bills." The Arbitrator notes that petitioner's last TTD check in this case was issued on December 7, 2010, and covered the period

from December 2, 2010, through December 8, 2010. The Arbitrator notes that petitioner did not testify that he was unable to work from December 9, 2010, through March 27, 2011, nor did petitioner testify that he did not in fact work during that time period.

The Arbitrator finds the opinions and findings of Dr. Salehi and of Dr. Walsh to be more persuasive than those of Dr. Malek and those of Dr. Malek's practice partners at Advanced Health Medical Group, a practice group with which the Arbitrator is very familiar. The Arbitrator adopts the findings and opinions contained in Dr. Salehi's report and in all of Dr. Walsh's reports except where they may be inconsistent with the Arbitrator's Decision.

The Arbitrator specifically adopts the following findings and opinions contained in Dr. Walsh's September 30, 2010, report: (1) petitioner continues to report subjective complaints out of proportion to objective abnormalities; (2) petitioner has a normal EMG study and no evidence of radiculopathy, yet he demonstrates serve limitation in motion; (3) petitioner's diagnosis is status post-excision of herniated disk, lumbar microdiskectomy; (4) petitioner did not develop mechanical instability as a result of the work injury; (5) there is no clear evidence that petitioner developed mechanical instability as a result of the lumbar microdiskectomy; (6) further surgical intervention proposed by Dr. Malek is not causally related to the work injury; (7) petitioner is at maximum medical improvement with regards to the work injury; (8) there is no clear evidence that petitioner sustained a herniated disc on February 3, 2009; (9) there is no causal relationship between petitioner's current symptoms and his work injury; (10) no additional medical or surgical intervention is needed or advised for petitioner; (11) petitioner requires no permanent work restrictions as a result of the work accident; and (12) petitioner can return to work without restrictions, based on the review of his medical records and his physical examination.

The Arbitrator finds that, shortly after Dr. Malek first discussed with petitioner on April 12, 2010, the possibility of petitioner undergoing lumbar spine fusion surgery, petitioner informed Dr. Malek that he did not want to undergo lumbar spine fusion surgery and that thereafter petitioner never informed Dr. Malek that he had changed his mind regarding having lumbar fusion surgery. Petitioner testified at trial that he never wants to undergo lumbar spine fusion surgery.

The Arbitrator finds that Dr. Malek's recommended lumbar spine fusion surgery is not reasonable or necessary treatment. The Arbitrator finds that Dr. Malek's recommended lumbar spine fusion surgery, if later performed, is not causally-related to petitioner's work accident.

The Arbitrator finds that by May 1, 2010, Dr. Malek knew that petitioner would not undergo a lumbar fusion surgery. Consequently, the Arbitrator finds that the only treatment rendered to petitioner after May 1, 2010, that could be reasonable, necessary, and causally related to petitioner's work accident would be post-surgical care related to petitioner's February 25, 2010, surgery performed by Dr. Malek at Hind General Hospital.

The Arbitrator adopts the following opinions of Dr. Salehi that: (1) after Dr. Malek's February 25, 2010, surgery petitioner will require 12 sessions of physical therapy to be started no sooner than 3 week post-op; (2) after these 12 physical therapy sessions are completed petitioner can return to work at a lift duty capacity ; and (3) 4 months after this surgery petitioner will require 2 weeks of work conditioning, after which time petitioner will be at maximum medical improvement and can return to work without restrictions. The Arbitrator finds that 4 months and 2 weeks after petitioner's February 25, 2010, surgery corresponds to mid-July 2010. The Arbitrator also noted that on July 12, 2010, Dr. Malek recommended 2 more weeks of the conditioning program after which, if there was no improvement [as was the case], Dr. Malek

would discuss with petitioner whether to have a lumbar fusion surgery or whether to have a functional capacity evaluation and place petitioner at MMI. The Arbitrator finds that Dr. Malek acknowledged that by the end of July 2010 he would place petitioner at MMI if he refused to undergo Dr. Malek's fusion surgery.

Consequently, the Arbitrator finds that all care and treatment rendered to petitioner after July 31, 2010, was not medically reasonable, was not medically necessary, and was not causally-related to petitioner's February 3, 2009, work injury.

The Arbitrator awards petitioner the $1,500.00 in charges by Archer Open MRI, to be paid pursuant to the Fee Schedule and the Act, for services rendered on December 13, 2009, as the Arbitrator finds these medical services to have been reasonable, necessary, and causally-related to the work accident.

The Arbitrator awards petitioner the $818.00 in charges by AMIC, to be paid pursuant to the Fee Schedule and the Act, as the Arbitrator finds these medical services to have been reasonable, necessary, and causally-related to the work accident.

The Arbitrator awards petitioner $7,961.59 of the $22,760.75 unpaid balance of the $68,128.51 in charges by Advanced Health Medical Group ("AHMG") for services rendered from February 28, 2009, to January 20, 2011. The Arbitrator notes that each page of AHMG's itemized bill contains approximately 27 lines entries for charges but 0 line entries for payments or adjustments; however, each page of AHMG's itemized bill shows varying amounts of payments and/or adjustments made to the entries for charges on that page. The Arbitrator finds that it is impossible to determine how much was paid for each of the charges listed on each of the pages of AHMG's itemized bill. Consequently, the Arbitrator finds that it is impossible to determine whether AHMG is impermissibly "balance billing" the petitioner for what is left of a

charge after it has been paid pursuant to the Fee Schedule. After examining the itemized bills of AHMG, the Arbitrator notes that $14,799.16 of the $22,760.75 unpaid balance of the $68,128.51 in charges by Advanced Health Medical Group is for services rendered after July 31, 2010. Subtracting $14,799.16 from $22,760.75 yields the awarded sum of $7,961.59. The Arbitrator specifically finds that the services rendered by Advanced Health Medical Group after July 31, 2010, were not medically reasonable, were not medically necessary, and were not causally-related to petitioner's February 3, 2009, work injury. The Arbitrator notes that Advanced Health Medical Group failed to testify at the January 17, 2013, hearing in support of an award of their bills despite being given sufficient notice that said hearing would determine how much money, if any, would be awarded for their medical bills.

The Arbitrator declines to award any of the $2,537.82 charges of ATI Physical Therapy as they are for services rendered after July 31, 2010. The Arbitrator specifically finds that the services rendered by ATI Physical Therapy were not medically reasonable, were not medically necessary, and were not causally-related to petitioner's February 3, 2009, work injury. The Arbitrator notes that ATI Physical Therapy failed to testify at the January 17, 2013, hearing in support of an award of their bills despite being given sufficient notice that said hearing would determine how much money, if any, would be awarded for their medical bills.

The Arbitrator declines to award any of the $32,080.00 unpaid balance of the $36,803.00 in charges by Grand Avenue Surgery Center for services rendered on September 7, 2010, related to a repeat lumbar discogram. The Arbitrator specifically finds that the services rendered by Grand Avenue Surgery Center on September 7, 2010, were not medically reasonable, were not medically necessary, and were not causally-related to petitioner's February 3, 2009, work injury. The Arbitrator notes that Grand Avenue Surgery Center failed to testify at the January 17, 2013,

hearing in support of an award of their bills despite being given sufficient notice that said hearing would determine how much money, if any, would be awarded for their medical bills.

Pursuant to the stipulation of the parties and to the evidence admitted at trial, the Arbitrator specifically finds that, as a result of prior medical payments by respondent and as a result of payments respondent is ordered to make pursuant to this Arbitration Decision, respondent has paid, pursuant to the Fee Schedule and the Act, for all care and treatment incurred through the January 17, 2013, hearing date that is medically reasonable, medically necessary, and causally related to the February 3, 2009, work accident.

II. CONCLUSIONS OF LAW

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

Based upon the evidence presented at arbitration, the Arbitrator finds that the Petitioner did not meet his burden or proving by a preponderance of the credible evidence that his current condition of ill being in his back is casually related to his February 3, 2009, work accident.

G. Earnings

The Arbitrator finds that petitioner's average weekly wage is $352.50 rather than the $360.00 alleged by petitioner in his Application. The Arbitrator finds that this disputes as to petitioner's average weekly wage is irrelevant as in either case petitioner's TTD rate and his PPD rate are $299.67, the minimum rate for a married worker with 2 dependents for this date of accident.

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 that all care and treatment rendered to petitioner after July 31, 2010, was not medically reasonable, was not medically necessary, and was not causally-related to petitioner's February 3, 2009, work injury.

The Arbitrator awards petitioner the $1,500.00 in charges by Archer Open MRI, to be paid pursuant to the Fee Schedule and the Act, for services rendered on December 13, 2009, as the Arbitrator finds these medical services to have been reasonable, necessary, and causally-related to the work accident.

The Arbitrator awards petitioner the $818.00 in charges by AMIC, to be paid pursuant to the Fee Schedule and the Act, as the Arbitrator finds these medical services to have been reasonable, necessary, and causally-related to the work accident.

The Arbitrator awards petitioner $7,961.59 of the $22,760.75 unpaid balance of the $68,128.51 in charges by Advanced Health Medical Group ("AHMG") for services rendered from February 28, 2009, to January 20, 2011. The Arbitrator notes that each page of AHMG's itemized bill contains approximately 27 lines entries for charges but 0 line entries for payments or adjustments; however, each page of AHMG's itemized bill shows varying amounts of payments and/or adjustments made to the entries for charges on that page. The Arbitrator finds that it is impossible to determine how much was paid for each of the charges listed on each of the pages of AHMG's itemized bill. Consequently, the Arbitrator finds that it is impossible to determine whether AHMG is impermissibly "balance billing" the petitioner for what is left of a charge after it has been paid pursuant to the Fee Schedule. After examining the itemized bills of AHMG, the Arbitrator notes that $14,799.16 of the $22,760.75 unpaid balance of the $68,128.51

in charges by Advanced Health Medical Group is for services rendered after July 31, 2010. Subtracting $14,799.16 from $22,760.75 yields the awarded sum of $7,961.59. The Arbitrator specifically finds that the services rendered by Advanced Health Medical Group after July 31, 2010, were not medically reasonable, were not medically necessary, and were not causally-related to petitioner's February 3, 2009, work injury. The Arbitrator notes that Advanced Health Medical Group failed to testify at the January 17, 2013, hearing in support of an award of their bills despite being given sufficient notice that said hearing would determine how much money, if any, would be awarded for their medical bills.

The Arbitrator declines to award any of the $2,537.82 charges of ATI Physical Therapy as they are for services rendered after July 31, 2010. The Arbitrator specifically finds that the services rendered by ATI Physical Therapy were not medically reasonable, were not medically necessary, and were not causally-related to petitioner's February 3, 2009, work injury. The Arbitrator notes that ATI Physical Therapy failed to testify at the January 17, 2013, hearing in support of an award of their bills despite being given sufficient notice that said hearing would determine how much money, if any, would be awarded for their medical bills.

The Arbitrator declines to award any of the $32,080.00 unpaid balance of the $36,803.00 in charges by Grand Avenue Surgery Center for services rendered on September 7, 2010, related to a repeat lumbar discogram. The Arbitrator specifically finds that the services rendered by Grand Avenue Surgery Center on September 7, 2010, were not medically reasonable, were not medically necessary, and were not causally-related to petitioner's February 3, 2009, work injury. The Arbitrator notes that Grand Avenue Surgery Center failed to testify at the January 17, 2013, hearing in support of an award of their bills despite being given sufficient notice that said hearing would determine how much money, if any, would be awarded for their medical bills.

Pursuant to the stipulation of the parties and to the evidence admitted at trial, the Arbitrator specifically finds that, as a result of prior medical payments by respondent and as a result of payments respondent is ordered to make pursuant to this Arbitration Decision, respondent has paid, pursuant to the Fee Schedule and the Act, for all care and treatment incurred through the January 17, 2013, hearing date that is medically reasonable, medically necessary, and causally related to the February 3, 2009, work accident.

K. What temporary benefits are in dispute?

Petitioner stipulated at trial that all TTD benefits due and owing to him through December 8, 2010, have been paid by respondent. Petitioner claims entitlement to temporary total disability benefits for the period from December 9, 2010, through March 27, 2011.

Based upon the evidence presented at arbitration, the Arbitrator finds that the Petitioner did not meet his burden or proving by a preponderance of the credible evidence that petitioner was temporarily totally disabled from December 9, 2010, through March 27, 2011, due to injuries resulting from his work accident. Thus, the Arbitrator awards none of the TTD benefits sought by petitioner for the period from December 9, 2010, through March 27, 2011. The Arbitrator specifically finds that respondent has paid all TTD benefits due and owing to petitioner resulting from this work accident.

The Arbitrator declines to award petitioner any TTD benefits for the period requested from December 9, 2010, through March 27, 2011. Petitioner failed to meet his burden of proving by a preponderance of the credible evidence that injuries from his February 3, 2009, work accident rendered him temporarily totally disabled during this time period. Dr. Malek had returned petitioner to work without restrictions around December 9, 2010, based upon having

reviewed the September 30, 2010, report of Dr. Walsh, who opined in that report that petitioner was capable of returning to work as of September 30, 2010. Dr. Malek's records evidence that petitioner did in fact return to work in December 2010 shortly after his TTD benefits were terminated effective December 9, 2010. Petitioner failed to testify at trial regarding whether he in fact worked at any time from December 9, 2010, through March 27, 2011. Petitioner failed to testify at trial regarding how his injuries affected his ability to work at any time from December 9, 2010, through March 27, 2011.

M. Nature and Extent of the Injury

Based upon the evidence presented at arbitration, the Arbitrator finds that the Petitioner did not meet his burden or proving by a preponderance of the credible evidence that his current condition of ill being in his back is casually related to his February 3, 2009, work accident.

Petitioner had significant pre-existing degenerative changes in his lumbar spine. The Arbitrator notes that petitioner's symptoms have not significantly improved since his February 3, 2009, work accident despite all of the extensive care and treatment rendered to him by Dr. Malek and his practice group, including the left L4-L5 partial hemilaminectomy, foraminotomy, lateral recess decompression, nerve decompression, foraminotomy, and partial medial facetectomy performed by Dr. Malek on February 25, 2010. The Arbitrator also notes that petitioner has been working as a taxi driver without incident in the 2 months prior to the January 17, 2013, hearing. Given petitioner's poor surgical outcome, however, the Arbitrator awards petitioner a 37.5% loss of use of the person as a whole, or $56,188.13 using the minimum PPD rate of $299.67 for a married worker with 2 dependents for this date of accident.

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

KENNETH MADERAK, JR.,

Petitioner,

vs.

NO: 07 WC 33351 & 07 WC 33352

GERBER COLLISION AND GLASS,

14IWCC0955

Respondent.

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

This case comes before the Commission on Petitioner's §19(h) and §8(a) Petition, alleging a material increase in his disability since the June 16, 2011 hearing held by Arbitrator Kinnaman, claiming additional medical expenses and that the Petitioner is permanently totally disabled. Arbitrator Kinnaman's July 22, 2011 decision awarded Petitioner a wage differential pursuant to Section 8(d)1 of the Act as of June 16, 2011. A hearing on the current petition was held before Commissioner Thomas Tyrrell on April 24, 2014, in Chicago, Illinois and a record was made.

Section 19(h) of the Act states that

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

The Commission, having considered the entire record, finds that Petitioner has shown a

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material increase in disability, is entitled to additional medical expenses, and has shown by a preponderance of the evidence that he has become permanently and totally disabled as the result of both his June 12, 2007 and June 22, 2007 accidents, for the reasons set forth below.

HISTORY OF THE CASE

Arbitrator Kinnaman's prior decision indicates Petitioner worked for Respondent as an auto body man, performing all manner of repair to get a damaged vehicle back into pre-accident condition. On June 12, 2007 he attached a chain to a car frame in order to pull it into alignment, and the chain broke loose, striking Petitioner with significant force in the neck, chest and right shoulder areas. Petitioner had worked in the auto body field since leaving school in 10th grade. He continued to work with worsening pain in his neck and right shoulder, with pain and numbness down the right arm and difficulty turning his head. He is right handed.

On June 22, 2007 he was hammering in weather molding on a vehicle door when the overhead airbag went off, striking Petitioner in the top of his head and compressing his entire spine, aggravating the existing pain and causing low back pain, which also radiated to the right leg.

Petitioner underwent January 31, 2008 cervical discectomy and fusion surgery at C5 to C7 with Dr. Zindrick. Petitioner improved but had ongoing symptoms. On April 1, 2009 Dr. Zindrick performed a lumbar discectomy and fusion from L4 to S1. Following therapy and work hardening, Petitioner underwent a January 4, 2010 functional capacity evaluation (FCE), which was noted to be valid and indicated Petitioner could return to work at the very heavy demand level (occasional lifting of up to 100 pounds). Petitioner testified that his body "locked up" the day after the FCE, that he was taken off work, and was subsequently released at maximum medical improvement with permanent restrictions instituted by Dr. Zindrick: up to 35 pounds frequently, 50 pounds occasionally, and no repetitive bending, twisting or lifting. On February 25, 2010, Respondent's Section 12 examining physician Dr. Andersson agreed with these restrictions.

Petitioner returned to work for Respondent in a "make work" job earning $8.00 per hour until March 15, 2010, when he was told Respondent no longer had work available within his restrictions. Petitioner's vocational expert, Susan Entenberg, opined Petitioner was capable of earning $12.00 to $15.00 per hour. Vocational rehabilitation counselor Allen Olken assisted Petitioner in locating alternative employment, and Petitioner was offered employment as a security monitor at a friend's food store earning $10 to $12 per hour. Dr. Zindrick released Petitioner to the care of his primary care physician for medication management as of February 28, 2011.

Petitioner testified to continued soreness, swelling and stiffness in his neck and numbness and tingling into the right arm to the hand. He also had continued low back pain with numbness

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and tingling into the right leg. He had difficulty with sleep and prolonged walking and sitting, and he continued to take medication.

Petitioner was awarded a wage differential at $861.38, the statutory maximum, per week as of June 16, 2011. This was based on an average weekly wage of $2,400.45/week, and a finding that he was capable of earning $12/hour, or $480.00/week. The Arbitrator noted the wage differential would still be a maximum even if Petitioner were able to earn $15 per hour. Medical bills were also awarded per stipulation.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

Hearing was held pursuant to Sections 19(h) and 8(a) before the Commission on April 24, 2014. Petitioner testified that he remained unemployed after the June 16, 2011 hearing until early 2012, when a friend hired him into a job at his body shop that was within Petitioner's restrictions. This was the first time Petitioner had significantly increased his activity level, and as he did his neck and arm pain increased, and he complained of low back pain, migraines and difficulty sleeping. He left the job after about three months. Petitioner returned to Dr. Zindrick on June 7, 2012. He underwent physical therapy with no improvement, and he was becoming depressed. (8-13).

On July 16, 2012 Dr. Zindrick took Petitioner off work and recommended neurologist Dr. Bijari. On August 20, 2012, Dr. Bijari diagnosed occipital neuralgia and prescribed a brain MRI. Dr. Zindrick reinstituted work restrictions on a trial basis, but Petitioner had no job at the time. (13-15). On August 27, 2012, Dr. Zindrick opined that the brain MRI and occipital treatment "all appears to be work related." (Petitioner's Exhibits 1 & 4).

Following the September 24, 2012 brain MRI, Petitioner continued to have headaches and neck pain into the right arm. On October 4, 2012 Dr. Zindrick prescribed a cervical MRI and referred Petitioner to Dr. Chekka for the occipital neuralgia. Dr. Chekka did a nerve block into the top of the head, and it helped with the migraines. On January 9, 2013 Dr. Zindrick referred Petitioner back to Dr. Chekka for further injections, and Dr. Chekka performed a cervical injection on January 24, 2013 (15-17; Petitioner's Exhibits 1 & 2).

Sometime around January 2013 Petitioner obtained employment with Allstate in the auto repair field, in a job within his restrictions, but as he became more active his pain worsened to where his arm would go numb and his headaches started again. On January 31, 2013 Dr. Zindrick diagnosed a herniated C4/5 disc and sent Petitioner for neurosurgical evaluation with Dr. Kazan. On February 13, 2013 Dr. Kazan opined that surgery was not needed because the radicular symptoms were not significant enough at that time. (17-20; Petitioner's Exhibits 1 & 5).

Petitioner continued under Dr. Zindrick's care, but his symptoms continued to worsen. He took Petitioner off work as of March 5, 2013 and returned him to work on April 15, 2013

after a Medrol dosepak reduced the pain. Petitioner continued to work, but at some point he had lost his job with Allstate. He noted on May 28, 2013 he had begun working driving a fuel truck. On August 1, 2013 Petitioner indicated he was self-employed performing body work. On October 21, 2013 Petitioner reported his neck and right arm pain were preventing him from doing any work other than self-paced side jobs. Some of his sharper pain had subsided, but he was getting more and more depressed, with sleeping problems and anxiety attacks. Dr. Zindrick prescribed a repeat cervical MRI and referred Petitioner to psychologist Dr. Andrise (20-23; Petitioner's Exhibit 1).

After initially visiting Dr. Andrise in late October, 2013, she referred him to psychiatrist Dr. Tuder for medication, but Petitioner continued to get psych meds from Salt Creek Counseling because it was closer to his home. He was taking Clonazepam for anxiety and Mirtazapine for depression. (23-24; Petitioner's Exhibits 8 & 9).

Petitioner's symptoms began to radiate further into his right arm and hand. On November 12, 2013 Dr. Zindrick referred Petitioner back to Dr. Kazan with the updated cervical MRI. (24-26). Noting the MRI showed severe right sided foraminal stenosis ay C4/5 and C6/7, on December 5, 2013 he performed hemilaminotomies and foraminotomies at those levels. (Petitioner's Exhibits 1 & 5).

On December 12, 2013 the Petitioner was in downtown Chicago to go to court with his daughter. He was having a hard time breathing, had a severe anxiety attack and was hospitalized. He had the neck pain from surgery, pain shooting into his arm and ongoing depression. He had been diagnosed with asthma as a child. As to whether he ever had such a severe episode before, "the exact same thing happened the first time I had the (neck) operation before I got out, and then I wound up back in the hospital two days later . . . I didn't realize it was anxiety". He never otherwise has been hospitalized for a breathing problem. (26-28).

On February 18, 2014 Dr. Zindrick found that Petitioner had reached maximum medical improvement and was totally disabled from gainful employment, and that there was nothing more he could do other than lifetime medications and a home exercise program. Petitioner testified that he remained under Dr. Andrise's weekly care as well through the date of the April 2014 hearing (28-30; Petitioner's Exhibit 1).

Petitioner testified that, versus the time of his prior testimony in June 2011, he now has constant neck pain and right arm numbness, and his right hand is swollen, cramped and numb, making it hard to perform handwriting. He complained of ongoing depression and anxiety attacks. His low back pain shoots into his right leg and his foot will cramp up, sometimes causing him to "jump off the couch". He sleeps about 4 hours per night due to the pain severity. His psychiatrist and counselor were trying to resolve this with medication. Despite the last surgery, his pain continued to worsen (30-33).

14IWCC0955

The Commission finds that Petitioner, pursuant to Section 19(h), has sustained a material increase in his disability since the June 16, 2011 hearing, and that this increase has resulted in the Petitioner becoming permanently and totally disabled from employment.

The medical evidence supports the fact that once the Petitioner attempted to return to employment within his restrictions following the initial 19(b) hearing, the physical conditions that had previously been found related to the June 12 and 22, 2007 accidents began to worsen. His cervical condition continued to worsen to the point that he needed an additional surgery at two spinal levels on December 5, 2013.

Additionally, the Petitioner developed significant depression that required psychological treatment. Based on a review of the records of Dr. Andrise, it is clear to the Commission that Petitioner's depression was at least in part related to his work related medical conditions and resulting inability to return to work.

The Commission finds that Dr. Zindrick, who has been treating the Petitioner for several years with regard to his work-related physical injuries, credibly opined that the Petitioner was disabled from any gainful employment. The Commission believes that the evidence shows the Petitioner did his best in attempting to return to gainful employment following the June 2011 hearing, but that doing so increased his symptoms significantly over time. He has now undergone multiple surgeries, including lumbar and cervical fusions.

The evidence reflects what the Commission considers to be a material increase in his disability, based on ongoing post-surgical lumbar problems, the lack of real improvement following his December 5, 2013 cervical surgery, and the development of work-related depression. As such, based on Petitioner's inability to remain employed within his restrictions and the medical determination of Dr. Zindrick that Petitioner could not return to gainful employment, the Commission finds the Petitioner has proven by a preponderance of the evidence that he became permanently and totally disabled as of the February 18, 2014 visit to Dr. Zindrick, at which time he was determined to be at maximum medical improvement, and remained so as of the April 24, 2014 hearing date.

Additionally, the Commission finds that the Petitioner's December 12 through December 14, 2013 hospitalization was causally related to his June 12 and June 27, 2007 accidents, and hereby awards the medical expenses listed in Petitioner's Exhibit 11, as well as any other bills associated with this hospitalization, subject to the fee schedule in §8.2 of the Act, with Respondent receiving credit for any amounts already paid. In no event shall Petitioner receive double payment for these medical bills.

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

14IWCC0955

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner, as of February 18, 2014, the sum of $1,148.51 per week, the maximum allowable statutory amount per §8(b)4, for life, as provided in §8(f) of the Act, for the reason that Petitioner sustained a material increase in his disability to the extent that he is now, as a result of the accidents of June 12, 2007 and June 22, 2007, permanently and totally disabled.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay to Petitioner the medical expenses contained in Petitioner's Exhibit 11 pursuant to §8(a) of the Act, subject to the fee schedule in §8.2 of the Act.

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

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

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

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $21,300.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: NOV 07 2014
TJT: pvc
o 09/08/14
51

Thomas J. Tyrrell

Michael J. Brennan

Kevin W. Lamborn

STATE OF ILLINOIS)
) SS.
COUNTY OF DU PAGE)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Wojciech Skubik,

Petitioner,

14IWCC0956

vs.

NO: 12 WC 07540

A Warehouse on Wheels, Inc.,

Respondent.

DECISION AND OPINION ON REVIEW

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

14IWCC0956

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 $19,500.00. 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: NOV 1 0 2014

Charles J. DeVriendt

CJD/gaf
O: 10/21/14
49

Ruth W. White

Daniel R. Donohoo

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

SKUBIK, WOJCIECH
Employee/Petitioner

Case# **12WC007540**

14IWCC0956

A WAREHOUSE ON WHEELS INC
Employer/Respondent

On 8/20/2013, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

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

1938 BELCHER LAW OFFICE
MATTHEW GOLDSTEIN
350 N LASALLE ST SUITE 750
CHICAGO, IL 60654

0766 HENNESSY & ROACH PC
PETER PUCHALSKI
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 14IWCC0956

Wojciech Skubik
Employee/Petitioner

v.

A Warehouse on Wheels, Inc.
Employer/Respondent

Case # 12 WC 7540

An *Application for Adjustment 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 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 **Prospective medical treatment and surgical sequelae per recommendations of Mark Sokolowski, M.D.**

14IWCC0956

FINDINGS

On **January 18, 2012**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$46,575.50**; the average weekly wage was **$895.50**.

On the date of accident, Petitioner was **32** years of age, ***married*** with **2** dependent children.

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

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

ORDER

Respondent shall pay Petitioner temporary total disability benefits of $597.12/week for 76-5/7 weeks, commencing 1/19/2012 through 7/8/2013, as provided in Section 8(b) of the Act.

Respondent shall be given a credit of **$26,401.26** for TTD and advances, **$0.00** for TPD, and **$0.00** for maintenance, for a total credit of **$26,401.26**.

Respondent shall pay reasonable and necessary medical services incurred by Petitioner as provided in Sections 8 and 8.2 of the Act. Respondent shall receive credit for amounts paid, if any. Respondent shall authorize and pay for the prospective medical treatment plan of Dr. Sokolowski, as it relates to Petitioner's lumbar decompression surgery sequelae pursuant to Sections 8 and 8.2 of the Act.

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

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

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

8/20/13
Date

AUG 20 2013

FINDINGS OF FACT

Petitioner, a 32 year old welder/mechanic, worked for Respondent remodeling and modifying trailers on 1/18/12. The parties stipulated that Petitioner sustained a work related accident and injury on 1/18/12 and that timely notice was provided to Respondent. ARB EX 1.

Petitioner testified that his work duties as a welder/mechanic included lifting and carrying heavy tubing and that his duties required him to lift, carry and sit on the job. On 1/18/12, Petitioner arrived before 7 am on the job site. He testified that he was inside the container clearing debris so that he could have a place to stand. Petitioner testified that he tried to lift a large 8 x 10 steel pipe to place in a different area. As Petitioner bent down he grabbed the pipe to lift it and could not straighten up as he felt immediate strong and sharp pain in his back and down his right leg. Petitioner testified that he put on a lifting belt so he could continue to work. The accident occurred in the early morning. Around noon, Petitioner spoke with his "boss" who came into the shop and advised him that he had a back pain from lifting the pipe.

Petitioner testified that he went around 4 pm catching a ride with a co-worker. The next day his pain was worse and he was unable to work. The pain was in his back, buttocks and leg. Petitioner testified that he had no prior problems in these areas before this accident.

On 1/19/12, Petitioner sought treatment from Dr Wleklinski, a chiropractor. Dr. Wleklinski ordered a of the low back and physical therapy based on Petitioner's complaints of pain as 10/10. The MRI taken on 1/20/12 showed small central disc protrusions at L2-S1 with central and bilateral stenosis at all levels and an annular tear at L5-S1. The radiologist concluded multilevel disc disease at the described levels. PX 1. Petitioner's radiating pain improved over the next few days with the use of an SI belt. However, based on the MRI results, his continued antalgic gait to the left side and right leg sciatica, Petitioner was referred to Dr. Sieminonow for evaluation and treatment as of 1/23/12. PX 1.

Petitioner next saw Dr. Sokolowski on 1/24/12. On that date Dr. Sokolowski noted a consistent history of accident and injury on 1/18/12 and Petitioner's continued complaints of pain in his back and down the right leg which was worsening. Upon review of the MRI, Dr. Sokolowski noted the MRI was consistent with annular tear at L4-5 and at L5-S1 with resultant neural impingement and also noted a small central disc protrusion at L3-4. Petitioner was diagnosed with lumbar pain, radiculopathy, annular tears at L4-5 and L5-S1. He recommended PT, medrol dosepak, off work for four weeks and possible epidural injections. PX 2.

Petitioner attended physical therapy at Accelerated Rehabilitation and eventually underwent the recommended epidural injections in April 2012 with only temporary improvement. PX 2, PX 3. As of his May 8, 2012, visit to Dr. Sokolowski, Petitioner continued to complain of pain and discomfort when sitting or standing for more than 10 minutes. Dr. Sokolowski recommended more physical therapy but it was not approved. Dr. Sokolowski noted "I think he has a combination of lumbar radiculopathy and lumbar discogenic pain. His presenting feature today is principally one of a discogenic origin of pain. His pain radiates to the posterior aspects of this thighs to his knees, but not beyond. Therefore, I think he really would benefit form some incremental therap. Unfortunately, further therapy has not been approved. Therefore, my next step would be to proceed with a functional capacity evaluation. This

would objectively delineate his capabilities. I think this would help clarify the need for ongoing therapy. Going forward, I would like to review his result of functional capacity evaluation. At that point, a work hardening program may be appropriate to really intensively strengthen his back, as the only other alternative would be fusion surgery for discogenic back pain." He also recommended a repeat steroid injection for persistent radicular features. PX 2.

Petitioner underwent a functional capacity evaluation on May 23, 2012. The FCE results were valid and no symptom magnification was observed. Petitioner's functional abilities did not meet any of the specified job demands and was deemed unable to perform the heavy duty level required by his job with Respondent. Petitioner was placed at medium duty level with lifting, carrying, sitting and standing restrictions. Petitioner was restricted from any stooping. PX 2.

On June 13, 2012, Dr. Sokolowski determined that Petitioner was unable to return to work in an unrestricted capacity and noted, "to that end, with a predominantly discogenic etiology of pain, our options are either more intensive therapy such as work condition, or surgical management consisting of fusion. I think the better option for this young gentleman at this juncture would be an aggressive work conditioning program five times a week for four weeks. If work hardening ultimately failed to provide him relief, we can discuss more aggressive surgical options at that time." PX 2. Work hardening was not approved. On 7/13/12, Dr. Sokolowski noted that based on the fact that work hardening was not approved, "we will give him a trial of return to modified duty consistent with his functional capacity evaluation restrictions." Petitioner was returned to duty on 7/15/12 with his FCE restrictions in place. Petitioner was to return in 4 weeks to assess his progress.

Petitioner testified that he tried to return to work with his light duty restrictions on 8/6/12. However, he testified that he drove to work and was told by "Junior" that no light duty work was available and he was sent home. On 8/17/12, Dr. Sokolowski again recommended work hardening with a possible repeat FCE and injections followed by surgery should all conservative measures fail. Dr. Sokolowski kept Petitioner off work. Petitioner resumed work hardening in September 2012. PX 4. On 9/26/12, Petitioner reported a plateau in work conditioning progress and an increase in pain. Dr. Sokolowski ordered more injections and advised Petitioner to finish the course of work hardening. PX 2. Petitioner's symptoms increased with additional physical therapy sessions as noted by Dr. Sokolowski in his note of 11/16/12 and a new MRI was ordered. PX 2, PX 4. Petitioner had a new MRI on 12/4/12 and on 1/4/13, Dr. Sokolowski noted the impression of "congenitally narrow canal with stenosis as a result of multilevel annular tears noted principally from L3 to S1, with extrusion of nucleus pulposus in each of those levels with resultant neural impingement." Dr. Sokolowski noted that if further epidural injections were not approved he was recommending an L3 to S1 decompression. PX 2. Petitioner underwent additional injections in March 2013 which provided some relief. Dr. Sokolowski ordered an EMG to rule out etiologies other than the spine in preparation for the decompression. PX 2.

The EMG showed no electrodiagnostic evidence of right or left sided lumbar spine radiculopathy. The radiologist noted that clinically Petitioner demonstrated a lumbar spine radiculopathy and he recommended additional follow up. Dr. Sokolowski explained to Petitioner that the decompression surgery would likely relieve the buttock pain and radiculopathy but not the materially alter his back pain. Petitioner requested and received the L3-S1 lumbar decompression surgery on 6/26/13 performed by Dr. Sokolowski. PX 2.

Petitioner followed up post surgery with Dr. Sokolowski on 7/3/13. He was ordered to follow up in one weeks time for stitch removal and to begin formal physical therapy thereafter. PX 2. Petitioner reported diminished leg pain and was please with his progress. He was ready to start his post surgical PT.

The trial took place on 7/8/13- approximately 2 weeks after Petitioner's surgery. Petitioner testified that his back felt better at trial than before the surgery and that he did not have as much pain going down his legs. Petitioner was still taking pain medications for post surgical pain but testified that the pain was different from his pre-surgical pain. Petitioner testified that he wanted to continue with his post surgical care and return to work.

The parties submitted Joint EX 1 which contains TTD check stubs reflected the agreed amount that Petitioner received in TTD for the periods he was off work. The checks are dated from 2/6/12 through 12/21/12. Petitioner received one additional check dated 5/1/13. The checks do not reflect the periods of payment.

Respondent sent Petitioner to a Section 12 exam with Dr. Mather on 6/15/12. Dr. Mather reviewed the MRI report from 1/20/12 and noted it "shows mild diffuse degenerative bulging at L2 through S1 without nerve root compression." Dr. Mather examined Petitioner and noted "no objective findings on clinical examination to corroborate his ongoing subjective complaints. His MRI does not show findings of a disc herniation or any nerve root compression. He had appropriate treatment with physical therapy. His symptoms do not appear to be limiting." RX 2. Dr. Mather determined that based on the history, physical exam, and records, Petitioner sustained a lumbar strain and that he was able to return to work without restrictions as of 6/15/12 as he reached MMI.

Respondent sent Petitioner for a second Section 12 exam with Dr. Mather on 4/29/13. RX 3. He reviewed the "actual MRI" dated 12/4/12- the second MRI- taken 11 months post injury. Dr. Mather notes it shows a central right disc herniation at L4-5 with no nerve root displacement and a small annular tear at L3-4. He further interpreted the MRI to show "the ligamentum flavum is of normal size at each level, as are the facet joints, and , therefore, there is not lumbar stenosis. Based on this MRI alone, the patient would not be a candidate for lumbar laminectomy. The disk protrusion is noncompressive and there is no bony stenosis." Again, he notes his reading of the first MRI from 1/20/12 and when compared to the 12/4/12 MRI, Dr. Mather writes, "the comparison of the actual images, two MRIs in this case, definitely shows a new onset right L4-L5 disc herniation in the MRO of December 4, 2012 that was not present on the earlier MRI." RX 3. Dr. Mather again states that Petitioner sustained a lumbar strain as a result of the accident and that he showed "no objective findings" and/or improved leg symptoms during many of his visits to Dr. Sokolowski and to physical therapy and FCE through September 2012.

Dr. Mather disagreed with the need for decompression surgery based on what he believed to be a lack of radicular symptoms, nerve root compression or stenosis. Again, he agrees the 12/12 MRI shows a "new right L4-L5 disc protrusion" but notes no displacement of the nerve root, no left-sided nerve root compression and no stenosis. RX 3. He further concludes that the L4-L5 herniation occurred "some time after January 20, 2012 and before December 2, 2012," based on the MRIs. He opined that there was no objective evidence on physical examination or on the first MRI to show there was "anything but a lumbar strain." RX 3.

RX 4, RX 5 and RX 6 are three continued depositions taken of Dr. Mather on three occasions. After reviewing the deposition transcripts and ruling on the objections contained therein, the Arbitrator notes that Dr. Mather's opinions did not change from the opinions documented in the reports summarized above.

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?

Petitioner was injured at work on 1/18/12 as stipulated by the parties and as reflected in the initial histories contained in the treating records. The Arbitrator initially finds that Petitioner credibly testified at trial on all issues. Petitioner did not have any prior problems with his back or radiculopathy in his lower extremities prior to this accident. Immediately after the accident, Petitioner complained of back pain and radicular symptoms consistently and credibly through the time of his surgery in 2013. Between his accident and the time of his surgery shortly before trial, Petitioner followed and cooperated in the treatment recommendations of his treating physician Dr. Sokolowski. Dr. Sokolowski recommended a long course of conservative treatment for Petitioner's complaints of low back pain and radiculopathy which waxed and waned during treatment. The Arbitrator notes Dr. Sokolowski's recommendations for continued treatment were based on the results of two MRI's which buttressed Petitioner's complaints of radicular pain. The conservative care ultimately failed to relieve Petitioner's complaints of pain and radiculopathy and surgery was performed. The Arbitrator finds significant the fact that immediately after surgery Dr. Sokolowski noted improvement in Petitioner's radicular pain. Petitioner testified at trial less than two weeks after his surgery and credibly testified that he felt improvement following surgery.

Furthermore, the Arbitrator considered the opinions of Dr. Mather on the issue of causal connection for Petitioner's condition of ill-being and finds the opinions of the treating physician Dr. Sokolowski more credible and persuasive than the opinions offered by Dr. Mather on this issue. In so finding, the Arbitrator considered the proffered opinions together with the results of the objective testing, the lack of symptoms prior to this accident, the immediate development of symptoms after this accident, the failure of conservative care to alleviate the diagnosed condition and the favorable surgical results. Based on the foregoing, the Arbitrator finds Petitioner's condition of ill-being causally related to his work-related injury on 1/18/12.

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

Respondent's objection on the issue of medical expenses was based on liability. Based on the findings on the issue of causal connection the Arbitrator further finds that Respondent is to pay Petitioner the reasonable and necessary medical expenses incurred pursuant to Sections 8 and 8.2 of the Act. Respondent shall receive credit for amounts paid, if any.

K. What temporary benefits are in dispute? TTD N. Is Respondent due any credit?

Petitioner was temporarily and totally disabled from work commencing 1/19/12 through 7/8/13 for a period of 76-5/7 weeks pursuant to Section 8(b) of the Act. Respondent paid TTD for certain periods as reflected in Joint EX 1. Respondent shall receive credit for amounts paid.

O. Prospective medical treatment and surgical sequelae per the recommendations of Dr. Sokolowski

Based on the Arbitrator's finding of causal connection and the fact that Petitioner continued under active post-surgical care at the time of trial, the Arbitrator finds that Respondent is to authorize and pay for the post-surgical treatment and sequelae recommended by Dr. Sokolowski pursuant to Sections 8 and 8.2 of the Act.

M. Should penalties or fees be imposed upon Respondent?

The Arbitrator finds that Respondent's conduct in the delay or denial of benefits to Petitioner was neither so unreasonable nor vexatious so as to justify the imposition of fees or penalties in this matter.

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Sebastian Lopez,

Petitioner,

14IWCC0957

vs.

NO: 11 WC 44553

Inverness Golf Club,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of causal connection, medical expenses, prospective medical expenses, temporary total disability, wage rate, 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 21, 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.

14IWCC0957

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: NOV 10 2014

Charles J. DeVriendt

Ruth W. White

Daniel R. Donohoo

CJD/gaf
O: 10/22/14
49

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

LOPEZ, SEBASTIAN
Employee/Petitioner

Case# **11WC044553**

14IWCC0957

INVERNESS GOLF CLUB
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:

2333 WOODRUFF JOHNSON & PALERMO
JAY JOHNSON
4234 MERIDIAN PKWY SUITE 134
AURORA, IL 60504

2837 LAW OFFICES OF THADDEUS J GUSTAFSON
JAMES J MIRRO
2 N LASALLE ST SUITE 2510
CHICAGO, IL 60602

STATE OF ILLINOIS)
)SS.
COUNTY OF COOK)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

14IWCC0957

Sebastian Lopez
Employee/Petitioner

v.

Inverness Golf Club
Employer/Respondent

Case # 11 WC 44553

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 **Lynette Thompson-Smith**, Arbitrator of the Commission, in the city of **Chicago**, on **September 26, 2013**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

14IWCC0957

FINDINGS

On **May 4, 2011**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$37,996.00**; the average weekly wage was **$730.69**.

On the date of accident, Petitioner was **41** years of age, ***married*** with **4** dependent children.

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

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

Respondent shall be given a credit of **$1,037.14** for TTD, **$0.00** for TPD, **$0.00** for maintenance, and **$10,458.17** for other benefits, for a total credit of **$11,495.31**.

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

ORDER

Petitioner has not proven, by a preponderance of the evidence, that his current condition of ill-being, regarding his low back, is causally related to the accident, therefore prospective medical treatment and additional temporary total disability benefits are denied, pursuant to the Act.

Respondent shall pay for all reasonable and necessary medical treatment only for Petitioner's left leg injuries, pursuant to Section 8(a) of the Act.

Petitioner's average weekly wage is $730.69.

Respondent shall be given a credit of $11,495.31 for temporary, total disability payments and other benefits paid to Petitioner.

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

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

14IWCC0957

FINDING OF FACTS

The disputed issues in this matter are: 1) causal connection; 2) average weekly wage; 3) medical bills; 4) temporary total disability; and 5) prospective medical treatment. In addition, the petitioner's counsel made an oral motion to dismiss case number 11 WC 25550, as duplicative of case number 11 WC 44553. This motion was granted. *See,* AX1.

Sebastian Lopez ("Petitioner"), was 41 years old at the time of his injury, and testified that he started working for Inverness Golf Club ("Respondent") as a golf course maintenance worker in May of 2011. On May 4, 2011, petitioner was working in his capacity as a golf course maintenance worker when he was driving forward, looking backward; and struck his left leg against a tree while driving a golf cart. Petitioner further testified that he fell off the golf cart.

Petitioner was sent to Alexian Brothers Medical Group ("Alexian Brothers") the same day, where a history was given of driving a golf cart with his left leg sticking out, and when he turned around to look at something, he hit a tree, crushing his left leg between the cart and the tree. The Arbitrator notes that there is no mention of falling off the cart. An x-ray was performed which showed no acute bony changes. The diagnosis was left lower extremity abrasion/crush injury. He returned to Alexian Brothers on May 5, 2011, to have his bandage changed. He was released to return to work with restrictions of sedentary work; and keeping the wound clean and dry. *See,* PX2.

Petitioner returned to Alexian Brothers on May 9, 2011, where diagnosis remained abrasion on the left leg, crush injury of the left leg; and he was returned to work with instructions of alternate standing and sitting as tolerated. His last follow-up was on May 12, 2011, when he was referred to an orthopedist.

The Petitioner decided to seek his own physician and Petitioner's exhibit 4 is medical records from Centro Medico which show an initial visit by Petitioner on May 18, 2011, where he complained of pain in his left knee, left leg, left ankle, neck pain, and low back pain. There are 25 additional visits noted on May 20, 21, 25, and 27, June 1, 3, 6, 8, 10, 13, 15, 17, 22, 24, 27, 29, and July 1, 6, 8, 11, 13, 15, 18, 20, and 22. There is a separate billing statement for those dates printed on January 18, 2013. On June 3, 2011, he had the added complaint of left shoulder pain. Petitioner continued chiropractic treatment from July 27, 2011 through November 14, 2012. These eighty-four (84) additional visits have a separate billing record, also printed on January 18, 2013. Petitioner had continued complaints of pain in the left leg, neck, and back throughout approximately 110 visits in 18 months.

Petitioner went to Barrington Orthopedic Specialists on June 7, 2011, where he was diagnosed with left leg contusions. The Arbitrator notes that the pain chart from that date, as filled out by the petitioner, shows complaints of pain in the left knee and lower left leg only. There were no markings indicating pain in any other part of the body. Petitioner was placed on restricted duty for three weeks,

with maximum medical improvement ("MMI") anticipated in six (6) weeks. An MRI of the left knee was performed on June 7, 2011, with impression of signal change within the anterior cruciate ligament suggesting a sprain without distinct tear. Petitioner returned on June 17, 2011, and reported that he has left leg pain, but is getting much better, and felt ready to go back to work, in a full duty capacity, the next day. Petitioner was issued a full release with no restrictions for the following day. *See,* PXs 3 & 5.

Petitioner was referred by Dr. Dabbah, of Centro Medico, to Dr. Michel Malek, who saw him on July 1, 2011. He noted petitioner complaints of low back pain and numbness down the leg on the left side, as well as some mid-back pain, with no neck pain, headache, or radicular symptoms around the chest or upper extremities. His diagnosis was thoracolumbar, muscololigamentous sprain and lumbar radiculopathy. Dr. Malek took Petitioner off work and referred him for a second MRI. The first MRI of the lumbar spine, dated June 18, 2011, was interpreted as: the impression of L5-S1 demonstrating a left subarticular protrusion measuring approximately 6mm in its AP distance effacing and distorting the left S1 nerve root. Petitioner returned on July 29, 2011, and a caudal epidural steroid injection was recommended. Dr. Malek performed an epidural steroid injection on August 5, 2011. Petitioner again followed up on August 17, 2011, and another injection was recommended. It was noted that if there was improvement with the injections, then the next step would be a work conditioning program followed by an FCE, otherwise the doctor recommended a microdiscectomy. Petitioner underwent a second injection on August 26, 2011. When Petitioner returned to Dr. Malek on September 7, 2011, surgical intervention was recommended. *See,* PX8.

Petitioner saw Dr. Michael Kornblatt, at the request of Respondent, for an IME on August 31, 2011. Dr. Kornblatt opined that petitioner had suffered a left leg contusion and abrasion from the work accident. He noted a possible L5-S1 disk protrusion on the MRI, and that clinically the petitioner did not present with radiculopathy, but rather mechanical low back pain secondary to degenerative disc disease. Dr. Kornblatt opined that the petitioner did suffer a work injury to his left leg; but that the petitioner's back complaints are not related to the work accident, but rather to L5-S1 degenerative disk disease. He further opined that petitioner has undergone excessive chiropractic care and that he was at MMI for the left leg; and that the medical records did not document complaints referable to the lumbar spine at the time of the work accident on May 4, 2011. *See,* RX1 & 2.

Petitioner underwent an NCV/EMG on November 7, 2011, which showed sciatic nerve compression involving L4, L5 and S1 nerves and the associated nerve roots, left tibial nerve demyelization most likely leading to axonal degeneration, and bilateral S1 neuropathy. *See,* PX7.

Petitioner returned to Dr. Malek on November 20, 2012, where it is noted he had not been seen since September 7, 2011. Dr. Malek recommended an updated MRI and stated that it is likely he would need a left L5-S1 microdiscectomy. *See,* PX9.

A repeat MRI of the lumbar spine was performed on December 3, 2012; and read as the petitioner having an impression of a left bulge at L5-S1. More specifically, it showed L5-S1 disk height preserved with signal loss from desiccation; and residual left paracentral disk bulge protruding 2mm. *See,* PX6.

Petitioner returned to Dr. Malek on December 7, 2012, where it was recommended he proceed with a lumbar discogram and then lumbar fusion surgery. A CT of the lumbar spine post discogram done on December 12, 2012 demonstrated abnormal discs at L3-4, L4-5, and L5-S1. Dr. Malek again recommended a lumbar fusion at L5-S1 on December 19, 2012. *See,* PX9.

On January 3, 2013, petitioner underwent a repeat IME with Dr. Michael Kornblatt. Dr. Kornblatt assessed Petitioner as status post left leg contusion and abrasion, L5-S1 degenerative disc disease, chronic pain dysfunction, and deconditioned state. He opined that petitioner required no further formal medical care, as he has undergone an excessive amount of physical therapy referable to the lumbar spine. He again found petitioner at MMI for the left leg, and noted that the L5-S1 degenerative disc disease is mild in nature and only requires aerobic conditioning, weight reduction, and an active lifestyle. He felt that petitioner's treatment for the left leg was reasonable, necessary, and causally related to the work incident. Dr. Kornblatt did not feel that any workup and treatment for the lumbar spine was related to the work incident, and that neither a repeat MRI nor discogram was warranted, as the petitioner did not present with surgical indications referable to the lumbar spine. *See,* RXs 1 & 3.

Petitioner returned to Dr. Malek on January 23, February 13, March 27, and May 1, 2013, all in which lumbar fusion surgery was again recommended. *See,* PXs 10 & 11.

CONCLUSIONS OF LAW

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

A claimant has the burden of proving, by a preponderance of the evidence, all of the elements of her claim. It is the function of the Commission to judge the credibility of the witnesses and resolve conflicts in medical evidence. *See, O'Dette v. Industrial Comm'n*, 79 Ill. 2d. 249, 253, 403 N.E.2d 221, 223 (1980). In deciding questions of fact, it is the function of the Commission to resolve conflicting medical evidence, judge the credibility of the witnesses and assign weight to the witnesses' testimony. *See, R & D Thiel*, 398 Ill. App.3d at 868; See *also, Hosteny v. Workers' Compensation Comm'n*, 397 Ill. App. 3d 665, 674 (2009).

For an employee's workplace injury to be compensable to be compensable under the Workers' Compensation Act, she must establish the fact that the injury is due to a cause connected with the employment such that it arose out of said employment. *See, Hansel & Gretel Day Care Center v. Industrial Comm'n*, 215 Ill. App.3d. 284, 574 N.E.2d 1244 (1991). It is not enough that Petitioner is working when accident injuries are realized; Petitioner must show that the injury was due to some cause connected with employment. *See, Board of Trustees of the University of Illinois v. Industrial Comm'n*, 44 Ill.2d 207 at 214, 254 N.E.2d 522 (1969).

Petitioner testified that he struck his left leg against the tree in the accident. He subsequently went to Alexian Brothers for treatment on the same day. The medical records state the petitioner complained only of left lower extremity pain, and an x-ray of the left leg was performed. The diagnosis on the date of the injury was left lower extremity abrasion/crush injury. There was no mention of pain complaints to any other body part, no diagnostic tests taken for any other body part; nor was there any diagnoses for another body part. There is also no mention of the petitioner falling from the golf cart.

Petitioner went to Centro Medico on May 18, 2011, two weeks after the initial accident, where he reported pain in his left leg, knee, ankle, neck, and low back. Following multiple chiropractic treatments, he then went to Barrington Orthopedics on June 7, 2011, a little over one month after the accident. He gave a consistent accident history, but again only had pain complaints regarding the left leg. There is no mention of pain complaints or issues with any other body part. In addition, he was asked to complete a pain diagram; the petitioner only made markings on the left leg, nowhere else, and signed the form. He followed up on June 17, 2011, almost six weeks after the accident date, and again there is no mention of pain in any body part other than the left leg.

Petitioner testified at hearing however, that his body hurt all over, including bilateral arms and legs, neck, and back; and that he fell from the golf cart. Petitioner's testimony is inconsistent with the

medical records from Alexian Brothers, Barrington Orthopedics, and Centro Medico, and is therefore not credible.

Dr. Malek testified that the petitioner may have initially only focused on the leg problem even though the accident caused pathology to the back that eventually became painful. He further opined that in the immediate period after the accident, petitioner was most concerned about the leg pain, but then as it healed, within days or a week or two or even three, the leg took a back seat and back pain came to the forefront.

The records of Centro Medico, however, show that petitioner had complaints to that same left leg almost a year and a half after the accident; and at various times, had left shoulder and neck complaints as well. It is again noted that Petitioner made no low back complaints at Barrington Orthopedics four to six weeks after the initial accident. The Arbitrator also notes the significant gap in treatment, as the petitioner went over a year, i.e. from September 2011 to November 2012; without seeing Dr. Malek, yet the doctor maintained his recommendation for fusion surgery.

The subsequent repeat MRI showed a marked improvement in the L5-S1 disc, from a 6mm bulge to a 2mm bulge, without surgical intervention. Dr. Malek makes no mention of this improvement in his subsequent reports. Furthermore, in his March 27, 2013 report, in which he responds to the January 3, 2013 IME, Dr. Malek states that the petitioner became symptomatic, coincidentally with the injury. There are no medical records, with a report of back pain occurring at the same time as the leg contusion, that support this supposition. *See,* PXs 1 & 10. .

Dr. Kornblatt testified that petitioner's leg injury was consistent with the work accident and causally related, but the petitioner's degenerative disc disease was not. He testified that the work incident itself did not cause the degenerative disc disease, nor did it aggravate or accelerate it. In his first examination of the petitioner, on August 31, 2011, he found that the petitioner did not present with any clinical findings of radiculopathy, herniated disk, or nerve root impingement. Dr. Kornblatt also stated that the EMG results were mixed in nature; and more consistent with neuropathy rather than any type of radiculopathy.

He further reported that the petitioner did not have clinical radiculopathy when he re-examined him on January 3, 2013. Dr. Kornblatt further opined that regardless of causation, surgical intervention was not warranted for the petitioner. He noted that the fact petitioner did not respond to the injection would mean he should not have surgery. Dr. Kornblatt further noted that patients with long-standing, degenerative disk disease at the L5-S1 level; with subjective complaints of mechanical low back pain, needed surgery, in less than one (1) percent of the cases. He further stated that the failure rate is extremely high, and that Petitioner's condition would worsen with a spine fusion. Dr. Kornblatt testified that the recommendation for surgery is outside the recognized standard of care,

that there is no clinical indication for surgery whatsoever; and that it would harm the patient. *See,* RXs 1, 2 & 3.

The Arbitrator finds that petitioner's testimony is inconsistent with the medical records and not wholly credible. The Arbitrator further finds that Dr. Kornblatt's opinions are more persuasive than those of Dr. Malek. Therefore, the Arbitrator finds that Petitioner has not proven, by a preponderance of the evidence, that his current condition of ill-being, as to the condition of his low back, is causally related to the work accident.

G. What were Petitioner's earnings?

The parties agree that the petitioner earned $20,277.92 at Inverness Golf Club in the year preceding the injury, which results in an average weekly wage at that job of $389.96. The parties also agree that the petitioner worked a second job at Menard's concurrently in the year preceding the injury. The Arbitrator finds that, excluding bonus and overtime, the petitioner earned $17,718.08 at Menard's in the year preceding the injury, which results in an average weekly wage at that job of $340.73. The Arbitrator therefore finds that the total earnings of the petitioner in the 52 weeks preceding the injury were $37,996.00, which results in an average weekly wage of $730.69.

J. Were 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 received well over 100 chiropractic visits with Centro Medico. However, the Centro Medico notes show the same left leg pain complaints approximately 18 months after the accident. Despite the excessive number of visits, there was no apparent improvement in the petitioner. No other physician has recommended any additional diagnostic test, surgery, or other treatment for the left leg. Dr. Kornblatt also testified that the chiropractic treatment was unreasonable and unnecessary. In light of the fact that petitioner saw little, if any, documented improvement in his symptoms, and that Alexian Brothers and Barrington Orthopedics both released Petitioner from treatment for the left leg, the Arbitrator finds that the medical services provided to the petitioner for his left leg after June 17, 2011 were unreasonable and unnecessary. Because the Arbitrator finds that the petitioner's current condition of ill-being is not related to the work accident, the Arbitrator also finds that the respondent is not liable for any bills related to the alleged back injury.

K. Is Petitioner entitled to prospective medical treatment?

The Arbitrator finds that the petitioner's current condition of ill-being, regarding his low back, is not causally related to the accident. The Arbitrator further finds that Dr. Kornblatt's opinion as to whether the proposed surgery is reasonable and necessary, is more persuasive than that of Dr. Malek.

Petitioner has not proven, by a preponderance of the evidence, that he is entitled to prospective medical treatment, therefore said benefit is denied.

L. What temporary benefits are in dispute?

Petitioner was returned to work with restrictions by Alexian Brothers Medical Group on May 5, 9, and 12, 2011. Petitioner was returned to work, with restrictions, by Barrington Orthopedic Specialists on June 7, 2011. There is no indication in the record that petitioner attempted to return to restricted duty, nor that work within those restrictions was unavailable. Petitioner was subsequently returned to work, full duty, with no restrictions, by the doctors at Barrington Orthopedics, on June 17, 2011.

The Arbitrator further notes that there are large gaps between off work slips for the petitioner. For example, there is no evidence of off work slips between September 7, 2011 and November 20, 2012. In addition, the Arbitrator finds Dr. Kornblatt's testimony persuasive in that the petitioner was at MMI for his left leg with no restrictions, and that the back complaints are not related to the work accident. The Arbitrator therefore finds that petitioner is not entitled to any additional, temporary, total disability benefits.

14IWCC0957

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
11WC44553
SIGNATURE PAGE

Signature of Arbitrator

November 21, 2013
Date of Decision

NOV 21 2013

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

Lauri Cook,

Petitioner,

14IWCC0958

vs.

NO: 11 WC 1626

Richmond Burton HSD 157,

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 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 June 3, 2013, is hereby affirmed and adopted.

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

14IWCC0958

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: NOV 10 2014
CJD:yl
o 10/21/14
49

Charles J. DeVriendt

Daniel R. Donohoo

Ruth W. White

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

14IWCC0958

COOK, LAURI
Employee/Petitioner

Case# **11WC001626**

RICHMOND BURTON HSD 157
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:

0247 HANNIGAN & BOTHA LTD
KEVIN S BOTHA
505 E HAWLEY ST SUITE 240
MUNDELEIN, IL 60060

0863 ANCEL GLINK
ROBERT K BUSH
140 S DEARBORN ST SUITE 600
CHICAGO, IL 60603

STATE OF ILLINOIS)
)SS.
COUNTY OF LAKE)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

14IWCC0958

Lauri Cook
Employee/Petitioner

v.

Richmond Burton HSD 157
Employer/Respondent

Case # 11 WC 01626

Consolidated cases: _____

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Edward Lee**, Arbitrator of the Commission, in the city of **Waukegan**, on **March 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

14IWCC0958

FINDINGS

On the date of accident, **December 13, 2010**, Respondent *was* operating under and subject to the provisions of the Act.

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

On this date, Petitioner *did* 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 **$18,530.22**; the average weekly wage was **$356.35.**

On the date of accident, Petitioner was **50** years of age, ***married*** with **1** dependent child.

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

Respondent shall be given a credit of **$3,718.00** for TTD, **$0.00** for TPD, **$0.00** for maintenance, and **$1,144.00** for other benefits (a PPD advance), for a total credit of **$4,862.00**.

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

ORDER

- The Respondent shall pay Petitioner temporary total disability benefits of $**286.00**/week, for **13 4/7** weeks, from **12/14/2010** through **3/14/2011**, pursuant to §8(b) of the Act which is the period of temporary total disability for which compensation is payable (the minimum TTD Rate for married plus 1 dependant for accident date of December 13, 2010)

- Respondent shall receive credit for a total of **$4,862.00** representing TTD for the period 12/14/2010 through 3/14/2011 and a PPD advance of 4 weeks permanency.

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

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

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

Signature of Arbitrator

5/30/13
Date

ICArbDec19(b)

JUN -3 2013

In Support of the Arbitrator's Decision, the Arbitrator Finds the Following:

Section 1(d) of the Illinois Workers' Compensation Act states: "To obtain compensation under this Act, an employee bears the burden of showing, by a preponderance of the evidence, that he or she has sustained accidental injuries arising out of and in the course of the employment." 820 ILCS 305/1(d). Consistent with Section 1(d) of the Act, Illinois courts have held that for a claimant to recover benefits, she must prove all elements of her case, and any award must be supported by substantial evidence. *Canhan Sheet Metal Corp. v. Industrial Commission*, 31 Ill.2d 325, 201 N.E.2d 383 (Ill.Sup.Ct. 1964); *American Brake Shoe Co. v. Industrial Commission,* 20 Ill.2d.132, 169 N.E.2d 256 (Ill.Sup.Ct. 1960).

The primary function of the Commission is to determine the credibility of witnesses and to draw reasonable inferences from the testimony. *United States Steel Corp v. Industrial Commission*, 8 Ill.2d 407, 411. 134 N.E.2d 307 (Ill.Sup.Ct. 1956). Accordingly, it is well established in Illinois law that liability cannot rest upon imagination, speculation, or conjecture. *Mirific Products Co. v. Industrial Comm.*, 356 Ill. 645, 191 N.E. 203. Rather, liability must arise out of facts established by a preponderance of the evidence. *Id.* The Commission is not required to find for a petitioner merely because there is *some* testimony which, if it stood alone, might warrant such a finding. *Bernard v. Industrial Comm.*, 25 Ill.2d 254, 184 N.E.2d 864 (Ill.Sup.Ct. 1934).. Although a claimant's testimony alone may be sufficient to allow an award, an award is not justified if all of the facts and circumstances in the record support the opposite conclusion. *Id.*

On December 13, 2010, Petitioner was working as a bus driver for Respondent, Richmond Burton School District 157. At approximately 6:35a.m., she was walking in an icy area when her feet slipped from under her. Petitioner testified she grabbed hold of a nearby handrail but then let go of the handrail and went down to the ground. Petitioner's Arbitration testimony is consistent with what she told Dr. Avi Bernstein at the time of his examination on June 20, 2011. Petitioner told Dr. Bernstein she fell and struck her back on concrete, suffering immediate low back pain.

Petitioner's testimony about her accident is significantly different from the evidence produced by Petitioner and Respondent in statements made by numerous School District employees who either witnessed Petitioner's accident or spoke with her shortly after the event. The evidence from the witness statements shows that Petitioner merely slipped on the ice and twisted, being able to correct her posture before she fell. (*See Petitioner's Exhibits 5-15*). While both these descriptions constitute accidents under the Act, the significant discrepancy demonstrates that, from the very beginning of Petitioner's claim, her credibility must be questioned. This is especially true in light of a witness statement the Petitioner did not submit into evidence but is Respondent's Exhibit 22, wherein a witness, Patsy Thornburgh, saw Petitioner having problems on the ice and asked Petitioner if she wanted assistance. Petitioner's response was, "I don't care if I fall, I'll just sue this fucking place!". Also in the witness statements, contrary to the Petitioner's testimony and the deposition of Dr. Bernstein, Petitioner did not suffer immediate pain but, in fact, refused any request for assistance from her co-workers or Respondent.

The very day of Petitioner's incident, she underwent an MRI of her low back. As described in the MRI report and confirmed by Dr. Bernstein, Petitioner had a chronic degenerative minimal anterior subluxation of L4 and L5 in association with degenerative disc disease at the L4-5 level causing borderline central spinal stenosis. The radiologist noted that there was no significant interval change since September 25, 2008, the date of an earlier lumbar MRI. There was no new focal disc herniation. There was no mention of any acute changes or pathology as a result of any traumatic incident (*See Petitioner's Exhibits 1 and 5*). Both MRI reports are in evidence and, in fact, show no difference from the September, 2008 MRI study after the December 13, 2010 incident. While Petitioner had two hospitalizations in December 2010, she received no active medical treatment during either of these hospitalizations except for bed rest and medication.

The Arbitrator finds Petitioner suffered no neurological injury or significant permanent disability as a result of any incident which occurred on December 13, 2010. Petitioner started seeing her family physician, Dr. Arora, on January 11, 2011. In every one of the doctor's reports thereafter for examinations of Petitioner, he notes Petitioner had a "non-focal" neurological examination. A non-focal neurological examination finds that Petitioner had no neurologic abnormality. This is consistent with Dr. Bernstein's examination of Petitioner on June 20, 2011, wherein Dr. Bernstein also describes his examination of the Petitioner as a non-focal neurological examination. (*See Petitioner's Exhibit No. 3 and 5; and Petitioner's Exhibit 5, Page 29*).

Dr. Bernstein, Petitioner's IME physician, admits that all of his findings regarding the Petitioner's physical condition were either minimal or mild. (*See Petitioner's Exhibit No. 5*). The doctor's diagnosis is based on Petitioner's subjective complaints. Otherwise, Petitioner had only minimal subluxation causing borderline spinal stenosis (*Dr. Bernstein Deposition Transcript, Pages 22-23*) which was no different from the MRI performed on Petitioner on September 25, 2008 (*Dr. Bernstein Deposition Transcript, Pages 23-24*). Without the Petitioner's substantial subjective complaints of pain, Dr. Bernstein admitted his call for Petitioner to need surgery, based on her MRI study, would have been true regardless of whether she had any trauma or not. (*See Dr. Bernstein Deposition Transcript, Page 24*).

There is substantial evidence which proves Petitioner did not meet her burden to demonstrate that her L4/L5 spondylolisthesis was either caused or permanently aggravated by the incident of December 13, 2010. The condition was clearly not caused by the incident. As discussed above, the MRI findings of December 13, 2010 were identical to the findings of an MRI performed in September, 2008. Dr. Bernstein admitted the spondylolisthesis had been present for at least two (2) years, and he would expect it to have been there for possibly many years. (*See Dr. Bernstein Deposition Transcript, Page 24*).

Dr. Bernstein spent no more than twenty minutes with Petitioner on June 20, 2011. This was the only time he ever examined the Petitioner. (*See Dr. Bernstein Deposition Transcript, Page 14*). He examined no other reports or records for treatment given the Petitioner before he examined Petitioner in June, 2011. (*See Dr. Bernstein Deposition Transcript, Pages 24-25*). In contrast, Respondent presented numerous reports from Drs. Mark Levin and Martin Lanoff, who examined Petitioner on several occasions as well as evaluating medical records and other evidence about Petitioner's behavior and physical condition.

Petitioner was examined on December 23, 2010 by Dr. Mark Levin. Although Petitioner was complaining of constant and severe back pain, Dr. Levin found no clinical evidence of lumbar spasm with normal reflexes bilaterally. Dr. Levin examined the MRIs from December, 2010 and September 2008. These show only chronic degenerative changes with no evidence of any disc herniation. There was no evidence of any new acute changes on her new MRI study. Dr. Levin found Petitioner had marked subjective complaints of pain out of proportion to his objective findings. There did not appear to be any objective orthopedic cause for Petitioner's marked subjective complaints (*See Respondent's Exhibit 2*).

On January 19, 2011, Petitioner told Dr. Martin Lanoff, Respondent's examining physician that she would love to go to physical therapy and, in fact, knew a very good physical therapist, Steve Conrow from the past and that she trusted him implicitly. However, when Petitioner returned to see Dr. Lanoff on March 3, 2011, she admitted she had not gone to physical therapy because another doctor allegedly told her it would do her more harm than good. (*See Respondent's Exhibits 3 and 4*). There is nothing in any of the Petitioner's medical records from any physician which demonstrates any other doctor considered physical therapy and advised Petitioner against it. Petitioner told the Doctor's office she had no intention of trying physical therapy to improve her condition. In addition, while Dr. Bernstein, on June 20, 2011, recommended Petitioner could be assisted by surgery, Petitioner made no effort to pursue that course of treatment. Cost can not be seen as a factor for that refusal. Petitioner is claiming over $32,000 in unpaid medical expenses for medication and medical "management". This sum could have better been used to pursue physical therapy or surgery but Petitioner made the conscience decision that she did not need such treatment. Petitioner has pursued no medical care which might have actually helped her subjective complaints.

As early as January 19, 2011, Dr. Lanoff found Petitioner had no reliable signs or symptoms consistent with disc pathology/ridiculopathy. She was not a candidate for any injection therapy. Dr. Lanoff recommended an aggressive physical therapy program to mobilize Petitioner. Petitioner's subjective complaints were well out of proportion to her objective findings (*See Respondent's Exhibit 3*). It was expected that Petitioner would return to full duty within six weeks.

Dr. Lanoff next examined Petitioner on March 3, 2011, Petitioner complaining of being much worse. (*Respondent's Exhibit 4*). However, Petitioner continued to have no objective evidence of spondylolisthesis aggravation. Petitioner's subjective behavior made it virtually impossible for the doctor to complete an examination because she would not let him touch her and complained of significant pain in any position and with any type of movement. The doctor found Petitioner had maximal non-organic pain behaviors with significant evidence of symptom magnification or exaggeration. None of his findings or Petitioner's complaints were work related. There was no objective reason Petitioner could not continue working as a bus driver. What is most telling is evidence presented on Respondent's Exhibit 23, a video surveillance tape of various dates. One of these surveillance episodes shows Petitioner on March 16, 2011, not two weeks following her examination by Dr. Lanoff when Petitioner was complaining of significant subjective problems and being unable to perform the simpliest movement or task. On March 16, 2011, the surveillance tape shows Petitioner walking in a parking lot while doing errands, demonstrating no problems with no sign of pain. This behavior is totally inconsistent with what she had complained of to Dr. Lanoff not two weeks earlier.

Over the next several months, Dr. Lanoff either reviewed medical records or videotape of the Petitioner. (*See Respondent's Exhibits 5 - 9*). There was nothing in any of these records or evidence which caused the doctor to alter his opinion that Petitioner's complaints were not causally connected to her incident on December 13, 2010. Petitioner was fully capable of performing her job as a bus driver.

Petitioner complained to the Arbitrator that her condition had been deteriorating over time. This is totally refuted by the surveillance video. In addition to the March 16, 2011 video showing Petitioner walking with no problems and no signs of pain, Respondent presented video from various other dates (*Respondent's Exhibit 23*). On November 11, 2011, Petitioner is shown pushing a shopping cart in a parking lot, placing her purse and two shopping bags in the back of a vehicle with no evidence of any pain or distress. On March 16, 2012, Petitioner is driving a car to run an errand, again with no signs of pain or distress. There is video from September 1, 2012, which demonstrates even more active behavior by Petitioner. She is pushing a shopping cart and putting at least eight (8) bags of merchandise into the back seat of a Jeep-type vehicle. She then takes the cart to the cart coralle and drives the Jeep home. On September 4, 2012, the video shows her driving her Jeep. On October 31, 2012, the video shows Petitioner using a leaf blower in a driveway. In none of these videos does Petitioner exhibit any sign of pain or disability.

Petitioner's behavior on the video is in direct contrast to her complaints to her doctors. On September 12, 2012, a week or two after the September 1st and September 4th videos, Petitioner was seen by Dr. Carabene, making substantial complaints of pain, weakness, and numbness. (*See Petitioner's Exhibit 18*). None of these complaints were manifested by Petitioner on the video. Dr. Bernstein testified that Petitioner should not be able to drive, enter or exit a vehicle, do general shopping, and errands or use a leaf blower without experiencing pain. (*See Bernstein Deposition Transcript, Pages 14-16*). Dr. Bernstein also said Petitioner would have similar complaints of pain while driving a school bus. He did not testify she was physically incapable of doing so. (*See Bernstein Deposition Transcript, Page 15*). If Petitioner could engage in all the types of activities which Dr. Bernstein testified should have caused her pain but clearly demonstrated no evidence of such pain, she should have been able to drive a school bus and perform her regular work activities.

Petitioner was last examined by Dr. Lanoff on November 29, 2012 (*See Respondent's Exhibit 10*). Dr. Lanoff also examined additional surveillance videos on Petitioner on which he commented in a report dated November 30, 2012 (*See Respondent's Exhibit 11*). Dr. Lanoff's examination of November 29, 2012 shows numerous non-organic complaints by Petitioner but finds no evidence of a permanent aggravation of the Petitioner's L4/L5 spondylolisthesis. The Petitioner's complaints of numbness in her legs, low back pain radiating to the neck, and an inability to lay flat on her back, could not caused by a spondylolisthesis condition. (These opinions were confirmed by Dr. Bernstein in his testimony (*See Bernstein Deposition Transcript, Pages 29-30*). Dr. Lanoff's report of November 30, 2012 (*See Respondent's Exhibit 11*) goes on to give details of the doctor's report and all the episodes in which Petitioner's behavior outside of any physician's office is totally inconsistent with the complaints she registered.

Contrasting Dr. Lanoff's November 29, 2012 examination of the Petitioner with the surveillance videotape taken on the next day, November 30, 2012, proves the fallacy of Petitioner's complaints and any possibility of there being any causal connection between any

physical condition of which Petitioner suffers in the incident on December 13, 2010. During his examination on November 29, 2012, Dr. Lanoff found that Petitioner had significant complaints of pain with any movement, numbness in the entirety of both of her legs, low back pain radiating to her neck and into her buttocks, hops, back, legs, and outside of the legs, weakness with almost any muscle group, etc. However, the very next day, Petitioner was capable of driving her Jeep to the Volo Antique Mall. She walked into the building without using any cane and spent almost two (2) hours in the Antique Mall. She was observed for at least thirty (30) minutes by Respondent's investigator who testified Petitioner spent the entire time he could see her standing or walking around. This is not behavior consistent with Petitioner's terrible complaints from the day before. Not only was Petitioner able to go antiquing the day after her examination with Dr. Lanoff on November 29, 2012, she was using a power leaf blower and engaging in significant shopping activities within 1-3 months of Dr. Lanoff's November 29, 2009 examination.

Another clear demonstration of Petitioner's total lack of credibility is shown in every one of the different surveillance videos submitted as Respondent's Exhibit 23. Petitioner complained to every doctor she saw that she could only walk with a stooped posture. (*See Bernstein Deposition Transcript, Page 8*) However, in every video taken of Petitioner, from January, 2011 to November, 2012, she can be seen walking totally upright, with an unguarded gait. Petitioner's behavior when she believed she was unobserved, coupled with the lack of objective medical evidence suggesting a permanently aggravated spondylolisthesis, totally discredits her subjective complaints of physical impairment.

It is Petitioner's burden of proving a permanent aggravation of her chronic degenerative condition. Petitioner has failed to do so and the medical evidence submitted is inconsistent with a finding of a permanently aggravated spondylolisthesis, as deduced by Dr. Lanoff, and in many instances, admitted by Dr. Bernstein. Petitioner's activities demonstrated in the surveillance videos (*See Respondent's Exhibit 23*) totally contradicts her repeated subjective performance given both to the various doctors and the Arbitrator at her hearing.

For the reasons stated above, the Arbitrator finds Petitioner's condition of ill-being stabilized and reached maximum medical improvement by mid-March, 2011. As of March 14, 2011, Petitioner was not entitled to further temporary total disability compensation. Respondent has paid all reasonable and necessary medical expenses relating to Petitioner's accident of December 13, 2010. Petitioner's request for additional medical expenses is denied as is Petitioner's request for temporary total disability compensation after March 14, 2011.

Carl Lee

EDWARD LEE, ARBITRATOR

5/30/13

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Juan Lopez,
Petitioner,

vs. NO: 09 WC 15223

Northbrook School District #27,
Respondent.

14IWCC0959

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of temporary total disability, 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 July 29, 2014, is hereby affirmed and adopted.

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

DATED: NOV 10 2014

Daniel R. Donohoo

Charles J. DeVriendt

Ruth W. White

o-10/21/14
drd/wj
68

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

LOPEZ, JUAN
Employee/Petitioner

Case# **09WC015223**

NORTHBROOK SCHOOL DISTRICT 27
Employer/Respondent

14IWCC0959

On 7/29/2013, 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 0.07% 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:

1067 ANKIN LAW OFFICE LLC
JOSHUA RUDOLFI
162 W GRAND AVE SUITE 1810
CHICAGO, IL 60654

0863 ANCEL GLINK
BRITT ISALY
140 S DEARBORN ST 6TH FL
CHICAGO, IL 60603

STATE OF ILLINOIS)
)SS.
COUNTY OF COOK)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Juan Lopez
Employee/Petitioner

v.

Northbrook School District 27
Employer/Respondent

Case # 09 WC 15223

Consolidated cases: _____

14IWCC0959

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

DISPUTED ISSUES

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

FINDINGS

On **3/3/2009**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

In the year preceding the alleged injury, Petitioner earned **$31,088.00**; the average weekly wage was **$597.85**.

On the date of alleged accident, Petitioner was **39** years of age, *married* with **3** dependent children.

ORDER

Claim for compensation is denied. Petitioner failed to prove a work accident or causal connection.

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

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

Signature of Arbitrator

7/26/2013
Date

JUL 29 2013

14IWCC0959

FINDINGS OF FACT AND CONCLUSIONS OF LAW

On April 7, 2009, Petitioner filed an application for adjustment of claim, alleging that on March 3, 2009, he sustained accidental injuries to his right leg and foot while throwing away garbage.

Petitioner testified via a Spanish interpreter that he worked as a custodian for Respondent. His job duties included cleaning and taking out the trash. The following testimony was elicited regarding the alleged work accident:

"Q. Were you working for [Respondent] on March 3rd, 2009?

A. Yes.

Q. Did anything out of the ordinary happen on that day?

A. I don't remember too well. Is that the date of the accident?

Q. Were you injured on that day?

A. I don't remember quite the actual date.

Q. On that date in March of 2009, were you taking the trash out?

A. I was going along the hallway to pick up the trash. And when I arrived to the hallway, I grabbed the bag.

***

Q. Can you describe where the trash was?

A. It was in the garbage trash where they keep the trash, and that's when I was going to pick it up. And when I did pick it up, I was turning, and it hurt the back of my leg."

Petitioner explained that the trash bag was inside a garbage can with wheels. After the incident, he continued working and finished his shift.

Regarding his medical treatment, Petitioner testified that on March 6, 2009, he sought treatment with Dr. Franco for his right foot injury. Dr. Franco recommended an MRI. Petitioner maintained that he did not undergo the MRI. Petitioner recalled treating with Dr. Johnson for his right foot condition and undergoing surgery in late March of 2009. Further, Petitioner testified to sustaining an injury to his right shoulder when "[t]he cast on [his] foot wouldn't sustain [him]" and he fell on the stairs at home. Petitioner treated for the right shoulder injury with Dr. Johnson. In September of 2009, Dr. Johnson performed surgery on the right shoulder. Petitioner

continued to treat with Dr. Johnson for his right foot and right shoulder injuries through January 21, 2011.

Petitioner further testified that he returned to work for Respondent, but then stopped working because he felt he could not work, explaining: "[I]f I try to lift a box up, I can't. My shoulder won't permit it. And I have to brace my one hand with the other to be able to manage it." Petitioner indicated he cannot lift more than 25 pounds with the right hand alone, and his right foot starts to hurt if he is on his feet too long.

Petitioner admitted being in a car accident in February of 2009, describing the accident as "a bumper touch." He denied getting medical treatment after the car accident. Upon further questioning, Petitioner acknowledged seeing Dr. Franco on March 2, 2009, explaining that he sought treatment because "the forward part of [his right] foot *** was hurting." Petitioner stated the pain was different from the pain he felt from the alleged work accident on March 3, 2009. Petitioner introduced into evidence a photograph of his car, taken the date of the accident, asserting that it shows "a strike that demonstrates that it was a real accident for injury purposes." The photograph shows what appears to be a discoloration or transferred paint mark on the driver's side of the rear bumper.

On cross-examination, Petitioner admitted giving a statement to a claims adjuster approximately two weeks after the alleged work accident. When asked to explain his statement, Petitioner testified that he tied the garbage bag and "was shifting, turning like this to [his] right—to [his] left, that's when [he] felt a pain down here (indicating)." The following colloquy then occurred:

> "Q. But isn't it true that you told the insurance adjuster that you had tied it to close it but you had not lifted it?
>
> A. I was going to lift it. I was going to lift it. When I tied it and I was in the process of lifting and turning is when I felt it.
>
> Q. Well, this is important. Were you actually lifting it while you were turning, or as you said to the adjuster, had you just tied it but you had not lifted it yet?
>
> A. I had tied it, and when I was bracing myself getting ready to turn in the process and one movement is when I felt. So when I tied it and I was in the process and when one movement lifting and turning, and that's when I felt the pain in my right foot. The floor was, had a rug on it, carpeting on it.
>
> Q. Were you standing erect when this happened, or were you bent over?
>
> A. No, I was straight standing up.
>
> Q. Okay. And after you felt the pain in your right ankle, what happened next with the bag?

***

A. They remained inside the garbage.

Q. Okay. So he [*sic*] never took it out?

A. No, after that I left it there. I left the thing there, and I pulled it up and dragged it on the floor.

***

THE WITNESS: So I took a—the cart has a rope handle tied to it as an assist. I pulled the bag out of the cart, and then I dragged the bag along the floor.

***

THE WITNESS: So there's a garbage canister on the cart. I tilted the garbage canister over so that it would fall on the floor, and from that I grabbed the bag by the handles and dragged the bag across the floor.

[By Respondent's Attorney]: And all of that action happened after he [*sic*] tied it?

A. Yes, the accident, yes. Yes, so then I dragged the garbage. And I dragged it over by the larger container, and the young man threw it in."

The colloquy continued:

"Q. Now, this motor vehicle accident with the photograph, isn't it true that you saw Dr. Franco [on] March 2, 2009, for your right foot?

A. Yes, I went, but it wasn't for the accident.

Q. If I were to show you a note from Dr. Franco saying that on March 2, 2009, you had *** a motor vehicle accident, and you complained of right ankle pain. Would he [*sic*] have a dispute with that?

A. Yes, I disputed it because I didn't tell him it was from an accident or anything like that.

Q. Did he [*sic*] see Dr. Franco for his [*sic*] right ankle on March 2, 2009?

A. Yes, it was—

Q. Yes or no.

A. Yes.

Q. And the day after this visit to the doctor, you then hurt your right ankle at work; isn't that right? Yes or no.

A. I think that was right."

On redirect examination, Petitioner testified that he was turning to lift the garbage bag when he felt pain in the ankle. He did not throw the garbage bag into the larger dumpster because he "couldn't apply force to it. [His] foot would give out. It hurt *** too much."

On re-cross examination, Petitioner testified that his shift on March 3, 2009, started at approximately 3 p.m. Petitioner did not remember the time the alleged accident occurred. Upon further questioning, he indicated that the accident occurred "at night."

The parties asked Robert Enriquez, the parties' joint expert in Petitioner's Puerto Rican Spanish dialect, to listen to the recording of the statement Petitioner gave to the claims adjuster with the assistance of Priscila Baldovi Heymann, a Spanish interpreter retained by Respondent's workers' compensation carrier. The statement was taken on March 19, 2009. Mr. Enriquez testified that the translation provided by Ms. Heymann was accurate. Further, Mr. Enriquez confirmed the accuracy of his transcription and translation of the recording, introduced into evidence as Petitioner's Exhibit 7.

According to the translation provided by Mr. Enriquez and the translation provided by Ms. Heymann, Petitioner reported feeling strong pain in the back part of his right heel when he turned to the left after tying a garbage bag, but before he had a chance to lift it.

Respondent introduced into evidence a clinical note from Dr. Franco dated March 2, 2009. The note is handwritten and barely legible. It appears to indicate that Petitioner complained of pain in the neck, back, body, knee and right ankle after a motor vehicle accident. The medical records from Dr. Franco introduced into evidence by Petitioner show that on March 2, 2009, Dr. Franco ordered an X-ray of the right ankle. On March 6, 2009, Petitioner complained of a great deal of pain in the right lower leg and heel after twisting his body. Dr. Franco ordered an MRI and took Petitioner off work. The MRI, performed March 13, 2009, showed a complete tear of the Achilles tendon at the musculotendinous junction approximately 5.9 cm proximal to the distal insertion site of the Achilles tendon on the calcaneus. On March 26, 2009, Petitioner underwent an open repair of the Achilles tendon.

The medical records in evidence also show that Petitioner received extensive psychological/psychiatric care at Resurrection Behavioral Health Outpatient Clinic from 2009 through 2012, admitting visual and auditory hallucinations, delusions and drinking from time to time to forget his problems. Petitioner also exhibited a thought disorder and poor memory.

14IWCC0959

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, and (F), is Petitioner's current condition of ill-being causally related to the injury, the Arbitrator finds as follows:

The Arbitrator notes that Petitioner's testimony was confusing, inconsistent and often nonresponsive. The medical records in evidence show that Petitioner suffers from visual and auditory hallucinations, delusions, a thought disorder and poor memory. Petitioner testified he was in a car accident in February of 2009, not long before the alleged work accident on March 3, 2009. The medical records from Dr. Franco show that on March 2, 2009, Petitioner complained of pain in the right ankle, amongst other things. Dr. Franco ordered an X-ray of the right ankle.

The Arbitrator cannot give much weight to Petitioner's testimony. Furthermore, Petitioner's recorded statement, taken March 19, 2009, does not describe a mechanism of injury that would cause a complete tear of the Achilles tendon. Rather, the recorded statement indicates Petitioner felt pain from a prior injury to the right ankle when he turned after tying a garbage bag, but before he had a chance to lift it.

The Arbitrator finds that Petitioner failed to prove he sustained a work accident on March 3, 2009. Moreover, even if the event on March 3, 2009, could be considered a work accident under the Act, Petitioner failed to prove his complete tear of the Achilles tendon and the medical care, temporary total disability and permanent partial disability stemming therefrom are causally connected to the event on March 3, 2009.

All other issues are moot.

STATE OF ILLINOIS)
)
SS.
COUNTY OF DU PAGE)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Leigh Wehner-Lederman,
Petitioner,

vs. NO: 07 WC 08150

Community Unit School District # 200,
Respondent.

14IWCC0960

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, the nature and extent of Petitioner's disability, medical expenses and prospective medical expenses and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

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 the Respondent pay to Petitioner interest under §19(n) of the Act, if any.

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

DATED: NOV 10 2014

Daniel R. Donohoo

Charles J. DeVriendt

Ruth W. White

o-10/21/14
drd/wj
68

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

WEHNER-LEDERMAN, LEIGH
Employee/Petitioner

Case# **07WC008150**

14IWCC0960

COMMUNITY UNIT SCHOOL DISTRICT #200
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:

1747 STEVEN J SEIDMAN LAW OFFICE
TWO FIRST NATIONAL PLAZA
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CHICAGO, IL 60603

0683 ANCEL GLINK
ERIN M BAKER
140 S DEARBORN ST 6TH 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

Leigh Wehner-Lederman
Employee/Petitioner

v.

Community Unit School District #200
Employer/Respondent

Case # 07 WC 008150

Consolidated cases: _____

14IWCC0960

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Carlson**, Arbitrator of the Commission, in the city of **Wheaton**, on **June 11, 2013**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **October 27, 2005**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**30,058.79**; the average weekly wage was $**626.22**.

On the date of accident, Petitioner was **34** 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 $**960.65** for TTD, $**0** for TPD, $**0** for maintenance, and $**0** for other benefits, for a total credit of $**960.65**.

Respondent is entitled to a credit under Section 8(j) of the Act for any amounts paid by its group insurance carrier.

ORDER

No compensation is awarded in this matter.

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

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

Signature of Arbitrator

08-29-13
Date

AUG 30 2013

IN THE ILLINOIS WORKERS' COMPENSATION COMMISSION

LEIGH WEHNER-LEDERMAN,	)	14IWCC0960
	)	
Petitioner,	)	
	)	
v.	)	Case No. 07 WC 8150
	)	
COMMUNITY UNIT SCHOOL DISTRICT #200,	)	Arbitrator Carlson
	)	
Respondent.	)	

ARBITRATION DECISION

I. FINDINGS OF FACT

Petitioner stated that she is currently employed as a teacher at the Plano School District. However, Petitioner stated that on November 1, 2005, the original alleged date of the accident, she was employed by the Community Unit School District #200 as a teacher. Petitioner stated that she worked for the Community Unit School District #200 for about twelve years. Petitioner testified that she is 5'5" tall and 230 pounds.

Petitioner stated that on November 1, 2005, she injured her left ankle while reaching for art supplies. Petitioner stated that she was standing on a chair to get supplies to prepare for a class, and as she came down from the chair, her foot caught the edge and rolled her left ankle. Petitioner stated that she experienced pain and fell to the floor. Petitioner testified that the pain was different that what she had experienced before and was sharp and shooting up her left leg. Petitioner stated that following the accident, she was able to complete work. She testified that she had one more class and was able to teach it from a chair.

During trial, it was determined that Petitioner's actual accident date was October 27, 2005 and she sought no treatment until November 1, 2005, when she presented to the Urgent Care center at the Central DuPage Business Health Clinic.

Petitioner stated that she did not recall whether doctors at the Central DuPage Business Health Clinic placed any work restrictions on her after the accident. Petitioner also testified that she did not remember whether she took anytime off of work following the accident.

Petitioner stated that following the injury, she presented to Urgent Care at the Central DuPage Business Health Clinic. Petitioner stated that she was referred to Dr. Senall at OAS Orthopedics. Petitioner testified that she initially underwent conservative treatment with Dr. Senall, but later, on July 6, 2006, underwent a left ankle arthroscopy with synovectomy at DuPage Orthopedic Surgery Center. Following the surgery on July 6, 2006, Petitioner returned to work full duty on August 18, 2006.

Petitioner stated that currently, she has plantar fasciitis and heel spurs in her left ankle, which she admitted is unrelated to the claimed accident. Additionally, Petitioner stated that she no longer has sharp pain in her left ankle and has not had any ill effects in the left ankle since the July 6, 2006 surgery. Petitioner stated that she does not currently take any medication for her left ankle and is no longer treating for her left ankle condition. Petitioner stated that she works full duty as a grade school teacher with no permanent restrictions. Petitioner stated at trial that she does not have any partial or permanent disability.

Petitioner stated that prior to her alleged work accident, she had problems with her feet and ankles. Petitioner stated that she had been a runner and previously had heel pain, arch pain, plantar fasciitis, and occasional swelling of both ankles. Petitioner stated that she treated for these pre-existing conditions with a podiatrist and physical therapy.

Petitioner stated that she had injured her ankle in August 3, 2005, when she fell in a hole and rolled her left ankle. Petitioner stated that this injury caused swelling and ankle pain.

Petitioner stated that she did not tell Dr. Holmes about her pre-existing ankle conditions, and she did not recall whether she ever shared information about her pre-existing conditions with her treater, Dr. Senall.

When asked whether Petitioner had treated anywhere besides the Lyon Ankle and Foot Clinic for her foot and ankle conditions prior to the accident, Petitioner stated that she did not recall because "she has lived in several different areas" and has "had lots of doctors." Petitioner testified that it is possible that she treated elsewhere for these pre-existing conditions.

Petitioner testified that she treated for her pre-existing foot and ankle conditions between June 27, 2005 and August, 2005, which was only two months prior to the alleged November 1, 2005 accident date. Records from the Lyon Foot and Ankle Clinic show that Petitioner first treated there with Dr. Esther Lyon on June 27, 2005. (R.X. 3). Petitioner presented on that date with complaints of swelling on the outside of both ankles for the past three weeks and pain in the arches for the past month and a half. (R.X. 3). Petitioner indicated on the Lyon Clinic's intake form that she ran 4-5 days per week and played softball, ran 5Ks, kayaked, and bicycled. (R.X. 3). Petitioner returned to the Lyon Clinic on July 1, 2005 and July 6, 2005. (R.X. 3). On July 6, 2005, Dr. Lyon noted that although the right ankle was getting better, the left ankle was getting worse. (R.X. 3). Dr. Lyon noted continued complaints of left foot and ankle pain which was sharp and burning on July 8, 2005 and July 13, 2005. (R.X. 3). Petitioner again returned to the Lyon Clinic on August 3, 2005, with continued complaints of sharp pain in both ankles. (R.X. 3). Dr. Lyon noted that Petitioner suffered additional injuries to her right ankle after falling in a hole. (R.X. 3).

Dr. George Holmes conducted an IME of the Petitioner on November 21, 2006, and also wrote an IME addendum, dated January 4, 2007. In the November 21, 2006 IME report, Dr. Holmes diagnosed Petitioner with status post sprain and status post arthroscopic evaluation. (R.X.1). Dr. Holmes also found the Petitioner to be at MMI and recommended no further treatment. (R.X.1). Dr. Holmes indicated that he found no evidence of any partial or permanent disability. (R.X.1).

In the January 4, 2006 IME addendum, Dr. Holmes reviewed additional medical records pertaining to past injuries dating back as far as June, 2004, and found that the Petitioner's injuries predated the reported dated injury of November 1, 2005. (R.X.2). After reviewing x-rays and an MRI report, Dr. Holmes opined that the surgery for the left ankle was probably related to Petitioner's preexisting ankle problems. (R.X.2). Dr. Holmes determined that Petitioner had a preexisting, non-related work condition. (R.X.2). Further, Dr. Holmes stated that based upon the x-rays and MRI which were essentially normal after the November 1, 2005 accident, the surgery was not related to the alleged November 1, 2005 work accident. (R.X.2).

The deposition of Dr. Holmes was then taken on February 28, 2011. (R.X.4). During the deposition, Dr. Holmes testified that when he first saw the Petitioner, she made no mention of the prior injuries to her left ankle. (R.X.4, p. 23, lines 9-11). Further, Dr. Holmes testified that the podiatrist's records regarding the pre-existing condition indicated that the left ankle was more symptomatic than the right. . (R.X.4, p. 23, lines 17-21). Additionally, Dr. Holmes testified that Petitioner's history of pain with running and her height of 5'5" and weight of 215 pounds would both contributed to synovitis or arthritis in the ankle. (R.X.4, p. 23-24, lines 17-5). Dr. Holmes stated that Petitioner's preexisting complaints of pain and swelling in the left ankle would indicate synovitis. (R.X.4 p. 24, lines 11-16). Further, Dr. Holmes found that

Petitioner had a pre-existing left ankle condition, for which the alleged injury of November 1, 2005 was not the precipitating cause. (R.X.4, p. 25, lines 11-17). Dr. Holmes testified that Petitioner's left ankle condition was not caused by her work accident. (R.X.4, p. 25, lines 18-22). Dr. Holmes stated that he found no evidence of any acute injury that occurred as a result of her work accident. (R.X.4, p. 49, lines 9-14).

The deposition of Petitioner's treating physician, Dr. Jeffrey Senall was also taken on November 18, 2010. Dr. Senall testified that he had no knowledge of Petitioner seeing any podiatrists before treating with him. (P.X.8, p. 21, lines 7-10). Dr. Senall also stated that he was not aware of any prior complaints or prior injuries. (P.X.9, p. 26, lines 8-14). Further, Dr. Senall testified that she was not aware that Petitioner had any prior injuries or complaints to her ankles or feet. (P.X.8, p. 21-22, lines 22-3). Dr. Senall stated that certainly there was a preexisting condition of left ankle instability and pain, but that it was hard to determine that the reinjury was not related at all to her ongoing symptoms. (P.X.8, p. 22, lines 16-20). Dr. Senall testified that Petitioner weighted approximately 200 pounds and that it is possible that her weight could have contributed to her continuing complaints of ankle pain. (P.X. 8, p. 31, lines 2-8). Dr. Senall stated that each time he saw the Petitioner he released her to return to work except for the time after the surgery. (P.X. 8, p. 32, lines 8-12).

II. CONCLUSIONS OF LAW

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

The Arbitrator finds that the Petitioner's current condition of ill-being is not causally related to her accident while employed for the Respondent.

Throughout the arbitration hearing, Petitioner was too vague and evasive when questioned about her pre-existing ankle condition, and she did not even allege the correct accident date. Petitioner repeatedly stated that she did not remember answers when asked about treatment regarding both her pre-existing ankle condition and treatment following the alleged work accident.

Petitioner's pre-existing left ankle complaints consisted of sharp pain and burning, similar to what Petitioner described she felt after the alleged October 27, 2005 accident. Before this alleged accident, Petitioner treated for what appears to be the same condition between June 27, 2005 and August 3, 2005. (R.X. 3). Additionally, Petitioner admitted that she may have treated elsewhere for her left ankle condition.

Both Dr. Holmes and Petitioner's treater, Dr. Senall, noted that Petitioner did not inform them of her prior left ankle condition. Dr. Holmes was later made aware of the left ankle condition for the January 4, 2006 IME addendum. Dr. Senall testified at his deposition that he had no knowledge of Petitioner seeing any podiatrists before treating with him, and that he was not aware that Petitioner had any complaints or prior injuries to her left ankle and foot. (P.X.8, p. 21, lines 7-10, p. 26, lines 8-14, p. 21-22, lines 22-3).

The opinions of a treating doctor may be undermined, or even *disregarded* when it is based on inaccurate or incomplete information. *Gonzales v. United Airlines,* 03 IIC 30483 (2009), *citing Horath v. Indus. Comm'n,* 96 Ill.349, 449 N.E.2d 1345 (1980). Further, the standard for causal connection between the injury must not be contingent, speculative, or merely possible, but there must be such a degree of probability as to amount to a reasonable certainty that such causal connection exists. *Gonzales v. United Airlines,* 03 IIC 30483 (2009), *citing Manion v. Brant Oil Co.,* 85 Ill.App.2d 129. 136, 229 N.E.2d 171. 175 (4th Dist. 1967).

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

The Arbitrator finds that the Petitioner's present condition of ill-being is not causally related to her employment for the Respondent. The Respondent is therefore not liable for any past medical expenses.

K. What temporary benefits are in dispute?

The Arbitrator finds that the Petitioner's present condition of ill-being is not causally connected to her employment for the Respondent. (*See* discussion in Section "F" above). Therefore, any claim for compensation pursuant to Section 8(b) of the Act is denied.

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

The Arbitrator finds that the Petitioner's present condition of ill-being is not causally related to her employment. (*See* discussion in Section "F" above). Further, Petitioner testified that she "has no partial or permanent disability." As such, the Arbitrator finds the Petitioner is not entitled compensation for permanent partial disability benefits.

N. Is Respondent due any credit?

Petitioner and Respondent stipulated at trial that if found liable, Respondent would hold the Petitioner harmless for any treatment related to the alleged October 27, 2005 accident. In addition, the parties stipulated that Respondent would receive an 8(j) credit for any related payments made by its group health insurance carrier. Respondent is also entitled to a credit of $960.65 for TTD paid to the Petitioner.

In this case, Dr. Senall's opinions were based on incomplete information, and therefore are undermined by the opinions of Dr. Holmes. Dr. Senall testified that he was not aware of Petitioner's prior left ankle conditions, and Petitioner admitted that she never told him about her prior conditions despite treating for similar complaints only a few months before the alleged accident. The Arbitrator expressly finds the opinions of Dr. Holmes, finding no causal connection, to be persuasive in this case as he reviewed relevant documents related to the pre-existing ankle condition when making his findings. After reviewing records pertaining to Petitioner's prior condition, Dr. Holmes testified that Petitioner had a pre-existing left ankle condition, for which the alleged injury of November 1, 2005 was not the precipitating cause. (R.X.4, p. 25, lines 11-17). Further, Dr. Holmes found that Petitioner's left ankle condition was not caused by her alleged work accident. (R.X.4, p. 25, lines 18-22).

A finding of causal connection in this case would amount to mere speculation as Petitioner's treater was unaware of relevant information when making his findings on causal connection. During his deposition, Dr. Senall, even testified that Petitioner's weight of approximately 200 pounds could have contributed to her left ankle condition. (P.X. 8, p. 31, lines 2-8). Considering Petitioner's prior left ankle condition and complaints, her weight, and her inconsistencies while testifying at trial, it is mere speculation to make a finding of causal connection. As such, the Arbitrator finds no causal connection between Petitioner's left ankle condition and her alleged work accident of October 27, 2005.

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

Kevin Stewart,
Petitioner,

vs. NO: 12 WC 40435

Tower Automotive,
Respondent.

14IWCC0961

DECISION AND OPINION ON REVIEW

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

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

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

DATED: NOV 10 2014

Daniel R. Donohoo

Charles J. DeVriendt

Ruth W. White

o-10/22/14
drd/wj
68

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

STEWART, KEVIN
Employee/Petitioner

Case# **12WC040435**

TOWER AUTOMOTIVE
Employer/Respondent

14IWCC0961

On 10/10/2013, 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 0.06% 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:

1948 LIPKIN & HIGGINS
MITCHELL S LIPKIN
222 N LASALLE ST SUITE 2100
CHICAGO, IL 60601

2965 KEEFE CAMPBELL BIERY & ASSOC LLC
SHAWN R BIERY
118 N CLINTON ST SUITE 300
CHICAGO, IL 60661

STATE OF ILLINOIS)
)SS.
COUNTY OF COOK)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

KEVIN STEWART
Employee/Petitioner

v.

TOWER AUTOMOTIVE
Employer/Respondent

Case # **12** WC **40435**

Consolidated cases: **d/n/a**

14IWCC0961

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Molly Mason**, Arbitrator of the Commission, in the city of **Chicago**, on **August 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 the date of accident, **November 5, 2012**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

Petitioner failed to establish a causal connection between his claimed onset of bilateral shoulder pain on November 5, 2012 and his claimed current bilateral shoulder condition of ill-being.

In the year preceding the injury, Petitioner earned **$14,757.17**; the average weekly wage was **$540.00**.

On the date of accident, Petitioner was **50** years of age, ***single*** 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** for TTD, **$0** for TPD, **$0** for maintenance, and **$1,616.93** for other benefits, for a total credit of **$1,616.93**.

Respondent is entitled to a credit of **$788.73** under Section 8(j) of the Act.

ORDER

For the reasons set forth in the attached conclusions of law, the Arbitrator finds that Petitioner failed to establish a causal connection between his claimed onset of bilateral shoulder pain at work on Monday, November 5, 2012 and his claimed current bilateral shoulder condition of ill-being. The Arbitrator views the remaining disputed issues as moot. Compensation is denied, as is Petitioner's claim for prospective care.

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

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

Molly C. Mason
Signature of Arbitrator

10/10/13
Date

ICArbDec19(b)

OCT 10 2013

Kevin Stewart v. Tower Automotive
12 WC 40435

14IWCC0961

Arbitrator's Findings of Fact

At the hearing, Petitioner's counsel clarified that Petitioner is claiming only a bilateral shoulder condition. He is not claiming any back or neck condition. Respondent's counsel stated that Petitioner refused to sign release forms that would have permitted Respondent to obtain records concerning Petitioner's acknowledged SSDI claim. Petitioner's counsel represented that this claim was not related to Petitioner's shoulder problems.

Petitioner testified he began working for Respondent on April 19, 2012, after passing a pre-employment physical at Concentra. Petitioner testified Respondent directed him to Concentra.

Petitioner testified he worked in the "Y brace" area, processing and adding parts to plates. He worked on the second shift, from 6 PM to 4 AM. He stood during the entire shift. Rotation was the "norm" at Respondent's facility, with workers rotating from one position to another during each workday, but rotation was "eliminated" in early November 2012, at which point a lot of inexperienced workers began working at the facility.

Petitioner testified he was subject to a production quota while he worked in the "Y brace" area. He was required to complete 500 parts by the end of each 10-hour shift. Because each part consisted of "right" and "left" sections, however, he really had to complete 1,000 parts per shift.

Petitioner denied undergoing any shoulder-related treatment prior to his claimed accident of November 5, 2012. Before being hired by Respondent, he was off work and inactive due to knee and low back problems for which he was receiving Social Security disability benefits. He informed Social Security of his job with Respondent.

During the hearing, the Arbitrator watched a short video (PX 2) of job activities performed in the "Y brace" area, with Petitioner narrating as the video was advanced. The parties agreed that the worker shown in the video is not Petitioner. About nine seconds into the video, the worker can be seen holding a plate. Petitioner testified each plate weighed about 15 to 20 pounds. Over the next few seconds, the worker can be seen reaching for an insert, using his right hand, placing the insert into the welded plate and then using his left hand to put the finished product on a conveyor that goes off to the left. Petitioner testified each insert weighed about 3 pounds.

About 32 seconds into the video, the worker can be seen using both hands to lift the "first weld" and place it on the left side for another weld. At the 35-second point, the worker places the plate on pins inside a machine. The pins get "covered" with welds. After a while, the plate has to be pulled up.

Petitioner testified that some of the plates and inserts were kept in an adjacent holding area but he had to walk to another area that was 50 feet away in order to get other inserts. He carried some of those inserts from that area to the "Y brace" area. He carried the inserts in one hand to save time. About two or three times per shift, he had to pull a wheeled cart that was loaded with 200 plates.

Petitioner testified that the machine shown in the video was equipped with a light. When this light turned green, it meant the machine was "ready for production." The red light, which can be seen on the video, signified that the worker was "working too slowly." According to Petitioner, the red light functioned as a warning, alerting the worker that certain parts were already supposed to be in place and the worker was already supposed to have pushed the button. The worker in the video pushed the activation button 63 seconds into the video.

Petitioner testified that, 85 and 112 seconds into the video, the worker can be seen using both of his hands to move a plate. Petitioner testified he would have been using only his right hand at those points.

Petitioner testified he began experiencing shoulder pain on a daily basis after he began working for Respondent. This pain worsened on November 5, 2012, when he injured both shoulders while lifting plates off pins. He testified he experienced a simultaneous onset of pain in both shoulders. He reported this injury to his supervisor [notice is not in dispute, Arb Exh 1] and sought care at Concentra Medical Centers, where he saw Dr. Kathuria.

Dr. Kathuria's note of November 5, 2012 reflects that Petitioner reported injuring his back and both shoulders while picking up product and placing it on a revolving plate. The note also reflects that Petitioner "noticed gradually increasing pain to both shoulders."

Dr. Kathuria described Petitioner's past medical history as non-contributory.

On shoulder examination, Dr. Kathuria noted tenderness at the AC joint, left worse than right. He also noted a full range of motion with end range pain. Shoulder X-rays were negative on preliminary reading.

Dr. Kathuria diagnosed shoulder tenosynovitis and strain. He prescribed Motrin, ice/heat applications and two weeks of physical therapy. He released Petitioner to light duty as of November 7, 2012 with no lifting/pushing/pulling over 15 pounds and no reaching above shoulder level. PX 3.

Petitioner testified he performed light duty for Respondent between November 6th and 21st. He continued to experience shoulder pain while performing light duty.

Petitioner returned to Concentra on November 7, 2012 and complained of pain on the anterior aspects of both shoulders, left worse than right. Petitioner indicated he was working

within the restrictions. He also indicated his symptoms were aggravated by lifting or raising his arms overhead.

On left shoulder examination, Dr. Taiwo noted a normal range of motion, negative impingement, Apley and anterior apprehension testing and tenderness to palpation at the anterior area. There is no indication that he examined Petitioner's right shoulder. He diagnosed a supraspinatus strain and instructed Petitioner to continue therapy for one to two weeks and return to the clinic as needed. PX 3.

On November 9, 2012, Petitioner went to the Emergency Room at Ingalls Memorial Hospital. The triage notes reflect that Petitioner "states he sprained both shoulders Monday at work lifting material." The notes also reflect that Petitioner was "given Motrin but states no relief of pain."

Another history reads as follows:

> "Pt c/o lower back spasms that started this morning. Pt states he has chronic back pain. Pt states he injured his shoulder at work on Monday but he is not here for the shoulder, just the back pain. Pt describes the pain as sharp and throbbing and rates the pain as 9/10 on the pain scale."

The examining physician noted a normal range of back motion, paraspinal tenderness to the lower back and no pain with straight leg raising. The physician ordered lumbar spine X-rays, which showed minimal degenerative disc changes at the L3 and L4 superior endplates. He administered Norco along with injections of Ketorolac and Norflex. At discharge, Petitioner was given prescriptions for Flexeril, Norco, Naproxen and a Medrol Dosepak. He was instructed to follow up with an internist and orthopedic surgeon. PX 5.

Petitioner testified he complained of both his back and his shoulder when he went to the Emergency Room.

Petitioner returned to Concentra on November 13, 2012 and again saw Dr. Taiwo. Dr. Taiwo's note reflects that Petitioner complained of 8/10 lower back pain that worsened on November 10, 2012, prompting him to go to the Emergency Room at Ingalls Hospital. Petitioner indicated that lumbar spine X-rays taken at the hospital were negative. He denied paresthesias, sensory loss, numbness and weakness of the extremities.

On lumbar spine examination, Dr. Taiwo noted negative straight leg raising bilaterally, a decreased lumbar spine range of motion, normal sensation, tenderness to palpation at the L4-L5 spinous process and negative Waddell tests.

On left shoulder examination, Dr. Taiwo noted a decreased range of motion, with painful abduction to 120 degrees, negative impingement, Apley and anterior apprehension testing and tenderness to palpation at the scapular area. There is no indication that he examined Petitioner's right shoulder.

The "assessment" and "plan" portions of Dr. Taiwo's note are blank. The following paragraph appears at the end of the note:

> "Diagnosis, treatment plan and expectations were discussed with the patient. Advised of medication usage and side effects. Or ER, if symptoms worsen before next visit to clinic. Patient verbalized understanding of treatment plan."

Dr. Taiwo's note is silent as to work/activity status. PX 3.

Petitioner retained counsel on November 20, 2012 and filed an Application for Adjustment of Claim the following day, alleging injuries to his back and shoulders on November 5, 2012. Arb Exh 2.

On November 21, 2012, Petitioner went to Orland Park Orthopedics and saw Mark Bordick, PA-C, Dr. Rhode's certified physician's assistant. Petitioner completed a history form indicating he injured his shoulders and back at work on November 5, 2012. Bordick recorded the following history:

> "Mr. Stewart sustained a work-related injury on November 5, 2012. He works the production line for Tower Automotive. He states while working the production line he was lifting a Y brace and felt the left shoulder give out. He had subsequent pain to the left shoulder and, to a lesser degree, the right shoulder. He saw the company physician and was ultimately placed back to work, during which time his low back began hurting with stiffness and pain across the low back. He states he has no pain radiating into the legs. He states, however, he continues to have numbness radiating into both arms down to the hands."

On lower extremity examination, Bordick noted a full range of motion with an intact gross motor and sensory exam. On left shoulder examination, he noted a range of motion of 175/60/T6, a positive impingement sign, specifically with internal rotation, and no pain with palpation over the acromioclavicular joint. On right shoulder examination, he noted a range of motion of 175/60/T6, a negative impingement sign, no tenderness to palpation over the AC joint and no pain referred to the acromioclavicular joint with provocative testing. On cervical spine examination, he noted a full range of motion, negative Spurling's and pain over the

bilateral cervical paraspinous muscles. On lumbar spine examination, he noted bilateral lumbar paraspinous muscle pain and negative straight leg raising bilaterally.

Bordick obtained cervical spine X-rays. He interpreted the films as showing spurring and disc space narrowing at C5-6 and C6-7.

Bordick injected the left acromial space with 40 mg of Kenolog and 9 cc of Lidocaine.

Bordick diagnosed rotator cuff tendonitis secondary to the work injury. He took Petitioner off work and instructed him to return in seven to ten days. He indicated Petitioner might need a cervical MRI pending his response to the injection.

Petitioner returned to Orland Park Orthopedics on November 30, 2012 and again saw Bordick. Bordick noted that Petitioner "continues to have significant left shoulder pain but denies numbness and tingling to the left upper extremity."

Bordick's left shoulder examination findings remained unchanged. On cervical spine examination, he noted a limited active range of motion and positive bilateral Spurling testing. There is no indication that he examined Petitioner's right shoulder. On lumbar spine examination, he noted bilateral lumbar paraspinous muscle pain and negative straight leg raising bilaterally. He prescribed a left shoulder MRI based on the lack of response to the injection. He instructed Petitioner to stay off work and follow up after the MRI. PX 6.

The left shoulder MRI, performed without contrast on December 12, 2012, showed mild chondromalacia with subchondral fluid at the posterior aspect of the bony glenoid, an "intrasubstance tear of the distal supraspinatus tendon at the insertion site," fraying along the articular surface of the distal infraspinatus tendon and severe rotator cuff tendinosis, most marked involving the supraspinatus tendon. The interpreting radiologist noted "no evidence of complete rotator cuff tear."

Petitioner returned to Orland Park Orthopedics on December 14, 2012 and again saw Bordick. Bordick noted that Petitioner "continues to have significant left shoulder pain."

On left shoulder examination, Bordick noted a range of motion of 175/60/T6, a positive impingement sign, no pain with palpation over the acromioclavicular joint and no pain with resisted straight arm or crossed arm abduction. On cervical spine examination, Bordick noted a full range of motion, negative Spurling's and no evidence of atrophy. On biceps examination, Bordick noted no evidence of tendonitis or rupture. On lumbar spine examination, Bordick noted negative bilateral straight leg raising.

Bordick prescribed Norco and physical therapy. He instructed Petitioner to remain off work. He noted Petitioner might need arthroscopic surgery if he failed to respond to therapy. PX 6.

At the next visit, on January 16, 2013, Bordick recorded the following interval history:

> "Mr. Stewart sustained a work related injury on November 5, 2012. He continues to have significant left shoulder pain. It should be noted that, despite the fact the left shoulder is more painful, the right shoulder continues to cause him discomfort daily and is a direct result of his work-related injury."

Bordick's left shoulder and cervical spine examination findings were unchanged. On right shoulder examination, he noted external rotation and supraspinatus isolation strength of 5-/5 and a positive impingement sign, specifically with internal rotation.

Bordick noted that Petitioner was unwilling to live with his left shoulder pain. He recommended an arthroscopy and possible rotator cuff repair. He directed Petitioner to remain off work. PX 6.

Bordick again recommended surgery on January 29, 2013. He continued to keep Petitioner off work.

Dr. Rhode operated on Petitioner's left shoulder on February 12, 2013. The surgery consisted of a left arthroscopic rotator cuff repair and decompression.

Dr. Rhode testified by way of evidence deposition on March 14, 2013. Dr. Rhode testified he is board certified in orthopedic surgery, sports medicine and independent medical examination. PX 7 at 9. He did a sports medicine fellowship. He operates on multiple body parts but does not perform spine surgery or hip replacements. PX 7 at 11. About half of the surgeries he performs involve the shoulder. He considers himself a "high volume rotator cuff repair surgeon." PX 7 at 14. He has 5,000 patient visits per year. He performs 600 to 700 surgeries per year. PX 7 at 14-15. He co-wrote an article concerning access to care for carpal tunnel in the workers' compensation population. He has submitted that article to a medical journal for publication. PX 7 at 11. He operates an orthopedic implant company that produces "low cost implants," i.e., rotator cuff anchors, used in shoulder surgery. PX 7 at 12. He is on the editorial board of "Orthopreneur," an "orthopedic journal geared towards the physician entrepreneur." PX 7 at 13.

Dr. Rhode testified that shoulder impingement is a "progressive pathology." Impingement is an early-stage rotator cuff problem. PX 7 at 16. The rotator cuff tendon can become impinged, or pinched, under the acromion. When an individual raises his arm, he is abutting that tendon "and it becomes a repetitive overuse, progressive process." PX 7 at 17. Rotator cuff problems have different presentations. Patients typically complain of lateral shoulder pain, pain with forward elevation and weakness. PX 7 at 17.

Dr. Rhode testified that Petitioner gave a history of feeling his left shoulder "give out" while lifting a "Y brace" on Respondent's production line on November 5, 2012. Petitioner also indicated he experienced some right shoulder pain at that time. PX 7 at 19.

Dr. Rhode testified he saw a short video of Petitioner's job duties. [At the hearing, the parties agreed that the video Dr. Rhode saw is not the same video that Dr. Marra and the Arbitrator viewed. They also agreed that the video Dr. Rhode saw shows a portion of the "Y brace" job. The video Dr. Rhode watched was not offered into evidence because it was proprietary in nature, per Respondent.] The video showed an assembly line and a worker who had to perform a "highly repetitive" motion, using forward reach to take an object from one position to another. The "primary repetitive motion" Dr. Rhode saw on the video was the forward reach, waist to chest. PX 7 at 21. He understands that most of the objects shown in the video weighed 10 to 25 pounds. PX 7 at 21.

Dr. Rhode opined that "the repetitive duties [Petitioner] was exposed to [were] a causative factor which culminated in the November 5th event when he was lifting a "Y brace" when he basically reached the injury threshold." Petitioner was "persistently symptomatic" after the event. PX 7 at 22. Dr. Rhode indicated he is not aware of Petitioner engaging in any repetitive activities outside of work. PX 7 at 22. Nor is he aware of Petitioner having any shoulder problems before he began working for Respondent. PX 7 at 22-23.

Dr. Rhode testified that, on initial left shoulder examination, Petitioner exhibited a normal range of motion, intact strength, no pain over the acromioclavicular joint and a positive impingement sign. PX 7 at 23-24. On cervical spine examination, Petitioner had "some limited range of motion in a positive Spurling maneuver."

At the initial visit, Petitioner underwent a subacromial steroid injection for diagnostic and therapeutic purposes. Petitioner was instructed to stay off work and return in seven to ten days. When Petitioner returned, on November 30th, he still had significant left shoulder pain. Petitioner was directed to stay off work and undergo a left shoulder MRI. The radiologist interpreted the MRI as showing a high grade partial thickness supraspinatus tear and fraying along the articular surface of the distal infraspinatus tendon. When asked whether the term "fraying" implied chronicity, the doctor testified that "you can't read chronicity" off of an MRI. Based on the MRI, the doctor recommended a course of therapy. Petitioner underwent therapy at ATI thereafter, with the therapist noting significant strength loss and reduced range of motion in both shoulders. PX 7 at 35.

Dr. Rhode testified he operated on Petitioner's left shoulder on February 12, 2013. In his operative report, he documented a I.5 centimeter by 1 centimeter U-shaped supraspinatus tear. This was consistent with the MRI findings. PX 7 at 36-37. The doctor testified that, during the surgery, he decompressed a subacromial spur in the subacromial space and then addressed the rotator cuff pathology. PX 7 at 38. The doctor testified that spurs such as Petitioner's represent a "protective response of the acromion." PX 7 at 39.

Dr. Rhode testified that, when Petitioner returned postoperatively, on February 27, 2013, he complained of right shoulder pain. Petitioner underwent instruction in home exercises for his left shoulder. PX 7 at 39-42. As of the next visit, on March 1, 2013, Petitioner was "doing okay performing the home exercises" and was anticipating starting formal therapy. PX 7 at 43.

Dr. Rhode testified he has not seen Petitioner since March 1, 2013. He anticipated addressing Petitioner's right shoulder complaints at the next visit. PX 7 at 43-44.

Dr. Rhode opined that Petitioner's left rotator cuff was "causally connected to [his] exposure at" Respondent. PX 7 at 44. He explained this opinion as follows:

> "[T]hey've got some studies out there looking at forces that shoulders are exposed to. And I was always taught in fellowship that reaching out for a salt shaker puts twice your body weight across your shoulder. And it's all levers, so it doesn't matter if you're forward reaching or going above shoulders. This is all a lever. And that force, which is length times mass, is generated by the rotator cuff.
>
> So if someone is performing that activity repeatedly, repetitively over and over and over, they put themselves at risk for rotator cuff pathology.
>
> Obviously, you know, yeah, the patient's age has something to do with it as well because, as we get older, the blood supply to these tendons isn't as good. So they are more liable to damage but, nonetheless, the patient had an appropriate, what I call, dose response. He had enough exposure. He— and his – the actual job activities were appropriate for causation."

PX 7 at 44-45. Dr. Rhode testified his treatment was necessary. He further testified his charges were usual, customary and dictated by the Ingenix fee schedule. PX 7 at 50.

Under cross-examination, Dr. Rhode testified he did not know how Petitioner ended up in his care. PX 7 at 51. Mark Bordick is his assistant. The notes that Bordick signed are notes Bordick dictated while under his supervision. PX 7 at 52. Dr. Rhode testified he did not review any records concerning the treatment Petitioner underwent prior to coming under his care. PX 7 at 52. He does not know whether Petitioner reported injuries to Respondent. Petitioner's injury stemmed from a "repetitive exposure mechanism that culminated with his symptom onset when he was lifting the Y brace." PX 7 at 55. He has kept Petitioner off work since the initial visit. PX 7 at 55. He obtained the job video from Petitioner's counsel. PX 7 at 56. He discussed the job video only with Petitioner's counsel. PX 7 at 57. He does not know who created the video. PX 7 at 63. Petitioner would be able to resume one-handed work "at some

point but, in his experience, one-handed work is never truly one-handed. Inevitably, the claimant is assigned to sweeping. He does not want his patients to be put into situations that are harmful. PX 7 at 59. The condition that Petitioner has takes time to heal. PX 7 at 60. He would consider putting Petitioner back to work if Respondent offered an office job six to twelve weeks postoperatively. PX 7 at 51. He is "shooting for" Petitioner being able to resume full duty five to six months postoperatively. PX 7 at 61.

Dr. Rhode admitted he "received a censorship" in connection with a case in which he was sued for malpractice. He treated the patient's distal radius fracture but missed an elbow fracture. PX 7 at 63.

On redirect, Dr. Rhode testified that a partial rotator cuff tear can cause pain. It would have been difficult for Petitioner to perform the duties shown on the video with a partial rotator cuff tear. PX 7 at 64. When he said he anticipated Petitioner being able to resume full duty in five or six months, that was without regard to Petitioner's right shoulder problem. He will have to consider Petitioner's ability to resume full duty in the context of a bilateral shoulder condition. PX 7 at 64-65.

At Respondent's request, Petitioner saw Dr. Marra, an orthopedic surgeon, for a Section 12 examination on May 7, 2013. Dr. Marra is director of shoulder and elbow surgery at Northwestern University's Feinberg School of Medicine. RX 1.

Dr. Marra's report sets forth the following history:

> "Mr. Stewart is a 51-year-old right hand dominant male who presents for evaluation of bilateral shoulder pain as a result of an injury which occurred on November 5, 2012. Mr. Stewart states this was the result of repetitive work activity. He states that his work involves repetitively placing parts away from his body which weigh anywhere from 10 to 20 pounds. He states that on the initial day of his injury he worked approximately 10 hours and began developing significant pain in his shoulder. On the following day, he worked 3 hours and then was unable to work due to pain. Mr. Stewart states he reported bilateral shoulder pain to his supervisor."

Dr. Marra noted that Petitioner was undergoing therapy following the left rotator cuff repair of February 12, 2013. He reviewed Dr. Rhode's operative report as well as the intra-operative photographs. He interpreted the photographs as showing a "small localized full-thickness tear of the supraspinatus tendon."

On left shoulder examination, Dr. Marra noted a well-healed incision, active elevation to 120 degrees, external rotation to 30 degrees and internal rotation to the gluteal region. He also noted a positive impingement sign, a positive Hawkins' test, no acromioclavicular joint tenderness, negative crossover testing and negative Speed's and O'Brien's testing.

On right shoulder examination, Dr. Marra noted active elevation to 160 degrees, external rotation to 60 degrees and internal rotation to the gluteal region. He also noted a positive impingement sign, a positive Hawkins' test, no acromioclavicular joint tenderness, negative crossover testing and negative Speed's and O'Brien's testing. Strength of elevation was 4/5, external rotation strength was 5-/5 and the lift-off sign was negative.

Dr. Marra described Petitioner's current diagnosis as "status post left arthroscopic rotator cuff repair with right shoulder impingement and a possible rotator cuff tear." He characterized the treatment to date as reasonable. With respect to the left shoulder, he recommended continued therapy. He anticipated Petitioner would reach maximum medical improvement six months postoperatively. He did not anticipate any residual disability. With respect to the right shoulder, he recommended an MRI "given the signs of impingement and weakness on examination." He indicated maximum medical improvement would depend on the results of this MRI.

As for work capacity, Dr. Marra recommended no use of the left arm and a 15-pound overhead restriction with respect to the right arm.

Dr. Marra indicated he reviewed a job video showing a worker placing small metal parts into a machine. He indicated the worker performed this activity "primarily below shoulder height, occasionally having to reach out in space." He also indicated the parts appeared to be light, weighing "less than 5 to 10 pounds." He indicated he also reviewed a "second file showing similar activity" done primarily below shoulder height.

Dr. Marra opined that the activity shown on the job video would not be a competent cause of a rotator cuff tear as the video "does not demonstrate any repetitive strenuous overhead lifting sufficient to tear the rotator cuff tendon." RX 1.

[At the hearing, the parties agreed that the job video Dr. Marra saw is the same video the Arbitrator viewed.]

At the hearing, Petitioner testified Dr. Rhode took him off work as of November 21, 2012 and has not released him to any form of work. Petitioner also testified his left shoulder therapy ended in early June 2013. He last saw Dr. Rhode on August 16, 2013. Dr. Rhode is now focusing on his right shoulder. Dr. Rhode has recommended a right shoulder MRI. Petitioner wants to undergo this MRI. He is willing to undergo right shoulder surgery if Dr. Rhode recommends it. His left shoulder still hurts. He cannot lift his hands overhead. He is right-handed.

Under cross-examination, Petitioner testified he had a sudden onset of shoulder pain on November 5, 2012. He did not recall requesting any time off work from work around this date. When he experienced the pain on November 5, 2012, he was about two hours into his shift. The "Y brace" job sometimes rotated with other jobs. He performed other jobs during the period he worked for Respondent. One of those jobs was material handler but he could not recall the dates on which he performed this job. He performed the material handler job on an "as needed" basis. He could not recall whether he worked Sunday, November 4th. Respondent provided accommodated duty per Concentra's restrictions. He was not sure whether he received work restrictions when he went to the Emergency Room on November 9, 2012. He applied for Social Security disability in February 2012. When he applied to work at Respondent, he did not indicate he had any physical problems because he "didn't have any." The machine shown in the video "is not allowed to wait for the worker." If the worker is not working quickly and accurately, the red light comes on. The parts have to be in place in order for the green light to come on.

On redirect, Petitioner testified that, when he worked as a material handler, he would not be rotated into the "Y brace" job. Before November 5, 2012, he performed the "Y brace" job exclusively for two or three days. He had shoulder pain before November 5, 2012 but this pain increased on that date. He performed light duty in a different work area. His shoulder pain persisted while he was performing light duty. This is why he asked for an "emergency date" to undergo treatment. Concentra would not provide an "emergency date." While his records state he sought an "emergency vacation," he did not actually take a vacation. He worked light duty consistently until he saw Dr. Rhode. He does not recall losing time due to back problems.

Under re-cross, Petitioner testified he did not remember whether he took time off due to back problems. He could not recall whether he called in to work on November 12th and indicated he was taking the day off due to his back.

In response to a question posed by the Arbitrator, Petitioner testified he still had to pick up parts while performing light duty but he was not subject to a quota.

Two witnesses testified on behalf of Respondent. **Robert Irby** testified he used to work on the "Y brace" line but is now a production supervisor for Respondent. The video accurately depicts the "Y brace" job. That job does not involve any tasks above shoulder height. The speed of the machine is controlled by a robot, not the worker. The term "water spider" refers to a person who acts as a parts runner for a "Y brace" worker. The "water spider" puts inserts into racks for the "Y brace" workers. Irby testified he worked alongside Petitioner as of the claimed accident. He does not recall Petitioner complaining of any issues before the accident. Respondent has accommodated duty available.

Under cross-examination, Irby testified that a "Y brace" is a plate. A "Y brace" worker places inserts in "Y braces." Depending on the rotation, a "Y brace" worker may need to leave his work area to retrieve "Y braces." Before November 5, 2012, Petitioner might have been

required to leave his work area to retrieve "Y braces." If Petitioner worked a full 4-day week, and rotated positions, he would have needed to travel 10 feet a couple of times to retrieve parts. A "water spider" is responsible for retrieving all parts other than "Y braces." A "Y brace" worker is not required to retrieve other parts but he cannot say that Petitioner never had to do this. The job shown in the video is one of three jobs that are rotated. It is the "medium" job in terms of difficulty. The jobs are rotated every two hours. Irby could not recall whether there were any manpower issues before November 5, 2012.

James Commet testified he works for Respondent as a workers' compensation/insurance manager. He recalls the events that occurred during the week of Petitioner's claimed accident. Petitioner requested an "emergency vacation" while he was on light duty. Petitioner ended up taking a personal day. Petitioner called in to work on November 12, 2012 due to back problems. Respondent has a policy of supporting return to work. It is rare for Respondent not to accommodate a restriction. Petitioner was provided with accommodated duty and such duty is still available. There are workers at Respondent's facility who are currently performing light duty. Light duty is accommodated even when the worker is dealing with a personal health condition.

Under cross-examination, Commet acknowledged that Petitioner performed light duty for two weeks after November 5, 2012. Human resources indicated that Petitioner took days off due to his low back. He presumes that Petitioner took time off due to his lower back after November 5, 2012.

Petitioner was not called in rebuttal.

[CONT'D]

Kevin Stewart v. Tower Automotive
12 WC 40435

Did Petitioner sustain an accident on November 5, 2012 arising out of and in the course of his employment? Did Petitioner establish a causal connection between that claimed accident and his bilateral shoulder condition of ill-being?

Petitioner testified he began working for Respondent on April 19, 2012. One of the jobs he performed thereafter was a "Y brace" job. Petitioner testified the tasks involved in this job had to be performed within time constraints due to a production quota. The job required lifting and manipulation of 3-pound inserts and 15- to 20-pound plates. The Arbitrator watched a short video of this job during the hearing, with Petitioner providing running commentary. Petitioner distinguished his performance of the job from that shown on the video in several ways. He testified he worked more quickly than the worker shown on the video. Unlike that worker, who routinely used both hands, he primarily used his dominant right hand to lift the parts and inserts. He did this in order to save time. Petitioner also testified the video did not show all aspects of the job. For example, it did not show the worker having to travel about 40 feet to retrieve certain parts. It also did not show the worker having to pull a cart that was loaded with plates. He had to pull this cart two to three times per shift.

Petitioner acknowledged that, before early November 2012, rotation was the "norm" at Respondent, meaning he was rotated in and out of various jobs during each workday. It was only in early November 2012 that he began to exclusively perform the "Y brace" job due to manpower issues. He had experienced some degree of shoulder pain each day since his first day at Respondent but, on November 5, 2012, a Monday, he experienced an abrupt worsening of that pain. Both shoulders started hurting at the same time that day but his left shoulder was more symptomatic.

Under cross-examination, Petitioner could not recall whether he worked on Sunday, November 4, 2012. He admitted that, on November 5, 2012, he experienced the abrupt onset of shoulder pain only two hours into his shift. He worked as a material handler before November 5, 2012 but could not recall exactly when he did this.

On redirect, Petitioner clarified that, when he worked as a material handler, he was not rotated into the "Y brace" job. He performed the "Y brace" job in an exclusive, non-rotating fashion for only two or three days before November 5, 2012.

Robert Irby, who is now a production supervisor for Respondent, testified he worked alongside Petitioner as of November 5, 2012. Irby took issue with some of Petitioner's testimony about the "Y brace" job. According to Irby, another worker, known as a "water spider," was responsible for retrieving all parts other than "Y braces" for the "Y brace" workers.

Petitioner ultimately sought care from Dr. Blair Rhode, a surgeon who devotes about half of his practice to shoulder problems. Dr. Rhode's chart reflects that Petitioner primarily interacted with Mark Bordick, P.A., the doctor's assistant. Bordick's initial history of November 21, 2012 reflects that Petitioner was lifting a "Y brace" at work on November 5, 2012 when he "felt the left shoulder give out." Bordick also noted that, following this incident, Petitioner experienced bilateral shoulder pain, left worse than right.

Dr. Rhode gave a deposition on March 14, 2013, about a month after he performed a rotator cuff repair on Petitioner's left shoulder. Dr. Rhode described himself as a "high volume shoulder guy." He testified he watched a job video prior to the deposition. [While that video is not in evidence, the parties agree it depicted the "Y brace" job.] It was Dr. Rhode's understanding that most of the objects shown in the video weighed between 10 and 25 pounds. Dr. Rhode described the work activity shown in the video as involving forward reaching, waist to chest. Dr. Rhode did not recall whether Petitioner performed any duties other than the duties shown on the video. Dr. Rhode attributed Petitioner's bilateral shoulder condition to the "highly repetitive" activities shown on the video, with those activities leading to a culminating, lifting-related event of November 5, 2012. Dr. Rhode testified that, if someone performs forward reaching repetitively, "over and over and over," he puts himself at risk for rotator cuff pathology. He acknowledged that Petitioner's age might also have played a role in the development of this pathology but that, nevertheless, Petitioner had "enough exposure" to the repetitive work activities to establish causation.

The Arbitrator finds that Petitioner failed to establish causal connection in this case.

The Arbitrator finds Dr. Rhode unpersuasive. It appears to the Arbitrator that Dr. Rhode assumed Petitioner used both hands to lift and position the plates and inserts. Petitioner testified, however, that, unlike the worker shown in the job video, he typically used his dominant right hand to perform these tasks. Petitioner failed to establish why his symptoms were, at least at the outset, primarily left-sided. Dr. Rhode assumed the objects shown in the video weighed between 10 and 25 pounds. Petitioner acknowledged each insert weighed only 3 pounds. It also appears that Dr. Rhode assumed Petitioner performed the "Y brace" job for a significant period, i.e., "over and over and over." He had no recollection of Petitioner performing any other job for Respondent. He never expressed any understanding of the relatively short duration of Petitioner's employment. Petitioner acknowledged he performed the "Y brace" job on an exclusive basis for only two to three days before November 5, 2012. He also acknowledged he was only two hours into his shift on November 5, 2012, a Monday, when he experienced a sudden onset of bilateral shoulder pain, left worse than right. He could not recall whether he had worked the day before.

In short, Dr. Rhode's causation opinion is premised on an "adequate" exposure to "highly repetitive" and bilateral forward reaching/lifting of objects weighing 10 to 25 pounds. Petitioner did not establish such an exposure. The Arbitrator views the remaining disputed issues as moot. Compensation is denied, as is Petitioner's claim for prospective care.

STATE OF ILLINOIS)
) SS.
COUNTY OF Mc LEAN)

☒ 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

Tonya Tribbett,
Petitioner,

vs. NO: 12 WC 19132

Center For Health,
Respondent.

14IWCC0962

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 denial of 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 January 8, 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.

14IWCC0962

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $22,300.00. 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:

NOV 10 2014

Daniel R. Donohoo

Charles J. DeVriendt

Ruth W. White

o-10/22/14
drd/wj
68

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

TRIBBETT, TONYA
Employee/Petitioner

Case# **12WC019132**

CENTER FOR HEALTH
Employer/Respondent

14IWCC0962

On 1/8/2014, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

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

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

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

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

TONYA TRIBBETT,
Employee/Petitioner

v.

CENTER FOR HEALTH,
Employer/Respondent

Case # 12 WC 19132

Consolidated cases: NONE.

14IWCC0962

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Joann M. Fratianni**, Arbitrator of the Commission, in the city of **Bloomington**, on **October 16, 2013**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **April 4, 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 **$38,782.64**; the average weekly wage was **$745.82**.

On the date of accident, Petitioner was **46** years of age, ***married*** with **no** dependent children.

Petitioner ***has in part*** 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 **$ 7,280.23** for TTD, **$ 0.00** for TPD, **$ 0.00** for maintenance, and **$ 0.00** for other benefits, for a total credit of **$ 7,280.23**.

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 **$447.49**/week for **37.5** weeks, because the injuries sustained caused the **7.5%** loss to her **person as a whole,** as provided in Section 8(d)2 of the Act.

Respondent shall pay to Petitioner **$5,391.11** for medical expenses, pursuant to Section 8(a) of the Act, subject to the medical fee schedule as created by 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.

JOANN M. FRATIANNI
Signature of Arbitrator

December 30, 2013
Date

JAN 8 - 2014

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

Petitioner testified that on April 12, 2012, she worked for Respondent as a surgical technician. On that date she was attempting to adjust or remove a Schlein module while setting up an operating room for an orthopedic surgeon. The Schlein module attaches to an operating room table allowing the patient to be properly positioned for shoulder surgery. Petitioner testified the Schlein module had malfunctioned, and when she pulled on it to adjust a part, she experienced a pop and pain in her lower back. Following this injury, Petitioner asked for help and several coworkers came to her aid.

Petitioner that same day sought medical treatment at the emergency room of OSF St. Francis Medical Center. While in the emergency room, she complained of low back pain radiating down both legs and to her middle back. A history of injury was recorded that was consistent with Petitioner's testimony. Petitioner denied any history of back problems or treatment before this accident. X-rays revealed early degenerative changes with small marginal osteophytes anteriorly in the L3 through L5 vertebral bodies. These were unchanged from a CT renal stone study performed in 2008. Petitioner underwent a lumbar and thoracic MRI. The lumbar spine MRI revealed lumbosacral degenerative spondylosis, no significant central spinal canal impingement, and relatively minimal or mild encroachment suggested on the left L3-L4 and bilateral L4-L5 neuroforamina. The thoracic spine MRI revealed a left T11-T12 disc protrusion with partial effacement of the subarachnoid space, with no evidence of significant central spinal canal impingement or cord deformation. Petitioner was diagnosed with lumbosacral degenerative spondylosis without significant central spinal canal impingement and minimal or mild encroachment suggested on the left L3-L4 and bilateral L4-L5 neuroforamina. Petitioner was prescribed IV pain medication while in the emergency room, Neurontin, and was discharged with instructions for home healthcare and physical therapy. (Px6)

Petitioner testified she then received home healthcare for a few weeks subsequent to her discharge. She also saw Dr. Jujjavarapu, her family physician, on April 9, 2012. She presented Family Medical Leave Act paperwork for the doctor to fill out. Dr. Jujjavarapu noted the paresthesia was a little better and felt the prescribed Neurontin was working. Dr. Jujjavarapu prescribed continuing with physical therapy and referred her to an orthopedic surgeon. (Px3)

Petitioner returned to see Dr. Jujjavarapu on May 17, 2012, who noted improving lower back pain with less tingling in her toes. Juijjaviraapu diagnosed lumbago and sciatic. Petitioner returned to see Dr. Jujjavarapu on June 11, 2012. An EMG/NCV study that day was described as being unremarkable.

Petitioner saw Dr. Timothy VanFleet on June 1, 2012. This was at the request of Respondent. Dr. VanFleet noted following his examination, that the symptoms were causally related to the injury of April 4, 2012. Dr. VanFleet recommended she finish physical therapy and return to work upon completion of therapy, at which time she would be considered to be at maximum medical improvement. Dr. VanFleet noted the imaging studies revealed mild degenerative changes at L2-L3, with the adjacent disc spaces unremarkable. A mild disc protrusion was noted at T11-T12 with no focal neurologic compression. (Rx1)

On June 21, 2012, Dr. Jujjavarapu noted some lower back pain and swelling of the left leg with intermittent tingling and discoloration of her toes. Dr. Jujjavarapu prescribed additional physical therapy, and that she continue to remain off work until the next appointment of July 16, 2012. (Px3)

Petitioner last saw Dr. Jujjavarapu on July 16, 2012, who referred her to an orthopedic surgeon. Dr. Jujjavarapu diagnosed depression anxiety and lumbago and released her to return to work with no restrictions.

Petitioner testified she would not be allowed to return to work until cleared by Dr. Edward Moody, of Respondent's occupational health department. Petitioner in fact saw Dr. Moody on July 11, 2012 who noted negative straight leg raising bilaterally, no gross weakness and give way inconsistent weakness of the left foot and ankle flexors, extensors and big toe extension. Dr. Moody felt a functional capacity evaluation (FCE) was appropriate, and released her to return to work for four-hour shifts from July 11, 2012 through July 22, 2012, and eight hour shifts commencing July 23, 2012. Restrictions included no unsupervised clinical decision making and maximum lifting of 15 pounds, no bending over 45 degrees with positional changes as needed. (Px5)

Petitioner underwent a FCE study on July 23-24, 2012. She was found to be able to lift 60 pounds and carry 45 pounds. The FCE results matched Petitioner's required job duties. (Px5)

Petitioner testified she returned to work on a PRN basis on August 1, 2012 and continued working in such a fashion through November 18, 2012. Thereafter she returned to her regular work full time with no restrictions.

The parties have stipulated that no temporary total disability benefits are owed and respondent is entitled to a credit for such payments. The periods of TTD were not introduced into evidence.

On July 31, 2012, Petitioner came under the care of Dr. Kube, an orthopedic surgeon, on referral by Dr. Jujjavarapu. Dr. Kube testified by evidence deposition that he reviewed the imaging studies and noted no substantial degenerative changes and no neurocompressive lesion. Dr. Kube noted a small protrusion at L5-S1 more on the left than the right. No spondylolysis or spondylolisthesis was noted, but a loss of disc height at L5-S1 was found. Dr. Kube diagnosed lumbago, sacroiliitis and possibly some radicular pain consistent with sacroiliac joint dysfunction on the left. Dr. Kube prescribed an injection to the S1 joint that was performed on August 20, 2012. (Px2)

Petitioner returned to Dr. Kube on August 28, 2012. Petitioner reported good results from the injection with immediate relief of symptoms. The pain returned after 3-4 hours but the symptoms were better. Dr. Kube prescribed x-rays that revealed a good S1 trajectory approach with no significant abnormality. Dr. Kube classified this as a Type I SI joint and pelvis, with no substantial joint narrowing or sclerosis or degenerative changes. Dr. Kube prescribed with rehabilitation to see if the pain could get under better control and felt she could continue working with no restrictions. (Px2)

Petitioner returned to Dr. VanFleet on September 7, 2012. This too was at the request of Respondent. Dr. VanFleet noted the FCE results indicated a return to work. Physical examination revealed good range of motion including flexion and extension. Symmetric reflexes of both knees and ankles were noted, and strength testing was 5/5 with preservation of sensation. Petitioner was noted to have some left leg swelling which Dr. VanFleet felt was the result of some venous insufficiency. Dr. VanFleet felt the subjective complaints were not consistent with the objective findings, and felt she was now at maximum medical improvement. (Rx2)

Petitioner then saw Dr. Kube on October 30, 2012. She reported continuing physical therapy and was experiencing the pain that was alleviated after the injection. She continued working. Examination revealed a loss of sensation in the left foot, with the remainder of the exam normal. Dr. Kube prescribed a second lumbar injection, which was performed on November 12, 2012 at the SI joint. (Px2)

Petitioner last saw Dr. Kube on December 4, 2012. She reported immediate relief of symptoms within 5-10 minutes after the injection. After an hour or two, the pain returned. Dr. Kube prescribed a minimally invasive S1 joint fusion. (Px2)

Petitioner saw Dr. VanFleet for a third time on April 10, 2013. This too was at the request of Respondent. Dr. VanFleet felt his examination was unchanged from the earlier ones, and disagreed with the prescription by Dr. Kube for surgery. Dr. VanFleet diagnosed a low back injury and not an injury to the S1 joint. Dr. VanFleet felt the mechanism of injury described to him was not consistent with an S1 joint dysfunction, and felt it was a very nonspecific diagnosis from a medical standpoint. (Rx3)

Petitioner testified she does not have any follow up appointments with Dr. Kube, but continues to take Tramadol, as prescribed by Dr. Kube. (Px2) Petitioner testified that she returned to full duty work on November 19, 2012 with no restrictions or accommodations, but noted it was painful at times and she often struggles with her work.

The Arbitrator finds that based upon the above, including the evidence deposition testimony of Dr. Kube, along with the three reports of Dr. VanFleet, all substantiate a finding of causal relationship in this matter between the accidental injury of April 4, 2012 and the medical treatment and diagnoses.

J. Were 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 outstanding medical charges for treatment that were incurred after this accidental injury:

OSF Home Medical Equipment	$ 206.00
OSF St. Francis Medical Center	$1,691.00
OSF Occupational Health	$ 723.11
INI Physicians	$ 308.00
Prairie Spine & Pain Institute	$1,947.00
Prairie Surgical Care	$6,390.98
Accelerated Rehab	$1,576.00
Proctor Medical Group – Dr. Jujjavarapu	$ 60.00
Pharmacy Prescriptions	$3,752.07

These charges total $16,654.16.

See findings of this Arbitrator in "F" above.

The Arbitrator finds that Petitioner reached maximum medical improvement as of September 7, 2012, in accordance with Dr. VanFleet's opinion on that date. Dr. VanFleet further felt no further medical care was necessary at that time.

Based upon said findings, Respondent is found to be liable to Petitioner for the above medical expenses that predate September 7, 2012, which total $5,391.11. The awarded charges include OSF Home Medical Equipment ($206.00), OSF St. Francis Medical Center ($1,691.00), OSF Occupational Health ($723.11), Prairie Spine and Pain Institute ($1,938.00), Dr. Jujjavarapu ($30.00), and Prairie Surgical Care ($803.00).

Denied are the medical charges of INI Physicians in the amount of $308.00 that were not supported by any medical records, and the pharmacy prescriptions of $3,752.07, which were not corroborated with any documentation.

14IWCC0962

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

See findings of this Arbitrator in "F" above.

The Arbitrator adopts the opinions of Dr. VanFleet who felt that Petitioner reached maximum medical improvement as of his examination dated September 7, 2012, and is entitled to an award of permanent partial disability. (Px3)

Petitioner did sustain a back injury on April 4, 2012 and underwent physical therapy, two lumbar injections, and has been working full duty at her original job since November 19, 2012, with no restrictions or accommodations. She last underwent medical treatment on December 4, 2012.

Based upon the above, the Arbitrator finds the condition of ill-being to be permanent in nature.

O. Is Petitioner entitled to receive certain prospective medical care at the expense of Respondent?

Petitioner demands Respondent authorize and pay for the surgical fusion as prescribed by Dr. Kube. See findings of this Arbitrator in "F" above. Dr. Kube testified the need for such fusion surgery is causally related to the accident of April 2, 2012. Dr. Kube further testified there is a substantial amount of literature suggesting that females have an increased occurrence of S1 joint dysfunction, due to pregnancy and hypermobility of the S1 joint.

The Arbitrator notes the last medical examination occurred on April 10, 2013, with Dr. VanFleet. Dr. VanFleet on that date noted negative supine straight leg raising testing, symmetrical reflexes at the knees and ankles, and symmetric strength testing at 5/5 at all groups. Dr. VanFleet diagnosed a low back injury and not an injury to the S1 joint and did not feel that additional treatment such as a fusion at S1 was reasonable or appropriate.

The Arbitrator finds Dr. VanFleet's opinions in this matter to have greater credibility than those of Dr. Kube. Under these circumstances, the Arbitrator declines to order prospective medical care in the form of a fusion at S1.

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Maria de Jesus Cervantes,
Petitioner,

vs. NO: 13 WC 06757

Specialized Staffing,
Respondent.

14IWCC0963

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 Petitioner's issues of accident, temporary total disability, and medical expenses and Respondent's issue of accident and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof. 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.

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

14IWCC0963

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

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $1,700.00. 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: NOV 10 2014

Daniel R. Donohoo

Charles J. DeVriendt

Ruth W. White

o-10/21/14
drd/wj
68

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

CERVANTES, MARIA DE JESUS
Employee/Petitioner

Case# **13WC006757**
13WC006758

SPECIALIZED STAFFING
Employer/Respondent

14IWCC0963

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:

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

STATE OF ILLINOIS)
)
COUNTY OF COOK)

ILLINOIS WORKERS' COMPENSATION COMMISSION

19(b) ARBITRATION DECISION

MARIA DE JESUS CERVANTES
Employee/Petitioner

Case #13 WC 6757
13 WC 6758

v.

SPECIALIZED STAFFING
Employer/Respondent

14IWCC0963

An *Application for Adjustment 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 August 2, 2013. After reviewing all of the evidence presented, the arbitrator hereby makes findings on the disputed issues, and attaches those findings to this document.

ISSUES:

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

B. ☐ Was there an employee-employer relationship?

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

D. ☐ What was the date of the accident?

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

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

G. ☐ What were the petitioner's earnings?

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

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

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

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

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

M. ☐ Is the respondent due any credit?

N. ☒ Prospective medical care?

FINDINGS

- On January 25, 2013, and February 20, 2013, the respondent was operating under and subject to the provisions of the Act.
- The dates are the subject matter of claims #13 WC 6757 and #13 WC 6758, respectively.
- On those dates, an employee-employer relationship existed between the petitioner and respondent.
- Timely notice of accidents was given to the respondent.
- In the year preceding the injury on January 25, 2013, the petitioner earned $7,383.76; the average weekly wage was $295.35.
- In the year preceding the injury on February 20, 2013, the petitioner earned $8,957.44; the average weekly wage was $308.88.
- At the time of injuries, the petitioner was 47 years of age and single with no children under 18.
- The parties agreed that the respondent paid $2,545.71 in temporary total disability benefits for claim #13 WC 6758.

ORDER:

- The respondent shall pay the petitioner temporary total disability benefits of $220.00/week for 7-2/7 weeks, from February 25, 2013, through April 16, 2013, which is the period of temporary total disability for which compensation is payable.
- The medical care rendered the petitioner for her left hand and arm and little finger through April 16, 2013, and for her lumbar and cervical spines through May 7, 2013, was reasonable and necessary. The medical care rendered the petitioner for her left hand and arm after April 16, 2013, and for her lumbar and cervical spines after May 7, 2013, was not reasonable or necessary and is denied. The respondent shall pay the medical bills in accordance with the Act and the medical fee schedule. The respondent shall be given credit for any amount it paid toward the medical bills, including any amount paid within the provisions of Section 8(j) of the Act, and any adjustments, and

shall hold the petitioner harmless for all the medical bills paid by its group health insurance carrier.

- The petitioner's request for prospective medical 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 Williams

9/17/13
Date

SEP 5 - 2013

FINDINGS OF FACTS:

On January 25, 2013, the petitioner, a right-handed laborer, sought medical care for her left hand, arm and shoulder at Concentra Medical Centers and reported gluing cardboard that day. The incident is the subject matter of claim #13 WC 6757. Her work duties for two weeks were separating and gluing cardboard parts. X-rays of her hand were negative. The assessment by Dr. Maqsood Jafri was left-sided tendinitis in her hand and wrist, a forearm sprain and a shoulder strain. No use of her left extremity was advised and physical therapy was started on January 28th. She reported stable symptoms but no improvement on the 28th. The assessment by Dr. Angelo Lambos at Concentra Medical Centers on February 1st was shoulder pain, elbow and wrist tenosynovitis and hand sprain. On February 6th, the petitioner reported improved symptoms to Dr. Cindy Ross at Concentra Medical Centers, pain mostly in her left wrist and a better feeling left shoulder and upper arm. Her diagnosis was wrist tenosynovitis. She reported persistent positional pain in her left wrist and lateral elbow on February 13th but no upper arm, shoulder, neck or back pain. She was referred to a hand specialist to consider injections and told to return as needed.

On February 20, 2013, the petitioner received emergency care at Loyola University Medical Center. The incident is the subject matter of claims #13 WC 6758. She complained of pain on the entire left side of her body, pain in her left foot and ankle, neck, little finger and a twisted torso after catching her foot between two pallets. She reported falling, not falling and not recalling. X-rays of her little finger, ankle, foot and cervical spine were unremarkable. It was also noted she was ambulatory with a steady gait. There were no visible signs of acute injury upon examination. The petitioner was

discharged home and released from work until February 22, 2013. The same day, the petitioner received care from Dr. Charlotte Albinson at Concentra Medical Center. She reported missstepping, falling and landing on her left side, hurting her neck, shoulder, ankle, low back, 5th finger, ankle and left arm. The diagnosis was cervicalgia, facial pain, a lumbar strain and ankle sprain/strain. She was told to return to regular activities. She reported no improvement on February 22nd and complained of left shoulder pain and left scalp and external ear tenderness. Dr. Albinson noted that the x-ray technician reported that the petitioner was able to move her arm for x-rays without discomfort but not during the clinical examination. The petitioner was released to regular activity. The petitioner returned to work for one day.

On February 25th, the petitioner executed Applications for Benefits for both dates of injuries and began chiropractic care approximately three times per week for her left wrist, neck, back, and left shoulder, hand and ankle with Dr. Krysten Kuk at Rehab Dynamix pursuant to the referral of her attorney. On March 1st, the petitioner started care with Dr. Neeraj Jain of Chicago Pain & Orthopedic Institute pursuant to the referral of Dr. Kuk. The doctor's diagnosis was left foot and ankle sprain, lumbar strain, cervical strain, lumbar and cervical radiculopathy, left wrist and hand pain and left shoulder strain. She treated with Dr. Jain for her neck and back, Dr. Ellis Nam for her left shoulder, hand and wrist and Dr. Joshua Hedman for her left foot and ankle.

MRIs on March 7th showed spinal stenosis with mild degenerative changes and a small disc protrusion at C3-4 and a minimal disc bulge at C2-3; disc bulges at T10-11, T11-12, L4-5 and L5-S1, a broad-based left foraminal disc protrusion at L3-4, spondylosis with mild grade 1 retrolisthesis at L3-4 and L4-5, disc desiccation at L4-5;

and supraspinatus and subscapularis tendinopathy of her left shoulder. MRIs on March 9th revealed small wrist joint and distal radioulnar joint effusions and no evidence of acute ligament or tendon tear of her left wrist; mild osteoarthritic changes of her left forefoot but no evidence of acute internal derangement; and small tiblotalar joint and subtalar joint effusions but no acute osseous abnormalities or evidence of ligament or tendon tears.

On March 20th, Dr. Nam opined that the left shoulder MRI did not show any obvious tearing and recommended therapy and kept the petitioner off work. Dr. Hedman opined on March 25th that the MRIs of her left foot and ankle revealed no acute abnormalities indicative of a musculoskeletal injury and there was no localized pain. On March 29th, Dr. Jain recommended cervical and lumbar injections.

On April 16th, the petitioner's left arm and hand was evaluated by Dr. John Fernandez pursuant to Section 12 of the Act. Dr. Fernandez opined that the petitioner's complaints did not correlate with her objective findings and were relatively non-physiologic. He felt she was capable of full-duty work.

Dr. Nam opined on April 17th that the radiographs of the petitioner's left wrist and hand were normal and tried a cortisone injection into her left shoulder, which the petitioner reported on May 1st significantly reduced her pain. On May 13th, the petitioner began work conditioning at Rehab Dynamix. On May 22nd, the petitioner saw Dr. Axel Vargas of Chicago Pain & Orthopedic Institute, who gave her cervical and lumbar injections. On May 29th, the petitioner reported some relief with the cervical and lumbar injections and primarily left shoulder pain to Dr. Nam. He noted her wrist and hand were improved and recommended a left shoulder diagnostic arthroscopy with subacromial

decompression and possible tenodesis for his diagnosis of traumatic impingement syndrome, proximal biceps tendonitis with resolved adhesive capsulitis. Dr. Hedman's assessment on June 3rd was radiculopathy of the left lower extremity. He noted the MRIs of her left foot and ankle showed no acute pathology. On June 12th, it was noted at Rehab Dynamix that the petitioner reported overall improvement in her left hand, wrist, ankle and shoulder of 70%, and improvement in her lumbar and cervical spine of 80%. The petitioner had cervical and lumbar injections on June 21st.

After a Section 12 examination of the petitioner's cervical spine, lumbar spine and left shoulder on May 7th, Dr. Steven Mash of M&M Orthopaedics opined that the physical examination revealed inconsistencies with her pain behavior and the objective findings, inconsistent seated and supine straight leg raising, inconsistent direct and indirect range of motion and signs of symptom magnification. Dr. Mash felt the petitioner had reached maximum medical improvement and could work without restrictions.

In a surveillance video of the petitioner on July 24, 2013, she walked without any difficulty or apparent distress, caution or discomfort. The Payroll Summary for the petitioner indicates she worked 16 hours the week ending January 13, 2013, 48 hours the week ending January 20th and 52.75 hours the week ending January 27th.

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

Based upon the testimony and the evidence submitted, the petitioner proved that she sustained an accident on January 25, 2013, and February 20, 2013, arising out of and in the course of her employment with the respondent. The petitioner's testimony and complaints on January 25, 2013, and February 20, 2013, to the medical providers are consistent and sufficient to establish that her work duties caused in her injuries.

FINDING REGARDING WHETHER THE MEDICAL SERVICES PROVIDED TO PETITIONER ARE REASONABLE AND NECESSARY:

The medical care rendered the petitioner for her left hand and arm and little finger through April 16, 2013, and for her lumbar and cervical spines through May 7, 2013, was reasonable and necessary. On April 16th, Dr. Fernandez opined that the petitioner's left hand and arm complaints did not correlate with her objective findings and were relatively non-physiologic. On May 7, 2013, Dr. Mash opined that the petitioner had reached maximum medical improvement and could work without restrictions. The petitioner has not been truthful with her doctors regarding her symptoms, pain levels and abilities. The medical care rendered the petitioner for her left hand and arm after April 16, 2013, and for her lumbar and cervical spines after May 7, 2013, was not reasonable or necessary and is denied.

FINDING REGARDING WHETHER THE PETITIONER'S PRESENT CONDITION OF ILL-BEING IS CAUSALLY RELATED TO THE INJURY:

Based upon the testimony and the evidence submitted, the petitioner proved that her current condition of ill-being with her left hand, arm and shoulder, ankle and foot and lumbar and cervical spines is causally related to the work injuries.

FINDING REGARDING THE AMOUNT OF COMPENSATION DUE FOR TEMPORARY TOTAL DISABILITY:

Dr. Fernandez opined on April 16, 2013, that the petitioner's complaints did not correlate with her objective findings and she was capable of full-duty work and on May 7, 2013, Dr. Mash opined that the petitioner was magnifying her symptoms and was capable of returning to work. Moreover, the surveillance video of the petitioner belies her testimony of an inability to work and having a severe level of pain in her left shoulder, lumbar and cervical spine and left foot and ankle. Also, the petitioner has not been

consistent in her reports of her pain levels – complaining of persistent symptoms and severe pain levels to her doctors but improvement to the therapists. The petitioner is not believable. The petitioner has not been truthful with her doctors regarding her pain levels and abilities. The petitioner is not entitled to temporary total disability benefits after April 16, 2013.

The respondent shall pay the petitioner temporary total disability benefits of $220.00/week for 7-2/7 weeks, from February 25, 2013, through April 16, 2013, as provided in Section 8(b) of the Act, because the injuries sustained caused the disabling condition of the petitioner.

FINDING REGARDING PROSPECTIVE MEDICAL:

The petitioner failed to prove that the arthroscopic subacromial decompression recommended by Dr. Nam is reasonable medical care necessary to relieve the effects of the work injury. Dr. Fernandez opined that the petitioner magnifies her symptoms and is capable of full-duty work. The petitioner's request for prospective medical 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 Choose reason	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☐ Modify Choose direction	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Maria de Jesus Cervantes,
Petitioner,

vs. NO: 13 WC 06758

Specialized Staffing,
Respondent.

14IWCC0964

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 Petitioner's issues of accident, temporary total disability, and medical expenses and Respondent's issue of accident and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof. 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.

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

14IWCC0964

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

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

DATED: NOV 10 2014

Daniel R. Donohoo

Charles J. DeVriendt

Ruth W. White

o-10/21/14
drd/wj
68

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

CERVANTES, MARIA DE JESUS
Employee/Petitioner

Case# **13WC006757**
13WC006758

SPECIALIZED STAFFING
Employer/Respondent

14IWCC0964

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:

2553 LAW OFFICES OF JAMES P McHARGUE
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0238 WOLF & WOLFE LTD
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CHICAGO, IL 60602

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

STATE OF ILLINOIS)
)
COUNTY OF COOK)

ILLINOIS WORKERS' COMPENSATION COMMISSION

19(b) ARBITRATION DECISION

MARIA DE JESUS CERVANTES
Employee/Petitioner

Case #13 WC 6757
13 WC 6758

v.

SPECIALIZED STAFFING
Employer/Respondent

14IWCC0964

An *Application for Adjustment 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 August 2, 2013. After reviewing all of the evidence presented, the arbitrator hereby makes findings on the disputed issues, and attaches those findings to this document.

ISSUES:

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

B. ☐ Was there an employee-employer relationship?

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

D. ☐ What was the date of the accident?

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

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

G. ☐ What were the petitioner's earnings?

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

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

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

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

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

M. ☐ Is the respondent due any credit?

N. ☒ Prospective medical care?

FINDINGS

- On January 25, 2013, and February 20, 2013, the respondent was operating under and subject to the provisions of the Act.
- The dates are the subject matter of claims #13 WC 6757 and #13 WC 6758, respectively.
- On those dates, an employee-employer relationship existed between the petitioner and respondent.
- Timely notice of accidents was given to the respondent.
- In the year preceding the injury on January 25, 2013, the petitioner earned $7,383.76; the average weekly wage was $295.35.
- In the year preceding the injury on February 20, 2013, the petitioner earned $8,957.44; the average weekly wage was $308.88.
- At the time of injuries, the petitioner was 47 years of age and single with no children under 18.
- The parties agreed that the respondent paid $2,545.71 in temporary total disability benefits for claim #13 WC 6758.

ORDER:

- The respondent shall pay the petitioner temporary total disability benefits of $220.00/week for 7-2/7 weeks, from February 25, 2013, through April 16, 2013, which is the period of temporary total disability for which compensation is payable.
- The medical care rendered the petitioner for her left hand and arm and little finger through April 16, 2013, and for her lumbar and cervical spines through May 7, 2013, was reasonable and necessary. The medical care rendered the petitioner for her left hand and arm after April 16, 2013, and for her lumbar and cervical spines after May 7, 2013, was not reasonable or necessary and is denied. The respondent shall pay the medical bills in accordance with the Act and the medical fee schedule. The respondent shall be given credit for any amount it paid toward the medical bills, including any amount paid within the provisions of Section 8(j) of the Act, and any adjustments, and

shall hold the petitioner harmless for all the medical bills paid by its group health insurance carrier.

- The petitioner's request for prospective medical 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 Williams

9/17/13
Date

SEP 5 - 2013

FINDINGS OF FACTS:

On January 25, 2013, the petitioner, a right-handed laborer, sought medical care for her left hand, arm and shoulder at Concentra Medical Centers and reported gluing cardboard that day. The incident is the subject matter of claim #13 WC 6757. Her work duties for two weeks were separating and gluing cardboard parts. X-rays of her hand were negative. The assessment by Dr. Maqsood Jafri was left-sided tendinitis in her hand and wrist, a forearm sprain and a shoulder strain. No use of her left extremity was advised and physical therapy was started on January 28th. She reported stable symptoms but no improvement on the 28th. The assessment by Dr. Angelo Lambos at Concentra Medical Centers on February 1st was shoulder pain, elbow and wrist tenosynovitis and hand sprain. On February 6th, the petitioner reported improved symptoms to Dr. Cindy Ross at Concentra Medical Centers, pain mostly in her left wrist and a better feeling left shoulder and upper arm. Her diagnosis was wrist tenosynovitis. She reported persistent positional pain in her left wrist and lateral elbow on February 13th but no upper arm, shoulder, neck or back pain. She was referred to a hand specialist to consider injections and told to return as needed.

On February 20, 2013, the petitioner received emergency care at Loyola University Medical Center. The incident is the subject matter of claims #13 WC 6758. She complained of pain on the entire left side of her body, pain in her left foot and ankle, neck, little finger and a twisted torso after catching her foot between two pallets. She reported falling, not falling and not recalling. X-rays of her little finger, ankle, foot and cervical spine were unremarkable. It was also noted she was ambulatory with a steady gait. There were no visible signs of acute injury upon examination. The petitioner was

discharged home and released from work until February 22, 2013. The same day, the petitioner received care from Dr. Charlotte Albinson at Concentra Medical Center. She reported missstepping, falling and landing on her left side, hurting her neck, shoulder, ankle, low back, 5th finger, ankle and left arm. The diagnosis was cervicalgia, facial pain, a lumbar strain and ankle sprain/strain. She was told to return to regular activities. She reported no improvement on February 22nd and complained of left shoulder pain and left scalp and external ear tenderness. Dr. Albinson noted that the x-ray technician reported that the petitioner was able to move her arm for x-rays without discomfort but not during the clinical examination. The petitioner was released to regular activity. The petitioner returned to work for one day.

On February 25th, the petitioner executed Applications for Benefits for both dates of injuries and began chiropractic care approximately three times per week for her left wrist, neck, back, and left shoulder, hand and ankle with Dr. Krysten Kuk at Rehab Dynamix pursuant to the referral of her attorney. On March 1st, the petitioner started care with Dr. Neeraj Jain of Chicago Pain & Orthopedic Institute pursuant to the referral of Dr. Kuk. The doctor's diagnosis was left foot and ankle sprain, lumbar strain, cervical strain, lumbar and cervical radiculopathy, left wrist and hand pain and left shoulder strain. She treated with Dr. Jain for her neck and back, Dr. Ellis Nam for her left shoulder, hand and wrist and Dr. Joshua Hedman for her left foot and ankle.

MRIs on March 7th showed spinal stenosis with mild degenerative changes and a small disc protrusion at C3-4 and a minimal disc bulge at C2-3; disc bulges at T10-11, T11-12, L4-5 and L5-S1, a broad-based left foraminal disc protrusion at L3-4, spondylosis with mild grade 1 retrolisthesis at L3-4 and L4-5, disc desiccation at L4-5;

and supraspinatus and subscapularis tendinopathy of her left shoulder. MRIs on March 9th revealed small wrist joint and distal radioulnar joint effusions and no evidence of acute ligament or tendon tear of her left wrist; mild osteoarthritic changes of her left forefoot but no evidence of acute internal derangement; and small tiblotalar joint and subtalar joint effusions but no acute osseous abnormalities or evidence of ligament or tendon tears.

On March 20th, Dr. Nam opined that the left shoulder MRI did not show any obvious tearing and recommended therapy and kept the petitioner off work. Dr. Hedman opined on March 25th that the MRIs of her left foot and ankle revealed no acute abnormalities indicative of a musculoskeletal injury and there was no localized pain. On March 29th, Dr. Jain recommended cervical and lumbar injections.

On April 16th, the petitioner's left arm and hand was evaluated by Dr. John Fernandez pursuant to Section 12 of the Act. Dr. Fernandez opined that the petitioner's complaints did not correlate with her objective findings and were relatively non-physiologic. He felt she was capable of full-duty work.

Dr. Nam opined on April 17th that the radiographs of the petitioner's left wrist and hand were normal and tried a cortisone injection into her left shoulder, which the petitioner reported on May 1st significantly reduced her pain. On May 13th, the petitioner began work conditioning at Rehab Dynamix. On May 22nd, the petitioner saw Dr. Axel Vargas of Chicago Pain & Orthopedic Institute, who gave her cervical and lumbar injections. On May 29th, the petitioner reported some relief with the cervical and lumbar injections and primarily left shoulder pain to Dr. Nam. He noted her wrist and hand were improved and recommended a left shoulder diagnostic arthroscopy with subacromial

decompression and possible tenodesis for his diagnosis of traumatic impingement syndrome, proximal biceps tendonitis with resolved adhesive capsulitis. Dr. Hedman's assessment on June 3rd was radiculopathy of the left lower extremity. He noted the MRIs of her left foot and ankle showed no acute pathology. On June 12th, it was noted at Rehab Dynamix that the petitioner reported overall improvement in her left hand, wrist, ankle and shoulder of 70%, and improvement in her lumbar and cervical spine of 80%. The petitioner had cervical and lumbar injections on June 21st.

After a Section 12 examination of the petitioner's cervical spine, lumbar spine and left shoulder on May 7th, Dr. Steven Mash of M&M Orthopaedics opined that the physical examination revealed inconsistencies with her pain behavior and the objective findings, inconsistent seated and supine straight leg raising, inconsistent direct and indirect range of motion and signs of symptom magnification. Dr. Mash felt the petitioner had reached maximum medical improvement and could work without restrictions.

In a surveillance video of the petitioner on July 24, 2013, she walked without any difficulty or apparent distress, caution or discomfort. The Payroll Summary for the petitioner indicates she worked 16 hours the week ending January 13, 2013, 48 hours the week ending January 20th and 52.75 hours the week ending January 27th.

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

Based upon the testimony and the evidence submitted, the petitioner proved that she sustained an accident on January 25, 2013, and February 20, 2013, arising out of and in the course of her employment with the respondent. The petitioner's testimony and complaints on January 25, 2013, and February 20, 2013, to the medical providers are consistent and sufficient to establish that her work duties caused in her injuries.

FINDING REGARDING WHETHER THE MEDICAL SERVICES PROVIDED TO PETITIONER ARE REASONABLE AND NECESSARY:

The medical care rendered the petitioner for her left hand and arm and little finger through April 16, 2013, and for her lumbar and cervical spines through May 7, 2013, was reasonable and necessary. On April 16th, Dr. Fernandez opined that the petitioner's left hand and arm complaints did not correlate with her objective findings and were relatively non-physiologic. On May 7, 2013, Dr. Mash opined that the petitioner had reached maximum medical improvement and could work without restrictions. The petitioner has not been truthful with her doctors regarding her symptoms, pain levels and abilities. The medical care rendered the petitioner for her left hand and arm after April 16, 2013, and for her lumbar and cervical spines after May 7, 2013, was not reasonable or necessary and is denied.

FINDING REGARDING WHETHER THE PETITIONER'S PRESENT CONDITION OF ILL-BEING IS CAUSALLY RELATED TO THE INJURY:

Based upon the testimony and the evidence submitted, the petitioner proved that her current condition of ill-being with her left hand, arm and shoulder, ankle and foot and lumbar and cervical spines is causally related to the work injuries.

FINDING REGARDING THE AMOUNT OF COMPENSATION DUE FOR TEMPORARY TOTAL DISABILITY:

Dr. Fernandez opined on April 16, 2013, that the petitioner's complaints did not correlate with her objective findings and she was capable of full-duty work and on May 7, 2013, Dr. Mash opined that the petitioner was magnifying her symptoms and was capable of returning to work. Moreover, the surveillance video of the petitioner belies her testimony of an inability to work and having a severe level of pain in her left shoulder, lumbar and cervical spine and left foot and ankle. Also, the petitioner has not been

consistent in her reports of her pain levels – complaining of persistent symptoms and severe pain levels to her doctors but improvement to the therapists. The petitioner is not believable. The petitioner has not been truthful with her doctors regarding her pain levels and abilities. The petitioner is not entitled to temporary total disability benefits after April 16, 2013.

The respondent shall pay the petitioner temporary total disability benefits of $220.00/week for 7-2/7 weeks, from February 25, 2013, through April 16, 2013, as provided in Section 8(b) of the Act, because the injuries sustained caused the disabling condition of the petitioner.

FINDING REGARDING PROSPECTIVE MEDICAL:

The petitioner failed to prove that the arthroscopic subacromial decompression recommended by Dr. Nam is reasonable medical care necessary to relieve the effects of the work injury. Dr. Fernandez opined that the petitioner magnifies her symptoms and is capable of full-duty work. The petitioner's request for prospective medical 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 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 Skoronski,
Petitioner,

vs.

NO: 10 WC 46929
14IWCC0965

Alro Steel Corporation,
Respondent.

DECISION AND OPINION ON REVIEW

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

After considering the entire record, the Commission affirms the Arbitrator's Decision that Petitioner failed to prove by a preponderance of the evidence that he sustained an accident that arose out of and in the course of his employment for Respondent on January 26, 2009. In addition to the findings of the Arbitrator in his September 11, 2012 Decision, the Commission makes the following findings of facts and conclusions of law:

For an alleged accident to be compensable under the Act, the employee must prove that some act or phase of the employment was a causative factor in the ensuing injury. The burden is on the party seeking an award to prove by a preponderance of the credible evidence the elements of the claim, particularly the prerequisites that the injury complained of arose out of and in the course of the employment. *Hannibal, Inc. v. Industrial Comm'n*, 231 N.E.2d 409 (1967). The mere fact that an employee is at work when a heart attack occurs is insufficient to justify an award absent proof of a causal connection between the employment and the disability. *Vesco Ventilation & Equipment Sales v. Industrial Comm'n*, 523 N.E.2d 111 (1st Dist. 1988). Whether a given set of activities is sufficient to support a causal connection between the work activity and the heart attack is a question of fact for the Commission.

Bearing these general principles in mind and turning to the facts of this case, the Commission finds no credible evidence that the heart attack occurred in the course of or arose out of Petitioner's work activities or work related stresses. Petitioner testified that on the day of the heart attack, he arrived for second shift around 2:00 pm, after stopping at White Castles for hamburgers and a coke, with heartburn-like symptoms. Petitioner felt his heartburn symptoms were severe enough to advise his supervisor on arrival at work that day; he was advised to settle down and relax. It was after about 4-5 hours of regular work loading steel with cranes and heavy machinery that he began to notice he was sweating and "didn't feel right." Petitioner testified that the shop in which he was working was heated on that winter day. He left work and went to the Hammons Clinic around 6:00 pm because of his complaints and was advised after an EKG that he was experiencing a heart attack. There is no evidence in the record that the work site environment was a cause of the heart attack, that Petitioner was engaged in any heavy or stressful labor around the time of the heart attack, that the heart attack occurred while at work, that Petitioner was under any time constraints to perform his work duties, etc. Petitioner did not testify to any work activities on January 26, 2009, or in the days leading up to his heart attack, that might have been a contributing factor in his condition of ill-being.

The Commission finds there is credible evidence in the medical record that Petitioner was experiencing chest pain and/or chest symptoms in the months and hours leading up to the diagnosis of a heart attack. In contrast, there is no medical evidence, even from nine days of inpatient treatment at Franciscan Hospital that Petitioner ever gave a history of work activities or environment at work that contributed to his physical condition. Petitioner gave a history to Dr. Marks, a treating cardiologist, that he attributed his chest pains to the food he had eaten that day. The medical records also note Petitioner had suffered what he felt was indigestion on and off for many years that caused chest discomfort. A diagnostic study performed the day after Petitioner's alleged accident date confirms he suffered from significant and severe coronary arterial disease, severe peripheral vascular disease and reduced left ventricular function. Dr. Marks only noted that long standing coronary artery disease in the need for quadruple bypass surgery on January 29, 2009.

Dr. Nootens, one of Petitioner's treating cardiologists, is the only medical opinion in evidence in support of causation. Dr. Nootens opined in a report dated April 27, 2012, after a request in writing by Petitioner's attorney, that he "agreed" Petitioner's work activities on January 26, 2009 could have been a causative factor in his myocardial infarction which was diagnosed on the evening of January 26, 2009. Dr. Nootens did not state that his opinion was made within a reasonable degree of medical certainty. There is no evidence in the record that Dr. Nootens had any knowledge of Petitioner's work activities, either generally or specifically, or specifically performed on January 26, 2009. Dr. Nootens further failed to explain why Petitioner's work would be a causative factor in Petitioner's condition, especially in light of evidence that Petitioner was suffering chest pain prior to his attendance at work on January 26, 2009 and he had long standing multilevel coronary artery disease and a significantly diseased right coronary artery as diagnosed by another treating cardiologist, Dr. Marks. Dr. Nootens does not reference Petitioner's blood protein analysis or whether the levels would provide a basis for establishing Petitioner suffered a heart attack during the time he was working on January 26, 2009. For the foregoing reasons, the Commission affords Dr. Nootens causation opinion very little weight.

14IWCC0965

All else is affirmed and adopted.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed July 16, 2013, is hereby affirmed and adopted with additional reasoning. Petitioner's claim for compensation is denied.

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

DATED: NOV. 10, 2014

Daniel R. Donohoo

Charles J. DeVriendt

Ruth W. White

o-09/10/14
drd/adc
68

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

SKORONSKI, JAMES A
Employee/Petitioner

Case# **10WC046929**

10WC009624

ALRO STEEL CORPORATION
Employer/Respondent

14IWCC0965

On 7/16/2013, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

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

0317 LAW OFFICE OF PERRY M LAKS
120 N LASALLE ST
STE 1200
CHICAGO, IL 60602

0532 HOLECEK & ASSOCIATES
JEFF GOLDBERG
161 N CLARK ST SUITE 600
CHICAGO, IL 60601

STATE OF ILLINOIS)
)SS.
COUNTY OF Cook)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

James A. Skoronski
Employee/Petitioner

v.

Alro Steel Corporation
Employer/Respondent

Case # 10 WC 46929

Consolidated cases: 10 WC 9624

14IWCC0965

An *Application for Adjustment 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 **September 11, 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

14IWCC0965

On **1/26/09**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

Timely notice of this 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 **$29,775.72**; the average weekly wage was **$572.61**.

On the date of accident, Petitioner was **60** years of age, ***single*** with **0** dependent children.

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

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

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

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

ORDER:

The Arbitrator finds that Petitioner failed to prove by a preponderance of the evidence that he sustained an accident that arose out of and in the course of employment. Accordingly 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

7/15/13
Date

ICArbDec p. 2

JUL 16 2013

FINDING OF FACTS:

Petitioner, 60, single without dependents, a laborer assigned to pull steel off shelves, arrived at work at 1:30 p.m. and noticed that he "had a little heart-burn." Petitioner testified that he had lunch prior to arriving at work.

Petitioner testified that at the time he arrived at work, he was already feeling heart-burn. Petitioner characterized the heart burn as a little irritation. Petitioner clarified that he experienced his heart area irritation at the time he was entering the parking lot, and before he punched into work.

Petitioner talked to David, the shop supervisor at approximately 1:45 p.m.. Petitioner told David that he had stopped for lunch and that he had a "little heart-burn." Petitioner also informed David that he was going to work and that David approved but advised that if he felt bad to settle down a bit and relax.

Petitioner worked four or five hours that day. He removed steel from racks; placed them on "horses" and banded them together. The steel bars weighed from 50 to 1000 lbs. Petitioner used machinery to remove the steel. He used cranes and machinery to perform his work.

During the course of the work day, Petitioner noticed his strength deteriorating. After four or five hours he did not "feel right." Petitioner testified that he was sweating a little and getting weaker.

At approximately 6:00 p.m., Petitioner talked to his supervisor, R. J. and another co-worker, Eric. He could not recall their last names. Petitioner informed them he was not feeling well and that he felt like going home.

Petitioner left work and drove himself to a nearby clinic, the Hammond Clinic. At the clinic Petitioner advised that he was suffering chest pains, underwent an EKG twice and was then advised that he was having a heart attack " at that time."

Petitioner was taken by ambulance to Franciscan Hospital, approximately one block away. Petitioner was an in-patient at Franciscan Hospital for approximately nine days where he was treated by Dr. Nootens, a cardiologist.

Petitioner was then off work from January 27th to October 25th, 2009.

According to Petitioner, Respondent sent him to St. James Hospital for examination. Petitioner passed the examination and was returned to work. Petitioner was returned to work loading trucks. Petitioner testified that once he returned to work he was not as strong as he was prior to his heart attack.

Medical Evidence:

Franciscan Physicians Hospital:

Petitioner was admitted to Franciscan Physicians Hospital on January 26, 2009 at 10:00 p.m. The admitting records state Petitioner arrived by automobile.

On 1/27/07 Dr. Mark Nootens examined Petitioner and reported the following:

HISTORY OF PRESENT ILLNESS: This is a pleasant 60 year-old gentleman who has a no past medical history…..

He came to the urgent care center at the Hammond Clinic yesterday because of chest discomfort. He said that he has had "indigestion" on and off for many years. He suspects that may have actually been related to his heart. He had discomfort yesterday.

(Pet. Ex. 10).

Petitioner underwent a left heart catherization, left and right angiography, left ventriculography on 1/27/09 performed by Dr. Nooten. On 1/29/09 Petitioner underwent a coronary artery bypass graft involving four vessels. (Pet. Ex 10)

Petitioner was diagnosed as suffering a severe multi-vessel coronary angiogram which revealed severe systolic function. (Pet. Ex. 10)

At the time Petitioner was admitted he completed a hospital admission form on 1/26/09 wherein he reported that he suffered unintentional weight loss of greater than 5 lbs. or more in one month. (Pet. Ex. 10 and Pet. Ex. 3)

Petitioner's cardiac catheter study performed on 1/27/09 revealed Petitioner suffered three vessel coronary artery disease, severe peripheral vascular disease and moderately reduced left ventricular systolic function. (Pet. Ex. 3) Dr. Mark Nootens authored the cardiac catheter report and believed Petitioner would benefit most from coronary artery bypass grafting. (Pet. Ex. 10)

Dr. Mark Kevin, Petitioner's cardiac surgeon, examined Petitioner on 1/29/09 and reported that Petitioner has a "long history of chest heaviness and borderline hypertension." Dr. Kevin noted Petitioner was a smoker. Dr. Kevin found that Petitioner's heart catheter procedure revealed multi-vessel coronary artery disease and significant disease of the right coronary artery.

Dr. Mark Nooten's Report:

On April 27, 2012 Dr. Mark Nootens authored a report sent to Petitioner's counsel wherein he stated that he agreed that Petitioner's work activities could have been a causative factor in his myocardial infarction which was diagnosed on the evening of January 26, 2009. (Pet. Ex. 9)

Dr. Nootens reported Petitioner was initially diagnosed at the Hammond Clinic Urgent Care Center and then transferred to Franciscan Physician's Hospital. Dr. Nootens then stated Petitioner was treated for the myocardial infarction from January 26, 2009 through February 3, 2009. Dr. Nootens also reported that Petitioner returned to work on October 23, 2009. (Pet. Ex. 9)

With Respect To Issue (C), Did An Accident Occur That Arose Out Of And In The Course Of Petitioner's Employment by Respondent, The Arbitrator Finds As Follows:

The Arbitrator finds that Petitioner did not sustain an accident which arose out of and in the course of his employment.

Petitioner testified that he experienced "heart-burn" prior to his arrival at work. Petitioner testified he suffered heart area "irritation" before he punched into work and at the time he was entering the employer's parking lot.

Petitioner's medical records establish that Petitioner sought treatment due to chest discomfort. As reported in the Franciscan Physicians Hospital medical records, Petitioner was quoted that he has had "indigestion" on and off for many years and suspected that was related to his heart.

The Arbitrator notes that there are no medical records which report Petitioner was engaged in repetitive lifting activity which precipitated his chest area "heart-burn" pain.

The Arbitrator further notes that Petitioner reported in his admission form when he was admitted to Franciscan Physicians Hospital that he had suffered unintentional weight loss of 5lbs. or more in one month.

One of Petitioner's treating physicians, cardiologist Dr. Mark Nootens authored a report dated 4/27/12 wherein he stated Petitioner's work activities could have been a causative factor in his myocardial infarction diagnosed on the evening of January 26, 2009. Dr. Nootens does not make reference to Petitioner's specific work activities, neither generally performed, or specifically performed on the day of his heart condition. Dr. Nootens, further, does not explain how or why Petitioner began to suffer chest pain prior to his attendance at work. Dr. Nootens does not reference Petitioner's blood protein analysis and does not state whether the protein levels provide a basis for establishing Petitioner suffered his heart attack during the time he was performing work activity on January 26, 2009.

The Arbitrator also finds that Petitioner's heartburn was not insignificant as he thought it sufficiently significant to report to his supervisor, fifteen minutes after arriving at work, that he was suffering heart-burn. Further, his supervisor also took seriously his complaints as he advised Petitioner that he should settle down a bit and relax. Petitioner reported indigestion to his employer, soon after he arrived, indicates Petitioner believed his condition was serious. Dr. Nootens does not explain why Petitioner would report a simple case of heartburn or indigestion to his employer at the beginning of his work shift if the irritation, as Petitioner characterized it, was only that which one would suffer from eating.

The Arbitrator notes that a diagnostic study performed on the day after Petitioner's heart incident confirmed that he suffered significant and severe coronary arterial disease, severe peripheral vascular disease and reduced left ventricular function. The Arbitrator finds that Dr. Nootens did not provide sufficient to state why Petitioner's coronary artery bypass surgery was related to his myocardial infarction and not to repair and alleviate Petitioner's long standing multi-level coronary artery disease, and significant diseased right coronary artery, as found by Dr. Kevin Marks.

Lastly, the Arbitrator notes Dr. Kevin Marks never mentioned Petitioner's work activities as a causative factor in the need for surgery, but only Petitioner's long extant coronary artery disease.

For the foregoing reasons, the Arbitrator finds that Petitioner has not proven by a preponderance of the evidence that he suffered a heart attack which arose out of and in course of his employment.

Having found that Petitioner failed to prove that he sustained an accident which arose out of and in course of his employment, all remaining issues are moot.

STATE OF ILLINOIS)
) SS.
COUNTY OF)
CHAMPAIGN

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Kevin Warmuth,

Petitioner,

vs.

14IWCC0966

NO: 11WC 29040

Maines Paper and Food Service,
Respondent,

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed January 21, 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.

14IWCC0966

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $25,513.00. 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: NOV 12 2014
MJB/bm
o-11/3/14
052

Michael J. Brennan

Kevin W. Lamborn

Thomas J. Tyrrell

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

WARMUTH, KEVIN
Employee/Petitioner

Case# **11WC029040**

14IWCC0966

MAINES PAPER & FOOD SERVICE
Employer/Respondent

On 1/21/2014, 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:

2208 CAPRON & AVGERINOS PC
STEPHEN SMALLING
55 W MONROE ST SUITE 900
CHICAGO, IL 60603

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

14IWCC0966

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

Kevin Warmuth
Employee/Petitioner

v.

Maines Paper & Food Service
Employer/Respondent

Case # **11 WC 29040**

Consolidated cases: **N/A**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Nancy Lindsay**, Arbitrator of the Commission, in the city of **Urbana**, on **November 22, 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 **5/27/11**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

Petitioner's current condition of ill-being in his left upper extremity *is* causally related to the accident but his current condition of ill-being in his cervical spine *is not* causally related to the accident.

In the year preceding the injury, Petitioner earned **$82,959.11**; the average weekly wage was **$1,626.65**.

On the date of accident, Petitioner was **33** 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 **$5,306.58** for TTD, **$0.00** for TPD, **$0.00** for maintenance, and **$4,020.00** in non-occupational indemnity disability benefits for which credit may be allowed under Section 8(j) of the Act for a total credit of **$9,326.58**. (See AX 5)

Respondent is entitled to a credit of **$76,250.82** in medical bills paid through its group medical plan for which credit may be allowed under Section 8(j) of the Act.

ORDER

Petitioner's current condition of ill-being in his left elbow and arm is causally connected to his May 27, 2011 accident; however, Petitioner failed to prove that his cervical condition is causally related to his May 27, 2011 accident. All claims for benefits associated with the cervical condition are denied.

Respondent shall pay the medical expenses from Carle Foundation Hospital, Carle Foundation Physicians, Midwest Sports Medicine, and the July 1, 2011 bill from The Medical Care Group pursuant to the Fee Schedule and Sections 8(a) and 8.2 of the Act.

Respondent shall pay Petitioner permanent partial disability benefits of $669.64 per week (the statutory maximum rate) for 37.95 weeks representing 15% loss of use of Petitioner's left arm, as provided in Section 8(e)10 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.

Kenny Lindsay
Signature of Arbitrator

January 15, 2014
Date

JAN 21 2014

ADDENDUM TO ARBITRATION DECISION

This matter was tried pursuant to an agreement of the parties on November 22, 2013, in Urbana, Illinois. This claim involves two injuries: (1) an accepted injury to Petitioner's left elbow and (2) a disputed injury to Petitioner's cervical spine. At trial, the parties placed the following issues in dispute: causation for the disputed cervical condition, medical expenses for the disputed cervical condition, temporary total disability for the cervical condition, and the nature and extent of Petitioner's injuries. (AX 1) The attorneys for both parties further stipulated that there might be a stipulation regarding an 8(j) credit for short-term non-occupational disability benefits paid to Petitioner in conjunction with his cervical claim and that if they reached an agreement they would notify the Arbitrator via e-mail. That e-mail was forwarded to the Arbitrator on December 6, 2013 and has been printed, marked as AX 5, and included as part of the record.

FINDINGS OF FACT and CONCLUSIONS OF LAW

The Arbitrator finds:

According to medical records, Petitioner was treated by Dr. Mary Morrell between January of 2010 and January of 2011 for bilateral carpal tunnel syndrome. When Petitioner originally presented to Dr. Morrell in January of 2010 he gave a history of experiencing progressive numbness over the preceding year. While Petitioner was right hand dominant, his symptoms were worse on the left side. Petitioner was experiencing difficulty sleeping and noticed that he had recently been dropping boxes while working at his job unloading trucks. Medication and rehab had been of no help. Petitioner also gave a history of having wrestled in high school and experiencing a "stinger" but it had resolved in two months. Petitioner rated his pain as "7/10" on the right side and "8/10" on the left side. Petitioner's symptoms included burning, throbbing, and aching, along with numbness, stiffness, tingling, and a loss of feeling. Petitioner subsequently underwent splinting, and cortisone injections. As of January 25, 2011 he was reporting increasing numbness and tingling in his fingers and problems with the symptoms waking him up at night. Surgery was discussed on January 25, 2011 but Petitioner indicated it would be difficult with work. (RX 5)

At the time of his undisputed May 27, 2011 accident Petitioner was employed by Respondent as a food service truck driver. In addition to driving, his job duties required him to unload the truck. While unloading a truck on May 27, 2011, Petitioner was involved in an undisputed accident when he was knocked off a lift gate and fell to the ground.

An accident report was completed on May 27, 2011, with Petitioner reporting an injury to his left elbow and back. (RX 1 - 0003) Petitioner included a written statement as to how the accident occurred. There is no mention of any neck or radicular complaints. (RX 1 – 0004)

After transferring his load to another driver, Petitioner sought medical care at Carle Foundation Hospital, reporting that he had fallen off a lift gate landing directly on his left elbow

and slightly on his lower back. The intake nurse recorded that Petitioner "broke his fall so his head didn't hit hard." The emergency department physician noted complaints of mild pain in the left elbow and left hand. Petitioner denied numbness, tingling, or weakness. No cervical or shooting/radicular complaints were recorded. X-rays of the left elbow were obtained and interpreted to show a fracture through the radial head without significant displacement. An examination of Petitioner's neck did not include any positive findings. Petitioner was placed in a long-arm posterior splint and discharged. (PX 1)

Petitioner testified that he then returned to the Chicago area where he lived and followed-up with Dr. Virchow, his primary care physician. Petitioner testified he was then referred to Dr. Mary Morrell for an orthopedic evaluation.

Dr. Mary Morrell is a board certified orthopedic surgeon. (RX 6 – 0002) She initially evaluated Petitioner on June 6, 2011, recording that Petitioner reported that he "landed on his back and left elbow which was hyperextended when he fell." (PX 2; RX 5 – 0035) Petitioner had complaints of pain in his elbow as well as "some swelling and bruising in his back and stiffness in his elbow but otherwise no other complaints." The doctor conducted a physical examination of Petitioner, noting that his "neck does not show any tenderness, deformity, or injury. Range of motion is unremarkable. There is no gross instability. Strength and tone are normal." (PX 2; RX 5 – 0037) No shooting pains/radicular complaints were recorded. Dr. Morrell obtained x-rays of the left elbow and provided a diagnosis of left radial head fracture and coronoid process fracture, and Dr. Morrell continued conservative management. She gave Petitioner a note for "No Tae Kwon Do for 2 months" and took Petitioner off work at that time. (PX 2; RX 5 – 0037) She did not diagnose a cervical injury.

Petitioner continued to treat with Dr. Morrell for his left shoulder injury. The Arbitrator notes that there were no neck or cervical complaints or shooting pain/radicular complaints documented in Dr. Morrell's record of June 20, 2011 (PX 2; RX 5 – 0030) Petitioner testified that he returned to work several weeks after the injury, which was also noted by Dr. Morrell on July 14, 2011. (RX 5 – 0026) There were no neck or cervical complaints or shooting pain/radicular complaints documented in Dr. Morrell's record on that date.

Petitioner signed his Application for Adjustment of claim on July 23, 2011, alleging a left elbow injury. (AX 2)

Petitioner underwent an Occupational Therapy Evaluation on July 27, 2011. Petitioner reported an elbow injury when he fell off the gate of a trailer at work. He had returned to full duty work but was still experiencing pain and needing assistance. Petitioner reported the inability to fully extend or flex his elbow and decreased strength along with difficulty performing housework, dressing/bathing, lifting/carrying and occupational duties. No complaints regarding his neck or radiating arm or leg pain or shocks were noted. (RX 5)

Petitioner continued to treat with Dr. Morrell on August 15, 2011 (PX 2; RX 5 – 0023), September 12, 2011 (PX 2; RX 5 – 0018-0019), October 10, 2011 (PX 2; RX 5 – 0015-0016), or December 27, 2011. (PX 2; RX 5 – 0012-0013) There were no neck or cervical complaints or shooting pain/radicular complaints documented during these visits. At the time of the August 15, 2011 visit Petitioner was told he could progress with martial arts as tolerated. (PX 2) At the time

of the September 20, 2011 visit Petitioner reported he was continuing to work full duty. Therapy was continued albeit with a different provider to continue to try and improve Petitioner's left elbow range of motion. (PX 2) The Arbitrator notes that there were no neck or cervical complaints or shooting pain/radicular complaints documented in the physical therapy records submitted by Petitioner during this period of treatment. (PX 2, RX 5)

On December 27, 2011, Dr. Morrell noted that Petitioner had been working unrestricted duty but still had "occasional mild pain at his elbow" and lacked terminal motion. Petitioner reported he was unable to continue with physical therapy due to his busy work schedule. He also reported that work was very physical but he was not restricting himself in any way. Petitioner denied any other symptoms or complaints except for the foregoing elbow symptoms. X-rays were obtained which showed a left radial head fracture and coronoid process fracture. Dr. Morrell advised Petitioner to continue to participate in a home exercise program and to return for a one year follow-up from his injury. (PX 2)

Petitioner received prescriptions from Dr. Virchow on August 3, 2011, September 6, 2011, October 11, 2011, October 31, 2011, and December 5, 2011, discussed labs on January 12, 2012, and again received prescriptions on February 28, 2012. (PX 6) There is no mention of any cervical complaints or shooting pain/radicular complaints on those dates. (PX 6)

On April 4, 2012 Petitioner presented to Dr. Virchow. According to the note Petitioner reported that sharp jolts from his neck were occurring more frequently. While difficult to read there is a reference to "neck pain. [Illegible] since work accident." (PX 6)

Petitioner returned to Dr. Morrell on May 1, 2012, reporting both occasional pain and the inability to fully extend his elbow. (PX 2; RX 5 – 0009) She noted that Petitioner had been working full duty, and released him at MMI for his left elbow injury. (PX 2; RX 5 – 0010)

On referral of Dr. Virchow, Petitioner was evaluated by Dr. DiGianfilippo, a neurosurgeon, on May 18, 2012. Petitioner reported that when he moved his head a certain way, in a flexion type position, he would experience tingling and jolting symptoms down his whole body, both arms, and both legs down into his ankles. Petitioner reported the symptoms began about 1 ½ months after his May 27, 2011 fall. Petitioner noted his symptoms sometimes came on with sneezing. He denied any real neck pain. He also gave a history of having been diagnosed with mild carpal tunnel syndrome and having undergone steroid injections for it with some improvement. (PX 3) DiGianfilippo's diagnosis included an impression of diffuse paresthesias with the potential for cervical spinal cord impingement, compression, or a Chiari I malformation, and he recommended MRIs of Petitioner's brain and cervical spine for further evaluation. (PX 3)

Following the MRIs, Petitioner returned to Dr. DiGianfilippo on June 4, 2012. The doctor noted the brain scan was unremarkable but the cervical MRI revealed an un-united C2 area that looked like an os odontoideum "which could be a congenital finding." According to his office note, "we do not know how long he has had this problem." Dr. DiGianfilippo stated it was possible Petitioner fractured his C2 in his work injury but "I cannot say for certain how this occurred." Dr. DiGianfilippo ordered flexion/extension x-rays for further evaluation and a referral to Dr. Kolavo for consideration of a cervical fusion at the C2 level. (PX 7)

A second injury report was completed by Petitioner on June 4, 2012. (RX 2) Petitioner now claimed an injury to his neck and elbow. In a supervisor's statement, it was noted that Petitioner referenced falling off the liftgate on May 27, 2011 and fracturing his left elbow and hurting his low back. "He told me that he had been experiencing numbness in his neck and back when he moved his head a certain way which caused him to seek treatment on his own." (RX 2 – 0006)

Petitioner was evaluated by Dr. Kolavo on June 22, 2012, for neck pain which reportedly began 9-10 months earlier. (PX 3) Petitioner wrote that his complaints "all started after I fell off the lift gate of a semi trailer about a year ago." Dr. Kolavo recorded that Petitioner fell at work on May 27, 2011, and that his neck and back pain began a few days later, but later recorded that he immediately had numbness and tingling in all four extremities that slowly improved over time. Petitioner's main issue was recorded as easily reproducible neurological symptoms but he also complained of minor neck pain. Reviewing the diagnostic studies, Dr. Kolavo opined that Petitioner had an OS odontoideum at C2 and cervical spinal stenosis due to instability at C1-C2. In his opinion the findings on the MRI were consistent with myelomalacia and a cord contusion. Dr. Kolavo opined that Petitioner sustained an aggravation to a pre-existing condition as a result of his accident, which resulted in a spinal cord contusion or injury.

A CT scan was obtained on July 9, 2012, and was reviewed by Dr. Kolavo on July 17, 2012, who felt that Petitioner had a true os odontoideum present his entire life and that due to contact with the clivus, Petitioner would require a fusion from C1-C3. (PX 3) Although the os odontoideum is pre-existing, Dr. Kolavo felt that Petitioner's symptoms were aggravated and accelerated by the accident.

On August 6, 2012, Dr. Kolavo performed surgery comprised of a: (1) posterior cervical fusion occiput C1-C2, (2) posterior cervical fusion C2-C3, (3) complex segmental instrumentation occiput C1, C3, and C3, (4) local bone graft with Bank bone allograft augmentation including INFUSE BMP-2, and (5) SSEP, EMG, and MEP neurogenic monitoring. (PX 3) Dr. Kolavo provided a post-operative diagnosis of OS odontoideum with occipitocervical instability and spinal cord injury. He continued to monitor Petitioner's care post-operatively.

On September 25, 2012, a records review was completed by Dr. Steven Mather at Respondent's request. (RX 8 – 0051-0054) Dr. Mather is a board certified orthopedic surgeon. (RX 8 – 0047) As part of his evaluation, he reviewed copies of the medical records from this claim but he did not have Dr. DiGianfilippo records at that time. Dr. Mather opined that Petitioner had a congenital instability (os odontoideum) of the cervical spine. He noted that there was significant hypertrophy of the transverse ligament on the June 1, 2012 MRI which indicates this condition was severe and pre-existing. Although he agreed that Petitioner required a C1-C3 fusion, it was his opinion that the condition was "certainly not related to his fall of May 27, 2011" noting that there were "no myelopathic or objective findings in this patient for approximately one year after this injury." He noted that Petitioner had been evaluated by Dr. Mary Morrell on many occasions and that he did not believe that the medical records supported Petitioner's contention that his neck was injured in the May 27, 2011 injury. "This clearly was a significant, severe pre-existing condition that likely would have required surgery even absent any trauma at all." (RX 8 – 0054)

Dr. Mather was subsequently provided with Dr. DiGianfilippo's records, and in his report dated October 19, 2012, he noted that the records "confirm my suspicion that this was not a work injury, but rather a degenerative stenotic segment that would have required surgery even absent the injury." (RX 8 – 0101)

Dr. Kolavo testified on January 15, 2013. (PX 4) He testified that Petitioner reported his complaints began after an injury at work on May 27, 2011, and that Petitioner denied any significant prior problems with his neck. (PX 4 dep. p. 10) It was his understanding that Petitioner "landed hard on his back, jarring his head and neck, hitting his left elbow. At that triggered issues with numbness, tingling and electricity in all for extremities. And he presented with ongoing similar symptoms that would come and go based on his head and neck position." (PX 4 dep. p. 11) After his evaluation and review of diagnostic imaging, Petitioner was diagnosed with cervical spinal stenosis with os odontoideum and C1-2 instability. (PX 4 dep. p. 13)

Dr. Kolavo testified that the foregoing findings pre-existed the work injury (PX 4 dep. p. 14, 15) and that the condition could exist in the absence of any symptoms. Addressing the os odontoideum, he testified "I think it's probably been there since early childhood." (PX 4 dep. p. 25) Because the first cervical vertebra was not connected to the second cervical vertebra in a reliable fashion, a trauma could irreversibly injury his spinal cord at that level and a high spinal cord injury is usually a fatal event. (PX 4 dep. p. 16)

Although Dr. Kolavo testified that it was his opinion that the work injury aggravated the pre-existing degenerative condition in Petitioner's neck (PX 4 dep. p. 17), he admitted that "[w]ell, I think the impression I got from him was that his symptoms were – developed sooner than a week or a month and a half after (sic) [the injury]." (PX 4 dep. p. 18) He confirmed that an immediate onset of complaints was documented in his records during cross examination. (PX 4 dep. p. 33) Although he had Dr. DiGianfilippo's records for his review, the only records Dr. Kolavo had prior to his evaluation were from June of 2012. (PX 4 dep. pp. 34-35)

While Dr. Kolavo testified that he thought Petitioner's fall was enough to trigger his symptoms (PX 4 dep. p. 28) he admitted that Petitioner's condition could have become symptomatic just from a gradual worsening of instability at C1-2, or in other words with aging. (PX 4 dep. p. 26)

When asked by Respondent's attorney when he would have expected the onset of Petitioner's complaints based on the mechanism of injury as described by Petitioner, Dr. Kolavo testified it could be immediate or if the segment was loosened up and becomes progressively unstable, it could gradually develop. (PX 4 dep. p. 31) Dr. Kolavo admitted that there was a little discrepancy in the histories but testified: "I guess I would expect if there was real causation, you'd see it in the first two or three months, yes." (PX 4 dep. p. 32) When asked if he could establish causation if Petitioner's complaints began five or six months after the injury he admitted "I think, yes, that far out, I guess I'd have a hard time with causation." (PX 4 dep. pp. 32-33)

Dr. Steven Mather testified on February 1, 2013. (RX 8) Dr. Mather testified that he performed a record review on behalf of Respondent (RX 8 – 0006), and produced a report based

on his review of Petitioner's treatment records. (RX 8 – 0007) Dr. Mather testified that based on the medical records and diagnostic studies, he formed an opinion that Petitioner had a congenital problem at C2 called os odontoideum and a hypertrophied ligament called the transverse ligament. (RX 8 – 0011) He explained that Petitioner's spine had never fully fused at birth, causing an unstable segment. (RX 8 – 0011) Dr. Mather testified that this was a congenital condition, and while Petitioner did need a C1-C3 fusion, the surgery was unrelated to the work injury. (RX 8 – 0012, 0029)

Dr. Mather testified that "there's no evidence on physical examination or by MRI that this condition was aggravated by the accident. Petitioner had pre-existing numbness and tingling in his arms, and the history that the accident report validated that it was aggravated was not reliable." (RX 8 – 0012) There were no objective neck findings or radicular neck complaints on May 31, 2011 (RX 8 – 0015-0016) The neck stiffness noted by Dr. Morrell on June 6, 2011, is not associated with os odontoideum. (RX 8 – 0016) Dr. Mather further testified that there were no neck complaints documented in Dr. Morrell's follow-up notes in June, July, and August of 2011. (RX 8 – 0017) As such, the history Petitioner gave to Dr. Kolavo was inconsistent with the medical records he reviewed. (RX 8 – 0019.

Dr. Mather disagreed with Dr. Kolavo's causation opinion for two reasons: first, because there was no evidence on physical examination or by imaging studies that the condition was aggravated by the accident (RX 8 – 0020) and second, the June 4, 2012 accident report completed by Petitioner was unreliable because the condition doesn't cause numbness of the neck or back, the condition causes paresthesias or numbness and tingling of the arms and legs and the entire trunk. (RX 8 – 0021) Dr. Mather testified that normal activities of daily living could cause Petitioner's injuries to become symptomatic. (RX 8 – 0022, 0023) The condition could also become symptomatic on its own. (RX 8 – 0029) According to Dr. Mather, if Petitioners complaints did not begin until 7 months after the alleged injury, Dr. Mather opined that the accident would not have aggravated the condition. (RX 8 – 0021) He would have expected Petitioner to become symptomatic immediately after the fall. (RX 8 – 0036) Dr. Mather further testified that Petitioner's os odontoideum was not aggravated by the alleged accident. (RX 8 – 0025)

On May 14, 2013, Petitioner returned to Dr. Kolavo's office nine months out from his occipital cervical fusion. (PX 3) Petitioner reported occasional low-grade neck complaints with intermittent numbness and tingling in fingertips of his left hand, but Dr. Kolavo was not sure whether these complaints were due to a peripheral nerve condition of his cervical spine. Petitioner was not using any medications at that time. Dr. Kolavo was optimistic about Petitioner's progress and released him to return to work without restrictions on June 1, 2013. (PX 3)

At the arbitration hearing Petitioner denied any medical problems with his left arm or neck prior to May 27, 2011. Petitioner described his health as "fine" before his accident.

In describing the accident Petitioner explained that he fell approximately five feet onto the pavement landing on his left arm, back, buttocks, left neck region, and head. Petitioner testified that the whole back of his head hit the ground and he fell backwards with his right arm on his chest. When he came to, he was in pain and feeling "pins and needles" in his whole body which

got better. He called his supervisor to report the accident, and waited at his truck approximately five hours until another driver could pick up his trailer.

Petitioner testified that he drove himself to Carle Hospital that same day. He was in extreme pain throughout his body – including his shoulder blades, head, neck, and elbow. It was his elbow that hurt the most and his arm was swollen around the elbow region. Petitioner was seen, his elbow x-rayed and treated and then he was released. Petitioner testified that he continued experiencing some "small shocks;" however, the Carle doctor said they should go away. Petitioner testified that the Carle doctor ran his fingers along Petitioner's neck and back but, otherwise, focused his attention on Petitioner's elbow. Petitioner drove his truck home to the Chicago area.

Petitioner testified that he saw his regular doctor, Dr. Virchow, the following Monday and he referred him to an orthopedist, Dr. Mary Morrell. Petitioner acknowledged that he had previously treated with Dr. Morrell for carpal tunnel syndrome. On cross-examination Petitioner admitted he had experienced tingling sensations with his prior carpal tunnel syndrome; however, those sensations had resolved prior to his visit at Carle post-accident.

Petitioner testified that he treated with Dr. Morrell from June 6, 2011 through May 31, 2012. During that time he underwent some physical therapy. Petitioner testified that his head and neck remained sore and that he was told it would be that way. Dr. Morrell was only treating his arm.

Petitioner was off work until approximately June 29, 2011. He then performed light duty work for Respondent (which primarily consisted of answering the phone) until Respondent needed another driver, due to being short-handed, and he resumed driving (but did no lifting).

Petitioner eventually returned to near full duty work, including driving, unlocking stores, and wheeling product with a hand cart. However, he still performed no lifting. After about 3 ½ weeks of working at that level, he progressed to full duty.

Petitioner testified that any low back pain he experienced after the accident ultimately resolved after a few weeks and he received no active treatment to his back. It was sore and tender, however, when he presented to Carle after the accident.

Petitioner testified that sometime "several months after the accident" he developed shooting/jolting pains down his upper and lower extremities. Petitioner could not state for certain when the complaints began – only that it was several months after his accident. Initially, the symptoms were rare and Petitioner testified he did not seek medical treatment because he thought they would resolve on their own. By December or January he was noticing them 2-3 times per month. They would go away immediately for awhile. Petitioner went to Dr. Virchow in April of 2012 because they weren't getting any better. He was then referred to Dr. DiGianfillipo who saw him, wasn't comfortable with what was wrong with him, and referred him to Dr. Kolavo. Dr. Kolavo subsequently took him off work, performed cervical spine surgery on him, and released him to return to work on May 27, 2013. Petitioner's employment with Respondent, however, had ended January 26, 2013. Petitioner testified that Dr. Kolavo did not impose any formal restrictions but did advise him to find an easier type of driving job.

Petitioner obtained new employment as a truck driver from J.B. Hunt, beginning on May 26, 2013. (PX 7) He continues to work at J.B. Hunt and perform all job duties without restrictions. Petitioner only drives for J.B. Hunt. He does not handle the freight expect for the occasional use of a forklift to haul. Petitioner testified he has occasional pain in his neck which he treats with over-the-counter medication. Due to the cervical fusion, he has some difficulty rotating his neck, and the Arbitrator notes that he would shift his torso rather than his neck when responding to questions from the attorneys at trial. Petitioner testified that the jolts he had been experiencing have resolved since surgery.

Petitioner further explained that his neck injury and surgery has changed his way of life. To illustrate, Petitioner explained that it is hard to get comfortable on a couch due to limited neck movement. He can experience throbbing neck pain for five minutes to one hour perhaps 2-3 times per week. He takes Tylenol as needed.

Petitioner submitted paystubs into evidence showing that he had worked consistently for J.B. Hunt from May 26, 2013 through November 9, 2013. (PX 7)

On cross-examination Petitioner acknowledged that when he returned to see Dr. Virchow in April of 2012 he had returned to full duty work for Respondent. The symptoms he reported to Dr. Virchow occurred when he sneezed, danced or moved his head a certain way. He had never experienced such jolts before the accident.

Petitioner also acknowledged that he had been involved in martial arts – more specifically Tae Kwon Do. However, he further testified that he engaged in limited striking as he was in a lower class level. Petitioner testified that he only performed it for a limited time.

Petitioner testified that he has had no further treatment for his left elbow since May 1, 2012. Petitioner testified that he has restricted range of motion with his left arm. When he extends his left arm out in front of himself, he can't quite put his arm (forearm and hand) parallel to the table. Petitioner denied any shoulder problems. He believed he had some loss of strength in his left arm. Petitioner also testified to an occasional sharp throbbing pain in his elbow joint which happens when it happens – such as when he is driving. Over the counter Tylenol helps with the pain but not much. Petitioner testified he cannot take any narcotic medication due to his commercial drivers' license. Petitioner also testified that his limitations have no impact on his ability to drive a semi truck.

The Arbitrator concludes:

As to F, whether Petitioner's current condition of ill-being is causally related to the injury, the Arbitrator concludes as follows:

Respondent has stipulated to causation for Petitioner's left elbow injury, but has challenged medical causation for Petitioner's cervical condition. The courts have consistently held that a claimant has the burden of proving by the preponderance of credible evidence all elements of the claim, including that any alleged state of ill-being was caused by a workplace accident. See, e.g., Parro v. Industrial Comm'n, 260 Ill.App.3d 551 (1993). It is the function of the Commission to

judge the credibility of the witnesses and to resolve conflicts in the medical testimony. Caterpillar Tractor Co. v. Industrial Comm'n, 124 Ill.App.3d 650 (1984). Even when evidence in the record might sustain a claim, such evidence is insufficient if it appears from all the testimony and circumstances shown in the record that such a finding is against the manifest weight of the evidence. Board of Educ. of the City of Chicago v. Industrial Comm'n, 83 Ill.2d 475 (1981).

Based on the totality of the evidence presented, the Arbitrator concludes that Petitioner failed to prove a causal connection between his accident of May 27, 2011 and his cervical condition. In so concluding the Arbitrator relies upon the lack of objective evidence of a cervical problem prior to April 14, 2012, a gap in any medical treatment between December 27, 2011 and April 4, 2012, Petitioner's resumption of full duty work and activity (ie., Tae Kwon Do), and Dr. Kolavo's acknowledgement that the actual onset date of Petitioner's complaints could undermine his causation opinion. The Arbitrator also notes discrepancies in Petitioner's description of the accident in terms of his injuries (see Carle records and his testimony) and when his neck/extremity complaints began (several months v. the accident v. 1 ½ months after the accident).

While Dr. Kolavo and Dr. Mather both agree on the nature of Petitioner's condition and the fact that the os odontoideum was a pre-existing medical condition they disagree as to whether Petitioner's work accident aggravated that pre-existing condition. The existence of health problems of a claimant prior to a work-related injury neither deprives the claimant of a right to benefits nor relieves the claimant of the burden of proving a causal connection between the employment and the subsequent health problems. Neal v. Industrial Comm'n, 141 Ill. App. 3d 289 (1986). The claimant bears the burden of showing that the pre-existing condition was aggravated by the employment and that the aggravation occurred as a result of an accident which arose out of and in the course of his employment. Lawless v. Industrial Comm'n, 96 Ill. 2d 260 (1983); Lyons v. Industrial Comm'n, 96 Ill. 2d 198 (1983). Dr. Kolavo's and Dr. Mather's disagreement on causation is based on the onset of Petitioner's complaints.

Petitioner bears the burden of proving his case and, in this instance, relies upon the opinion of Dr. Kolavo to establish a causal connection between his accident and his cervical condition. The Arbitrator finds Dr. Kolavo's causation opinion unpersuasive due to the doctor's flawed understanding of the onset of Petitioner's complaints. Petitioner's own testimony undermines Dr. Kolavo's understanding of when the complaints began. Petitioner testified that his complaints began "several months" after the accident. However, the first mention of any "shooting pains" was documented on April 4, 2012 (PX 6) which was over ten months after Petitioner's accident. Furthermore, Dr. Kolavo did not have any of Petitioner's treatment records prior to June 2012. As such, his opinion was not based on the review the records from Carle Foundation Hospital, Dr. Virchow, or Dr. Morrell.

Additionally, the Arbitrator notes that there is an absence of cervical/radicular extremity complaint notations in the medical records. No shock-like sensations or neck complaints are noted in the Carle Hospital records. Second, Petitioner testified he went to Dr. Virchow when he returned home after the accident and, yet, no office note of such a visit is found in the record. At Third, while Dr. Morrell noted Petitioner complained of a stiff neck when initially examined on June 6, 2011, the doctor's examination of Petitioner did not reveal any tenderness, deformity or

injury. Range of motion was unremarkable. Strength and tone were normal. There is no mention of "electrical shocks." In a September 12, 2011 Patient Health History Questionnaire Petitioner specifically denied any additional problems. In the October 10, 2011 and December 27, 2011 office notes, Dr. Morrell specifically noted "No other concerns or complaints" and "No other new symptoms or complaints." (PX 2) Petitioner further denied any other concerns on May 1, 2012. (PX 2) While Dr. DiGianfilippo's May 18, 2012 letter to Dr. Virchow includes a history wherein Petitioner indicated his symptoms of numbness and jolting sensations began approximately a month and a half after his accident, the aforementioned records don't corroborate that alleged history and, furthermore, Petitioner also advised Dr. DiGianfilippo that he occasionally experienced the symptoms when sneezing and he advised him he didn't really experience any neck pain or spine pain. This history is also contrary to Petitioner's testimony at arbitration suggesting ongoing neck pain since the time of the accident.

While Petitioner may suggest that he would not have mentioned his complaints to Dr. Morrell since she was only treating him for his left elbow problems, such a contention does not make complete sense to this Arbitrator. Indeed, if Petitioner was experiencing numbness and jolting sensations in his extremities, and most notably his upper extremities one of which was being treated by Dr. Morrell, it seems reasonable to infer he would have mentioned it to the doctor. Petitioner also mentioned to Dr. DiGianfilippo (as part of his pertinent history) that he had mild carpal tunnel syndrome bilaterally. Yet, at arbitration, he tried to suggest no correlation between his symptoms and carpal tunnel syndrome.

The Arbitrator finds the foregoing significant because, as noted by Dr. Mather, there are no cervical complaints or radicular complaints documented in the records. In fact, the first time Petitioner's complaints were documented in the records was by Dr. Virchow on April 4, 2012 (PX 6), over ten months/312 days after the accident. It is well established that the Commission can disregard unreliable medical opinions based on unproven, incomplete, or inaccurate information. Gregor v. City of Chicago, 99 I.I.C. 686, 1999 Ill. Wrk. Comp. LEXIS 976. The Arbitrator finds that Dr. Kolavo's opinion was, in fact, based on both incomplete and inaccurate information.

The Arbitrator further notes that there is no credible evidence corroborating Petitioner's testimony that his complaints began as a result of his accident. While Dr. Virchow's records suggest that Petitioner had complaints prior to April 4, 2012, the Arbitrator concludes that if Petitioner had complaints while he treated with Dr. Morrell, then he would have reported or mentioned those complaints to her during those examinations. She had treated him for carpal tunnel syndrome and was treating his left arm as a result of this injury. As Petitioner later told Dr. DiGianfilippo, it wasn't his neck that hurt as much as his extremities which were experiencing shock-like sensations. Petitioner had previously treated with Dr. Morrell for carpal tunnel syndrome, and therefore, she was perhaps the logical choice to evaluate any further complaints of numbness and tingling in Petitioner's extremities. Additionally, many of Dr. Morrell's office notes specifically deny Petitioner had any other complaints or concerns. Also, Dr. Virchow could have been deposed regarding his notes and the history contained therein. He was not.

Finally, Dr. Kolavo testified that Petitioner's condition could have become symptomatic on its own, with aging, or with activities of daily living. This is consistent with the testimony given by Dr. Mather. When asked if he could establish causation if Petitioner's complaints began five

or six months after the injury Dr. Kolavo admitted "I think, yes, that far out, I guess I'd have a hard time with causation." (PX 4 dep. pg. 32-33).

As to J, whether Respondent paid all appropriate charges for all reasonable and necessary medical services, the Arbitrator concludes as follows:

Respondent does not dispute liability for Petitioner's left elbow injury. While not a part of the record, Respondent admitted liability for the medical expenses from Carle Foundation Hospital, Carle Foundation Physicians, and Midwest Sports Medicine. Respondent is also liable for the July 1, 2011 bill from The Medical Care Group in its proposed decision. Based upon her causation determination Respondent is not liable for the medical expenses from Central DuPage Hospital, Alexian Brothers Medical Center, The Medical Care Group (4/4/12-7/30/12), Winfield Radiology Consultants, West Central Anesthesiology, Hanger Prosthetic & Orthotics, Cadence Physician Group Orthopedics, and Dr. Alfred Ceballos.

Pursuant to the stipulation of the parties, Respondent shall receive credit for the medical benefits paid on this claim. Respondent shall satisfy any outstanding medical expenses directly with the providers in accordance with the Fee schedule.

As to K, whether Petitioner is entitled to any temporary total disability (TTD) benefits, the Arbitrator concludes as follows:

Incorporating the aforementioned determination that Petitioner failed to prove his cervical complaints are causally related to the May 27, 2011 work accident, the Arbitrator concludes that Respondent is not liable for additional TTD benefits.

As to L, what is the nature and extent of Petitioner's injury, the Arbitrator concludes as follows:

Petitioner sustained a compensable injury to his non-dominant left elbow, which resulted in a left radial head fracture and coronoid process fracture. Petitioner did not require surgery and was able to return to work shortly after his accident. He admitted that he returned to work full duty within two months of his injury. Although Petitioner had slightly decreased extension and rotation of the elbow, he received a full duty release and was able to return to his regular job duties. Petitioner has permanent residual loss of motion and intermittent pain. Petitioner admitted he has not sought treatment in the last year and a half for his elbow injury and that he only takes over the counter medication on an as-needed basis. The Arbitrator concludes that Petitioner sustained injuries resulting in permanent partial disability of 15% loss of use of the left arm at the statutory maximum rate of $669.64/week.

****

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

CHRISTINE CHERRY,

Petitioner,

14IWCC0967

vs.

NOS: 00 WC 50577
00 WC 50578
00 WC 59042
01 WC 02350

M&M MARS COMPANY,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by Petitioner herein and notice given to all parties, the Commission, after considering the issue of vacating the May 10, 2013, Settlement Contract and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator to deny the motion to vacate said contract.

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

14IWCC0967

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: NOV 13 2014
KWL/mav
O: 10/06/14
42

Kevin W. Lamborn

Thomas J. Tyrrell

Michael J. Brennan

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

Donald Michael,
Petitioner,
vs.

14IWCC0968
NO: 08 WC 33507

ARCELOR MITTAL, INC,
Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of accident, medical expenses, permanent partial disability, wages, benefit rate 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 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 the Respondent shall have credit for all amounts paid, if any, to or on behalf of the Petitioner on account of said accidental injury.

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $7,600.00. 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: NOV 13 2014
Kwl/vf
O-11/3/14
42

Kevin W. Lamborn

Thomas J. Tyrrell

Michael J. Brennan

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

14IWCC0968

MICHAEL, DONALD
Employee/Petitioner

Case# 08WC033507

08WC033506

ARCELOR MITTAL INC
Employer/Respondent

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:

0400 LOUIS 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)

☐ Injured 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

14IWCC0968

DONALD MICHAEL,
Employee/Petitioner

v.

ARCELOR MITTAL, INC.,
Employer/Respondent

Case # **08** WC **33507**

Consolidated cases: **08 WC 33506**

An *Application for Adjustment 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, IL**, on **09/25/13**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **01/04/08**, 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 **$37,502.40**; the average weekly wage was **$721.20**.

On the date of accident, Petitioner was **59** years of age, ***married*** with **0** dependent children.

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

Respondent ***has 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 $_____ under Section 8(j) of the Act.

ORDER

Respondent shall not pay petitioner any temporary total disability benefits.

Respondent shall pay petitioner permanent partial disability benefits of $432.72/week for 10.75 weeks because the injuries caused a 5% loss of use of a leg.

Respondent shall pay petitioner compensation that has accrued from 01/04/08 through 09/25/13 and shall pay the remainder of the award, if any, in weekly payments.

Respondent shall pay petitioner reasonable and necessary medical services, pursuant to the medical fee schedule, of $2,800.05, as provided in Sections 8(a) and 8.2 of the Act and as set forth herein.

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

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

Signature of Arbitrator

October 3, 2013
Date

OCT 29 2013

STATEMENT OF FACTS

Employee, Donald Michael, testified at his arbitration hearing that he was employed by Arcelor Mittal, Inc., as a roll-grinder operator at their steel mill. He further testified that on January 4, 2008, he was working on a grinder and had to step down onto a metal grating before he had to walk sideways between the grinder and a jib crane. While performing this awkward maneuver, Petitioner experienced his right knee "pop", which immediately caused pain in his right knee. Petitioner identified the area where his accident occurred in the photographs marked as PX.1 and PX.2. His supervisor happened to be present at that time and Petitioner immediately informed him of the accident. Petitioner was able to continue working that day with his right knee pain.

Dr. Manuel Ascano

On January 7, 2008, Petitioner saw his primary care physician, Dr. Manuel Ascano, for the chief complaint of right knee pain. Petitioner gave a history that on January 4, 2008, he stepped off the grinder and his right knee popped. He further complained that there was some swelling and pain in his right knee. Dr. Ascano's chart note reflects that on examination, he found tenderness in Petitioner's right knee and his assessment was right knee injury. Dr. Ascano's treatment plan was light activity for right knee. Following the doctor's visit, Petitioner continued to experience right knee pain.

St. Margaret's Hospital

On January 18, 2008, Petitioner presented to St. Margaret's Hospital Occupational Health Department and gave a history of stepping down from a grinder onto a grating when he felt a "pop" in his right knee. Petitioner complained that his right knee was still giving him discomfort and rated his pain level as a "3." On examination, his right knee had good range of motion, but there was pain on external and internal rotation. The diagnosis was right knee pain, probably a sprain and treatment consisted of an x-ray of the right knee and Tylenol for pain. Petitioner was given a follow-up appointment for January 25, 2008.

Petitioner returned to the Occupational Health Department on January 25, 2008, complaining that his knee pain was unchanged since last visit. On examination, Petitioner

complained of right knee pain when his leg was rotated. The treatment plan included ordering a MRI of the right knee.

On January 30, 2008, the MRI of Petitioner's right knee revealed intact ligaments and menisci, however, there was a thickening of the supra patellar plica and also infra-patellar bursitis.

On February 8, 2008, Petitioner returned to Occupation Health and complained that his right knee bothered him more and rated his pain level between "4 to 5." The diagnosis at that time was a strained collateral ligament.

On February 18, 2008, Petitioner was again seen at Occupational Health complaining that his right knee felt worse and that he was having a burning sensation below the knee cap. He rated his pain level at a "5." The diagnosis was right knee supra-patella plica and mild infra-patellar bursitis. Treatment plan was to recommend that Petitioner be evaluated by an orthopedic surgeon for possible plica excision.

Dr. Ram Pankaj

On March 10, 2008, Petitioner saw Dr. Ram Pankaj, an orthopedic surgeon, for his right knee pain. He gave a history of being at work when he felt a pop in his right knee when he stepped down in a very close space and twisted his body. He complained that his right knee felt uncomfortable, that he had difficulty climbing stairs and that his knee sometimes gave out. Dr. Pankaj's diagnosis was a clinically normal examination of the right knee and L5-S1 radiculopathy on the right side caused possibly by a disc lesion. He ordered an EMG nerve conduction of both lower extremities to be done by the Institute of Physical Medicine and Rehabilitation and a MRI of the lumbar spine.

Dr. Manuel Ascano

On March 17, 2008, Petitioner saw his primary care physician and indicated that he was still receiving treatment for his right knee problem and that he was now under the care of Dr. Pankaj.

Institute of Physical Medicine & Rehabilitation (IPMR)

On April 10, 2008, Petitioner was referred to Dr. Lisa Snyder of the Institute of Physical Medicine and Rehabilitation and described his ongoing pain primarily in the region of the right knee and he also described intermittent pain that began in the buttock and radiated into the lower extremity. Dr. Snyder performed an electro diagnostic test which was remarkable for mild slowing of the right common peroneal nerve condition velocity below the knee as well as some mild slowing of the left tibial nerve conduction velocity below the knee.

Dr. Ram Pankaj

On April 14, 2008, Petitioner saw Dr. Ram Pankaj, who reviewed the lumbar MRI and EMG nerve conduction studies. Dr. Pankaj recommended that Petitioner be seen by a neurosurgeon for his opinions.

Dr. Steven Potaczek (Employer IME)

On June 24, 2008, Petitioner was examined by Dr. Steven Potaczek at the request of the employer. Petitioner gave a history of being injured on January 4, 2008, when he stepped off some type of platform and twisted his right knee. Dr. Potaczek's diagnosis was right knee strain, which he believed was related to the incident in question.

C. **DID AN ACCIDENT OCCUR THAT AROSE OUT OF AND IN THE COURSE OF PETITIONER'S EMPLOYMENT BY RESPONDENT?**

Petitioner testified uncontradicted that on January 4, 2008, he was working on a grinder and had to step down onto a metal grating and then had to walk sideways in a very tight space. While performing this awkward maneuver, Petitioner experienced his right knee "pop" which then caused him pain in the right knee. Petitioner further testified that he immediately reported his injury to his supervisor. The medical records at St. Margaret's Hospital and Dr. Ascano indicate that Petitioner gave the same history of stepping down from a grinder and onto a grating when he experienced a "pop" sensation in his right knee.

The Arbitrator finds that Petitioner was required to step down onto the metal grating and then had to maneuver in a tight space. Based on these facts, the Arbitrator finds that

Petitioner was placed at a greater risk than that to which the general public would be exposed. The Arbitrator therefore finds that Petitioner did sustain an accident that arose out of and in the course of employment.

J. **WERE THE MEDICAL SERVICES THAT WERE PROVIDED TO PETITIONER REASONABLE AND NECESSARY?**

Employee Donald Michael offered into evidence, the following unpaid medical expenses:

(PX. 8)St. Margaret's Hospital / Clinic

(a)	03/10/08	Lumbar spine x-rays	$430.00
(b)	03/24/08	Lumbar spine MRI	$109.05
(c)	04/14/08	Dr. Ram Pankaj office visit	$ 15.00
		Total	$554.05

(PX. 9)Hospital Radiology

(a)	03/10/08	Lumbar x-ray interpretation	$16.00
(b)	03/24/08	Lumbar MRI interpretation	$362.00
		Total	$ 378.00

(PX. 10) Institute of Physical Medicine & Rehabilitation

(a)	04/10/08	EMG.....	$1,868.00

Petitioner testified that on January 4, 2008, he injured his right knee at work. Following approximately a month of conservative care, Petitioner testified that his knee pain worsened. He also testified that began shifting his weight from his right side to his left, which caused him to also experience low back pain as well.

On March 10, 2008, Dr. Ram Pankaj examined Petitioner's right knee and low back since employee was having symptoms in both areas. Dr. Pankaj ordered x-rays of the low back, lumbar MRI and an EMG nerve conduction of both legs to rule out a possible disc lesion.

The Arbitrator finds that it was reasonable and necessary for Dr. Pankaj to order these diagnostic tests to determine if Petitioner had either injured his back in the accident or aggravated a pre-existing condition.

The Arbitrator orders respondent to pay petitioner reasonable and necessary medical services, pursuant to the medical fee schedule, of $2,800.05 as provided in Sections 8(a) and 8.2 of the Act to be paid pursuant to the fee schedule, and Respondent to receive credit for all sums previously paid.

K. **WHAT TEMPORARY BENEFITS ARE IN DISPUTE?**

Petitioner testified that following his accident on January 4, 2008, he was placed on medical restrictions. He further testified that his employer was able to accommodate these restrictions and that he had no lost time. The Arbitrator finds that there is no temporary benefits due and owing.

L. **WHAT IS THE NATURE AND EXTENT OF THE INJURY?**

Petitioner testified that he currently experiences problems with his right knee which affect his daily activities. Whenever he is involved in activities where he uses his right knee, he experiences pain and soreness. The medical records indicate that Petitioner sustained a strain of the collateral ligament in his right knee that has been consistent and chronic.

The Arbitrator finds that in consideration of Petitioner's age, occupation as well as the nature, extent and duration of his injury, that he has sustained a 5% loss of use of his right leg.

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

Donald Michael,
Petitioner,

vs.

14IWCC0969

NO: 08 WC 33506

ARCELOR MITTAL, INC,
Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of accident, medical expenses, temporary total disability, permanent partial disability, wages, benefit rate 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 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 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 $3,400.00. 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: NOV 13 2014
Kwl/vf
O-11/3/14
42

Kevin W. Lamborn

Thomas J. Tyrrell

Michael J. Brennan

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

14IWCC0969

MICHAEL, DONALD
Employee/Petitioner

Case# **08WC033506**

08WC033507

ARCELOR MITTAL INC
Employer/Respondent

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:

0400 LOUIS 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)

☐ Injured 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 14IWCC0969

DONALD MICHAEL,
Employee/Petitioner

v.

ARCELOR MITTAL, INC.,
Employer/Respondent

Case # 08 WC 33506

Consolidated cases: 08 WC 33507

An *Application for Adjustment 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, IL**, on **09/25/13**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

14IWCC0969

FINDINGS

On **06/27/08**, 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 **$37,502.40**; the average weekly wage was **$721.20**.

On the date of accident, Petitioner was **59** years of age, ***married*** with **0** dependent children.

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

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

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

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

ORDER

Respondent shall pay petitioner temporary total disability benefits of $480.80/week for 2-2/7 weeks, commencing on 06/28/08 through 07/14/08 as provided in Section 8(b) of the Act.

Respondent shall pay petitioner permanent partial disability benefits of $432.72/week for 5 weeks because the injuries caused 1% loss of use of a person as a whole.

Respondent shall pay petitioner compensation that has accrued from 06/27/08 through 09/25/13 and shall pay the remainder of the award, if any, in weekly payments.

Respondent shall pay petitioner reasonable and necessary medical services, pursuant to the medical fee schedule, of $35.42 as provided in Section 8(a) and 8.2 of the Act.

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

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

Nhell E Mc — October 3, 2013

Signature of Arbitrator — Date

OCT 29 2013

STATEMENT OF FACTS

Employee, Donald Michael, testified at his arbitration hearing that on June 27, 2008, he was employed by Arcelor Mittal, Inc., as a roll-grinder operator at their steel mill. He further testified that on June 27, 2008, while at work, he was pulling on a hose in order to wash the floor, when his feet slipped on oil, causing him to fall. He landed on his low back and right side. An ambulance was called and Petitioner informed the EMT at the scene, that he was having right side neck pain, right forearm pain and lower back pain. Petitioner was taken by ambulance to Perry Memorial Hospital for treatment.

Perry Memorial Hospital

During the early morning on June 28, 2008, Petitioner was seen in the emergency room at Perry Memorial Hospital, where he complained of pain in the right side of his neck, right forearm, right shoulder, right knee and low back. Plain x-rays were taken of those areas in addition to a CT scan of the cervical spine. Petitioner was diagnosed with a contusion to his right shoulder and right forearm and a strain/sprain to his neck and low back. The emergency room physician restricted Petitioner from work and ordered to see his primary care physician, Dr. Ascano.

Dr. Manuel Ascano

On June 30, 2008, Petitioner saw his primary care physician, Dr. Manuel Ascano, complained of pain in both hips, along with neck and right shoulder pain. Dr. Ascano diagnosed Petitioner with multiple contusions along with a lumbar and cervical sprain/strain. Dr. Ascano restricted Petitioner from all work activities.

On July 10, 2008, Petitioner returned to Dr. Ascano complaining of back pain, especially early in the morning and late at night. Dr. Ascano's assessment was healing contusions and lumbar sprain.

On July 14, 2008, Petitioner saw Dr. Ascano and complained that his back was still sore and that the pain was worse at the end of the day. Dr. Ascano's diagnosis was lumbar sprain. At that time, Petitioner was released to return to work on full duty.

C. **DID AN ACCIDENT OCCUR THAT AROSE OUT OF AND IN THE COURSE OF EMPLOYMENT BY RESPONDENT?**

Petitioner testified uncontradicted that on June 27, 2008, he was pulling a hose inorder to wash the floor when his feet slipped on oil, causing him to fall onto the floor. Petitioner gave a history to the EMT at the scene that he was at his work station when he fell onto a platform. At Perry Memorial Hospital, Petitioner gave a history of slipping and falling at work.

The Arbitrator finds that Petitioner was required to pull a hose while working on a floor with oil on it. Because of these facts, Petitioner was at a greater risk than the general public. The Arbitrator finds that Petitioner did sustain an accident that arose out of and in the course of employment.

J. **WERE THE MEDICAL SERVICES THAT WERE PROVIDED TO PETITIONER, REASONABLE AND NECESSARY?**

Employee, Donald Michael, offered into evidence the following unpaid medical expenses:

PX. 12 Perry Memorial Hospital	
06/28/08	$ 31.78
PX. 13 Prescription (by Dr. Ascano)	
06/30/08 Propoxyphene	$ 3.64
Total	$ 35.42

Petitioner testified that following his accident, he was taken by ambulance to the emergency room of Perry Memorial Hospital. He further testified that on June 30, 2008, he had a follow-up appointment with Dr. Ascano, who prescribed pain medication for his condition.

The Arbitrator finds that it was reasonable and necessary for Petitioner to receive treatment at Perry Memorial Hospital and for Dr. Ascano to prescribe medication.

The Arbitrator orders respondent to pay petitioner reasonable and necessary medical services, pursuant to the medical fee schedule of $35.42, as provided in Section 8(a) and 8.2 of the Act.

K. WHAT TEMPORARY BENEFITS ARE IN DISPUTE?

On June 27, 2008, Petitioner was injured at work and during the early morning hours on June 28, 2008, he was taken to the emergency room at Perry Memorial Hospital for medical treatment. Petitioner was examined by the emergency room physician, who restricted him from all work activities. On June 30, 2008, employee saw Dr. Ascano for his work injuries, who restricted him from full-duty work. On July 14, 2008, Petitioner saw Dr. Ascano, who released him to full duty. Petitioner testified that he then returned to work.

The Arbitrator finds that Petitioner is entitled to receive TTD payments in the amount of $480.80 per week from June 28, 2008 through July 14, 2008, representing 2-2/7 weeks.

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

Petitioner testified that he currently experiences neck and back pain, which affects his daily activities. He also testified that he has to be careful when it comes to lifting heavy objects and he has his cousin assist with lifting.

The Arbitrator finds that in consideration of Petitioner's age, occupation as well as the nature, extent and duration of his injury, that he has sustained a 1% loss of use of a person as a whole.

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

Christopher Caban,
Petitioner,
vs.

14IWCC0970

NO: 12 WC 33771

M.J. Electric LLC,
Respondent.

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed April 8, 2014 is hereby affirmed and adopted.

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

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

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $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: NOV 13 2014
KWL/vf
O-11/3/14
42

Kevin W. Lamborn

Thomas J. Tyrrell

Michael J. Brennan

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

14IWCC0970

CABAN, CHRISTOPHER
Employee/Petitioner

Case# **12WC033771**

M J ELECTRIC LLC
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:

4788 HETHERINGTON KARPEL BOBBER & ET AL
ALAN KARPEL
120 N LASALLE ST SUITE 2810
CHICAGO, IL 60601

1241 LEMP & ANTHONY PC
WILLIAM LEMP
10805 SUNSET OFFICE DR #203
ST LOUIS, MO 63127

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 141WCC0970

Christopher Caban
Employee/Petitioner

v.

M. J. Electric, LLC
Employer/Respondent

Case # 12 WC 33771

Consolidated cases: _____

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Deborah L. Simpson**, Arbitrator of the Commission, in the city of **Chicago**, on **February 24, 2014**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

14IWCC0970

FINDINGS

On **May 4, 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 **$93,475.72**; the average weekly wage was **$1,797.61**.

On the date of accident, Petitioner was **38** years of age, ***married*** with **2** dependent children.

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

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

Respondent shall be given a credit of **$36,636.59** for TTD, **$0** for TPD, **$54,612.74** for maintenance, and **$7,020.29** for other benefits, for a total credit of **$98,269.62**.

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

ORDER

The Respondent shall pay the Petitioner permanent partial disability benefits, commencing December 11, 2013, of $957.91/week until the Petitioner reaches age 67 or five years from the date of the final award, whichever is later, because the injuries sustained caused a loss of earnings, as provided in Section 8(d)(1) of the Act.

The Respondent shall pay Petitioner compensation that has accrued from May 4, 2012, through February 24, 2014, and shall pay the remainder of the award, if any, in weekly payments.

The Respondent shall be given a credit of $7,020.29 for permanent partial disability benefits that have been 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.

Deborah L. Simpson
Signature of Arbitrator

April 8, 2014
Date

APR 8 – 2014

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Christopher Caban,	)	**14IWCC0970**
	)	
Petitioner,	)	
	)	
vs.	)	**No. 12 WC 33771**
	)	
M.J. Electric, LLC,	)	
	)	
Respondent.	)	
	)	

FINDINGS OF FACTS AND CONCLUSIONS OF LAW

The parties agree that on May 4, 2012, the Petitioner and the Respondent were operating under the Illinois Worker's Compensation or Occupational Diseases Act and that their relationship was one of employee and employer. On that date the Petitioner sustained an accidental injury or was last exposed to an occupational disease that arose out of and in the course of the employment and his current condition of ill-being is causally connected to the accidental injuries. They agree that the Petitioner gave the Respondent notice of the accident within the time limits stated in the Act. It was stipulated by the parties that in addition to the TTD and maintenance benefits totaling $91,250.37 that have been paid to date, Respondent would pay a wage differential from December 11, 2013, through the date of trial on February 24, 2014, based on actual earnings. Further, that as of the date of trial on February 24, 2014, wage differential benefits would continue, based on projected earning capacity. Finally, that Respondent has paid or will pay for all reasonable and related medical charges and/or hold the Petitioner harmless for any payments relating to requests for payments or reimbursement for payments already made.

At issue in this hearing is as follows: (1) What is the nature and extent of the injury.

The Petitioner has opted to pursue a wage differential pursuant to Section 8(d)(1) as opposed to permanent partial disability. It is found that the facts of this case do merit a wage differential pursuant to Section 8(d)(1).

STATEMENT OF FACTS

The Petitioner testified that he is 40 years old, married and has four children, two of them under age 18. He grew up in Oak Lawn, Illinois and graduated from Oak Lawn Community High School. He joined the Navy after high school and became a gas turbine systems technician, electrical, which means that he worked on the electrical components of engines. After being honorably discharged from the Navy, he got a job with Federal Signal as an electronics

technician where he joined the International Brotherhood of Electrical Workers ("IBEW"). He then went to work for Moran Electric as an electrician apprentice and earned his "A card" from the union.

In November of 1999, Petitioner began working for Respondent. The union sent him to work on a project in downtown Chicago. Respondent was the electrical contractor on the project. Petitioner worked on the project for about a year. He completed all of the tax and insurance forms Respondent required of new employees while working on the project. He continued to work exclusively for Respondent for almost 15 years.

Respondent specializes in high voltage power plants. Its customers are power companies like Exelon. Beginning in about 2007, Respondent assigned Petitioner to work as a foreman on out-of-state projects. Most of the work involved construction of wind farms to produce wind power. He testified that typically five of us go out to the job. We must hire from the state we are working in to do all the work.

Wind farms have up to 100 "windmills" or wind turbines. Typically five turbines make a circuit. Each circuit is connected to a collection box. Electricians install the equipment needed to deliver power generated from the wind turbine to the collection box. They also install the equipment necessary to transfer electricity to the controls of the wind turbine.

A wind turbine can be 330 feet tall. It is typically equipped with a steel ladder that spans its length. When climbing the ladder, an electrician must tie into a safety line and extend his arms overhead while grabbing the sides or rungs of the ladder. It takes about 15 minutes for an experienced electrician to climb from the bottom to the top of the ladder. Every 80 feet there is a level where you can get off and do work or take a break. Each windmill has approximately three of these landings.

Petitioner described his duties as an electrician during the various stages of the construction of a wind farm. One task involves pulling spools of cable up by a rope. There is someone climbing along the spool, guiding it along, to keep it from gouging the tower or the cable. While doing this one hand is on the cable to guide it, the other is used to climb. It takes over an hour to get the cable from the ground to the top of the windmill.

Another task involves attaching 14 to 16 cables to the control box at the top of the turbine. The cables are then threaded down through a tight space adjacent to the ladder all the way to the bottom of the turbine. The cables must be threaded in a particular order. One electrician positions the cables and holds them while another follows him down the ladder and secures the bundle with cable ties. Each electrician is standing on the ladder while doing this job. The electrician's arms are fully extended and above shoulder level for more than 80% of the time. It takes two to three electricians 10 to 12 hours to complete this task in one wind turbine.

Petitioner testified that his job duties on a wind farm require him to have his arms in an extended overhead position 75% to 80% of the time. Once the turbines are erected, almost 100% of his work is performed from a ladder. The Petitioner testified that most of the work done on the windmills is done at the top.

Petitioner is right hand dominant. He never had problems with either arm or shoulder before the accident.

On May 4, 2012, Petitioner was working for Respondent on a wind farm in Michigan. It was a Friday, near the end of the day, somewhere around 3:00 p.m. The iron workers were behind schedule and the Petitioner, a passenger in one of the company trucks was filling out the job schedule. Another electrician was driving them out to the site of a planned turbine when their truck swerved out of control and rolled over in a ditch on the side of a service road. Petitioner was seated in the passenger's side front seat. Just before the truck flipped over, he secured himself by wedging his hands and feet between the roof and floor of the vehicle. The truck came to rest on the driver's side. Petitioner climbed out of the passenger's side window and then helped the driver climb out. After they climbed out of the truck they had to climb out of the ditch. The ditch was about five feet deep and filled with water.

Petitioner was "sore all over" after the accident. He rested for a couple of days and then returned to work. While working on May 7, 2012, he "didn't feel right." He was unable to lift some conduit. His shoulders "didn't feel right" when he lifted a heavy piece of equipment overhead. He told his supervisor and, later, his superintendent.

On May 8, 2012, Respondent sent Petitioner to the urgent care clinic at Henry Ford Macomb Hospital in Clinton Township, Michigan. Petitioner described the accident to the clinic personnel. Although he described pain in his calves, knees, and shoulders, his main complaint, was pain in his right shoulder. The examining physician noted pain in Petitioner's right shoulder during range of motion testing. He found muscle tightness and spasm of the right bicipital groove. He also noted pain with supraspinatus and biceps long head testing. The doctor diagnosed a right shoulder strain along with strains and contusions to the bilateral knees, calves, and right hip. He prescribed pain medication, range of motion exercises for the right shoulder, and made a follow up appointment. The doctor expected that most of Petitioner's injuries would resolve by then except for his right shoulder. He noted that the right shoulder had evidence of a biceps muscle strain and possibly a supraspinatus injury. He released Petitioner back to work with a 25 pound lifting limit and no overhead lifting with the right arm. (PX 3).

Petitioner returned to the urgent care clinic on May 15, 2012. As expected, he experienced significant improvement in all of his injuries except for the right shoulder. Certain movements of his shoulder caused pain. The doctor noted similar findings in the shoulder to the last exam. He maintained the diagnosis of a right shoulder strain. He ordered physical therapy to prevent the development of adhesive capsulitis. Petitioner was having difficulty sleeping because of shoulder pain so the doctor advised him to ice the shoulder and use Vicodin in the evening before bed. He maintained the same restrictions as he had imposed at the prior visit. (PX3).

Some time after the follow up appointment, Respondent transferred Petitioner to a project in central Michigan. Petitioner saw a physical therapist in the area who noted a popping in his right shoulder with certain movements and counseled him to stop therapy and get an MRI. Respondent sent Petitioner to Mid-Michigan Urgent Care in Alma, Michigan for further care. Petitioner was seen at the clinic for the first time on June 6, 2012. The physician diagnosed post-traumatic right shoulder pain. He ordered an MRI and imposed work restrictions. (PX4).

The MRI was done on June 8, 2012, and, according to the radiologist, revealed a tear of the supraspinatus tendon with retraction and some degenerative changes of the acromioclavicular

joint with impingement on the supraspinatus muscle. The radiologist also noted bone marrow edema and what appeared to be small cysts in the humeral head. (PX4).

Petitioner returned to the clinic in Alma on June 12, 2012. The physician noted the abnormal MRI and referred Petitioner to an orthopedic surgeon. He maintained the same restrictions as before. (PX4).

On June 20, 2012, Petitioner was seen by James Ware, D.O. of the Mid-Michigan Bone and Joint Center on the referral of the physician at the clinic in Alma. Dr. Ware noted that the MRI showed a torn rotator cuff. He found weakness on flexion and, in particular, abduction. He also found weakness on external rotation. He diagnosed a rotator cuff tear of the right shoulder and recommended arthroscopic surgery to repair the rotator cuff. (PX5).

Since Petitioner was going to have surgery and would not be able to work for some time, Respondent sent him home to Oak Lawn and instructed him to choose a surgeon near his home. On June 26, 2012, Petitioner saw Michael Durkin, M.D. with Hinsdale Orthopaedics. Dr. Durkin noted pain at a level of six to seven out of 10. His examination of the right shoulder revealed a limited range of motion, pain, and weakness with testing of the supraspinatus. He reviewed the MRI that had previously been done in Michigan and noted a large rotator cuff tear. He diagnosed a right shoulder acute rotator cuff tear that he concluded was related to Petitioner's accident on May 4, 2012. He recommended a right shoulder arthroscopy and debridement. He took Petitioner off of work in anticipation of the surgery. (PX6).

Surgery was performed on July 16, 2012. Dr. Durkin found a SLAP tear involving the bicep anchor region. He debrided and repaired the tear using bicep anchors both anteriorly and posteriorly. He found a large rotator cuff tear just behind the bicep tendon. The bicep tendon did not appear to be damaged and so he did not do a tenodesis. He debrided the edges of the rotator cuff tear and sutured all four limbs to anchors he placed in bone. He also shaved Petitioner's subacromial bursa, but did not find any spurs or other bony changes that needed decompression. (PX6).

Petitioner had his first post-operative visit on July 21, 2012. He described improvement in his shoulder pain although it was still at a constant five on a scale of 10. He was experiencing some numbness and tingling in his right hand. He was receiving physical therapy three times a week. He was taking Norco for pain four times a day. Dr. Durkin noted that Petitioner was recovering well from the rotator cuff repair and had decent range of motion. He removed the stitches. He instructed Petitioner to continue wearing his brace for another four weeks. He kept Petitioner off work. (PX6).

Petitioner returned to see Dr. Durkin a month later on August 28, 2012. The doctor noted an improvement in the range of motion in his right shoulder. Petitioner described some pain in his left shoulder as he was decreasing his use of pain medication. The doctor felt the left shoulder symptoms were either due to trauma from the accident or overuse in that Petitioner was compensating for the right shoulder surgery. Physical therapy was continued and Petitioner was released to very limited work, no lifting greater than two pounds, no climbing ladders, and no overhead activities. (PX6).

On September 28, 2012, Dr. Durkin noted that Petitioner's right shoulder strength was lagging. Rotator cuff strength was only 4+ out of 5. He ordered more physical therapy. Petitioner was having difficulty sleeping due to shoulder pain so he prescribed Ambien. The same work restrictions were maintained. (PX6).

When Petitioner returned to see Dr. Durkin on October 30, 2012, he expressed concern with the range of motion in his right shoulder. It was difficult for him to raise his arm above his waist. He experienced pain when reaching overhead. Dr. Durkin noted pain with cross arm adduction and overhead weakness. He ordered additional physical therapy and maintained the same work restrictions. (PX6).

Respondent scheduled an IME with Nikhil Verma, M.D. of Midwest Orthopaedics at Rush to evaluate Petitioner's left shoulder. The exam took place on November 1, 2012. According to Dr. Verma's history, Petitioner developed symptoms in his left shoulder two weeks after his right shoulder surgery. Physical therapy had been prescribed, and his left shoulder symptoms had improved. Dr. Verma diagnosed left shoulder impingement secondary to compensatory use which had resolved. He did not believe there was an acute injury to Petitioner's left shoulder in the motor vehicle accident based on a lack of complaints documented in the post-accident medical records. He did not feel that the left shoulder needed any further treatment or that it prevented Petitioner from returning to work. Dr. Verma did not examine or comment on Petitioner's right shoulder. (RX1).

On November 27, 2012, Dr. Durkin noted that Petitioner was still having right shoulder pain with overhead and cross body movements. The pain was located in the anterior shoulder. He prescribed Daypro, an anti-inflammatory medication, to help Petitioner get through the plateau he had reached in physical therapy. He considered administering a Cortisone injection at the next visit if the Daypro did not help. The same restrictions were maintained. (PX6).

On December 11, 2012, Petitioner told Dr. Durkin that he was having pain straightening his shoulder. Overhead activity was still difficult. The tenderness had improved. Dr. Durkin recommended that he continue taking the Daypro. He ordered the Petitioner to participate in a work conditioning program and took him off of work. (PX6).

On January 11, 2013, Dr. Durkin noted that Petitioner's range of motion had improved but his overhead motion was still limited. He stated that Petitioner would fatigue quickly doing overhead work. He concluded that Petitioner was functional below shoulder level, but his job required him to hold tools overhead at work. Dr. Durkin ordered an FCE to determine Petitioner's capacity for overhead work. He allowed Petitioner to return to work with restrictions of no overhead activity and would reassess him after the FCE. (PX6).

The FCE was done on January 16, 2013. According to the person administering the exam, Petitioner provided full effort and passed all of the validity testing criteria. Petitioner tested out at a modified very heavy physical demand level. He was able to lift over 100 pounds from floor to desk level, but only 21.4 pounds above shoulder level. Unilaterally with his left arm he could lift 35 pounds above shoulder level, but only 17.4 pounds with his right arm. The examiner noted that Petitioner experienced shoulder pain with any activity that required him to extend his right arm out away from his body or above shoulder level. During work simulation tasks, Petitioner was unable to maintain his right arm at or above shoulder level for sustained

periods and, at times, reported objects slipping out of his right hand. The examiner compared Petitioner's performance to the physical demand level required of an electrician according to the Dictionary of Occupational Titles. He concluded that Petitioner had the capacity to perform those demands from floor to desk level, but not above shoulder level. He also noted that Petitioner's job duties required him to climb a fixed ladder which involved reaching overhead repetitively. Based on the deficits Petitioner demonstrated with above shoulder activities, the examiner concluded that he may not be able to complete his job effectively or safely. (PX6).

Petitioner returned to see Dr. Durkin on January 25, 2013. Dr. Durkin noted the difficulties Petitioner demonstrated performing overhead activities during the FCE. He concluded that Petitioner was at MMI and imposed permanent restrictions of lifting no more than 10 pounds overhead, doing minimal overhead work and taking frequent breaks when performing overhead work, and only using a ladder to ascend or descend but not to perform work while standing on it. He asked Petitioner to follow up with him after returning to work. (PX6).

Petitioner testified that he communicated with Respondent after every doctor appointment. Initially, Respondent told him that they would assign him to a job in the spring of 2013. That never happened. To date, Respondent has not offered to re-employ Petitioner in any capacity.

Petitioner returned to see Dr. Durkin on March 8, 2013. The doctor noted no changes in Petitioner's condition and confirmed that he had reached MMI. He encouraged Petitioner to do a home exercise program and take anti-inflammatories. Petitioner told the doctor that he expected to be recalled to work in the spring. Dr. Durkin maintained the same work restrictions on a permanent basis. He told Petitioner to come back as needed or if he had further problems with his shoulder after returning to work. (PX6).

Petitioner's last visit with Dr. Durkin was on September 6, 2013. He complained of pain and swelling in the front of his shoulder. Dr. Durkin noted that Petitioner was still experiencing pain with overhead movements and soreness at night. He recommended a topical anti-inflammatory cream as needed at night or during the day to relieve some of the symptoms. He maintained the same permanent restrictions that he imposed after the FCE. (PX6).

Respondent's attorney scheduled another IME with Dr. Verma which took place on October 3, 2013. Dr. Verma examined Petitioner and reviewed his medical records. He found limited strength and range of motion in Petitioner's right shoulder compared to his left. He agreed that Petitioner was at MMI and that no further significant improvement could be expected. He also agreed that Petitioner required permanent restrictions. Unlike Dr. Durkin, however, he would not have restricted Petitioner beyond the limitations demonstrated in the FCE. (RX1).

Petitioner testified that his restrictions are incompatible with the responsibilities and physical demands of a standard commercial and residential electrician. He also testified that his union will not send an electrician to a job unless he is physically unrestricted.

Karen Taussig, Respondent's vocational counselor, also testified that Petitioner's restrictions prevent him from returning to work as an electrician.

On April 23, 2013 Respondent's third party administrator retained Karen Taussig, a certified vocational rehabilitation consultant, to assist Petitioner in returning to work. Ms. Taussig met with Petitioner on May 14, 2013, and conducted an interview focusing on his educational background, employment history, physical limitations and job goals. She noted that Petitioner liked using his mind, enjoyed working with his hands and had good people / communication skills. She concluded that Petitioner was unable or unlikely to return to his old job with Respondent. She suggested that he research re-training opportunities at local technical and community colleges. She wanted to complete a Transferable Skills Analysis to determine alternative job goals. She set a goal for Petitioner to secure employment with a new employer by November 1, 2013. At trial she explained that she had intended to complete the goal within six months and, for that reason, changed the date in later reports to December 1, 2013. (RX2).

On May 19, 2013, Ms. Taussig completed her Transferable Skills Analysis. She identified the following six occupations as potentially suitable for Petitioner: sales representative, building equipment and supplies; quality control technician; electronics mechanic; machine operator; electrical appliance servicer; driver, sales route. She then provided wage information for each job based on statistics from 2011 for the Chicago metropolitan area. A driver, sales route could expect to earn $8.65 an hour as an entry level wage. Three of the six jobs Ms. Taussig identified as potentially suitable for Petitioner paid entry-level wages under $9.25 an hour. (RX2).

Ms. Taussig ultimately concluded that re-training was not appropriate for Petitioner. She testified that the jobs for which he would be qualified after re-training would have paid the same range of wages as the jobs she identified in her Transferable Skills Analysis. Moreover, some of the jobs would have required physical demands that exceeded Petitioners permanent restrictions.

Petitioner looked for work under Ms. Taussig's guidance for over six months. He applied for hundreds of jobs. He received job leads from Ms. Taussig and developed them himself. He had several telephone and in person interviews. Ms. Taussig described Petitioner as motivated. She was complimentary of his job search efforts. (PX1 and RX2).

In November 2013, Petitioner applied for a job at Stella's Place, a gaming café. He found the job listed on Craigslist. After a couple of interviews, he was offered a position as a café attendant preparing and serving food and drinks. The starting wage was $8.25 an hour. Petitioner accepted the position, as he was previously instructed to do by Ms. Taussig. He then contacted Ms. Taussig and informed her of the job offer. He asked her whether he should maintain his acceptance of the job offer or call the employer back and decline the job. She told him that she would have to ask Respondent's claims adjuster and would call him back. She later contacted Petitioner and told him that she had spoken with Respondent's attorney and he had approved Petitioner's acceptance of the job offer. She counseled Petitioner to maintain his acceptance of the job offer from Stella's Place. She also advised him that she was suspending her vocational assistance. (RX2).

Stella's Place postponed the starting date for the job until the week of December 9, 2013. Ms. Taussig resumed her work with Petitioner to see if he could obtain a higher paying job in the meantime. She supplied him with job leads and he continued his job search on his own as well. Petitioner had additional interviews but was not offered any other jobs. (PX1 and RX2).

On December 11, 2012, Petitioner began working at Stella's Place. When they opened a new location in Hickory Hills he was promoted to manager. He currently earns $9.25 an hour and works 38 to 40 hours a week. The work is all within his restrictions and he enjoys it. Stella's Place is a growing company and Petitioner feels there is room for him to advance within the company. (PX2).

Ms. Taussig ceased providing vocational assistance to Petitioner after he began working at Stella's Place. She did not recommend that he continue his job search or seek a higher paying job.

Ms. Taussig followed up with Petitioner after he started work at Stella's Place. She feels the job is within his restrictions. She agreed that his wages from Stella's Place are within the range of wages for jobs that she identified as potentially suitable for Petitioner, although at the low end of the range.

At trial, Respondent's counsel asked for Ms. Taussig's opinion as to a "reasonable range of earnings that Petitioner could expect to earn." She referred to a Labor Market Survey she had completed in June 2013. Based on that survey she opined that a "reasonable range of earnings that Petitioner could expect to earn" was between $11 and $20 an hour with the average at $14.51 an hour.

On cross-examination, Ms. Taussig conceded that the jobs she included in her Labor Market Survey were the same jobs that she identified in her Transferable Skills Analysis. She explained that the wages identified in her Labor Market Survey were different from her Transferable Skills Analysis because they were based on her doing a survey of jobs being advertised, rather than a statistical database of all wages paid for those jobs in the Chicago metropolitan region. She only included jobs in her Labor Market Survey if she was able to speak with someone about the job requirements and rate of pay. Since the jobs included in her Labor Market Survey were potentially suitable for Petitioner, she provided these job leads to him and he pursued them. She testified that one of these job leads was a customer service position at Graybar, an electrical distributor. She acknowledged that Petitioner applied and interviewed for the job but it was not offered to him.

CONCLUSIONS OF LAW

The burden is upon the party seeking an award to prove by a preponderance of the credible evidence the elements of his claim. *Peoria County Nursing Home v. Industrial Comm'n*, 115 Ill.2d 524, 505 N.E.2d 1026 (1987). This includes the nature and extent of the petitioner's injury.

What is the nature and extent of the injury?

The Arbitrator adopts by reference all of the prior findings and conclusions into this Section without restating them herein.

The only disputed issue in this case is the nature and extent of permanent disability. More specifically, the parties agree that Petitioner is entitled to a wage differential award under Section 8(d)(1) of the Act but disagree as to the "average amount which he is earning or is able to earn in some suitable employment or business after the accident." 820 ILCS 305 8(d)(1) (2012). According to Petitioner, the appropriate measure is the amount he is currently earning in his job as a manager at Stella's Place. Respondent contends that Petitioner is able to earn more than he is currently paid and that the appropriate measure is the average wage of the occupations identified by its vocational counselor in her Labor Market Survey. For the reasons explained below, the arbitrator agrees with Petitioner.

First it should be noted that the Commission and courts have mandated that permanent partial disability benefits be awarded under section 8(d)(1) of the Act when the Petitioner has elected and proved entitlement to such an award. (See e.g. *Gallianetti v. Industrial Commission*, 315 Ill. App. 3d. 721, 734 N.E.2d 482 (2000),

> "(w)e conclude that the plain language of section 8(d) prohibits the Commission from awarding a percentage-of-the-person-as-a-whole award where the claimant has presented sufficient evidence to show a loss of earning capacity.... the only exception to this rule is where the claimant waives his right to recover under section 8(d)(1).... If claimant has requested a wage differential award and he proves that he qualifies for one, the plain language of section 8(d)(1) requires that he be awarded a wage-differential award." 734 N.E.2d at 488).

At the start of the hearing in this matter, Petitioner's counsel clearly stated that his client had elected to proceed under Section 8(d)(1) of the Act and that he was seeking a wage differential award. Furthermore, the arbitrator finds that Petitioner has met his burden of proving entitlement to such an award and that Respondent does not dispute this point.

In order to qualify for a wage differential award under section 8(d)(1), a claimant must prove: (1) partial incapacity which prevents him from pursuing his "usual and customary line of employment," and (2) an impairment of earnings. *Albrecht v. Industrial Commission*, 271 Ill. App. 3d. 756, 648 N.E.2d 923, 925 (1995). It is undisputed that Petitioner has sustained a permanent disability which precludes him from working as an electrician. Petitioner's treating physician, Dr. Durkin has imposed permanent restrictions of lifting no more than 10 pounds overhead, doing minimal overhead work and taking frequent breaks when performing overhead work, and only using a ladder to ascend or descend but not to perform work while standing on it. Respondent's examiner, Dr. Verma, agreed that Petitioner required permanent restrictions. Unlike Dr. Durkin, however, he would not have restricted Petitioner beyond the limitations demonstrated in the FCE. But even the FCE demonstrated that Petitioner was significantly limited in doing overhead activities and the examiner concluded that Petitioner did not have the capacity to do the above shoulder level demands of an electrician and that he "may not be able to complete his job effectively or safely."

It is undisputed that these restrictions are incompatible with Petitioner's specific job duties with Respondent. Petitioner testified that the majority of the work he performs for Respondent is above shoulder level and he often works while standing on a ladder. The fact that Respondent did not re-employ Petitioner after he was released with restrictions also supports this conclusion.

It is also undisputed that Petitioner's restrictions are incompatible with the general duties of an electrician. The examiner who performed the FCE determined that Petitioner was not capable of performing the above shoulder demands of an electrician as described in the Dictionary of Occupational Titles. This conclusion was not limited to the specific demands of Petitioner's job with Respondent. It applied to the job duties of an electrician generally. Petitioner also testified that his restrictions were incompatible with the responsibilities and physical demands of a standard commercial and residential electrician, and that his union will not send an electrician to a job unless he is physically unrestricted. Finally, Respondent's vocational counselor also concluded that Petitioner's restrictions prevent him from returning to work as an electrician, and she confirmed this fact on cross-examination.

To prove "impairment of earnings," Section 8(d)1 first requires a determination of "the average amount which (claimant) would be able to earn in the full performance of his duties in the occupation in which he was engaged at the time of the accident...." 820 ILCS 305 8(d)(1) (2012). The cases interpreting this language make it clear that it is acceptable for the Commission to use the claimant's Average Weekly Wage (AWW) as this amount. See e.g. *Gallianetti*, 315 Ill. App. 3d. 721, 730, 734 N.E.2d 482, 489 where the court reversed the Commission's denial of a Section 8(d)(1) award and directed the Commission on remand to use the AWW as the amount the claimant would be able to earn in the full performance of his occupation, and *Fernandes v. Industrial Commission*, 246 Ill.App.3d. 261,267, 615 N.E.2d 1191, 1195 (1993) where the court ruled the Commission could, in its discretion, use the wage rate in effect at the time of the accident rather than speculate on possible changes since the date of injury. In the instant case, the parties have agreed to use Petitioner's AWW of $1,797.61 as the amount he would be able to earn in the full performance of his occupation as an electrician.

Finally, the arbitrator will address the issue disputed by the parties, i.e. the "average amount which (Petitioner) is earning or is able to earn in some suitable employment or business after the accident." 820 ILCS 305 8(d)(1) (2012). To provide a foundation for her decision, the arbitrator will first provide a brief review of the jurisprudence guiding her analysis.

It is axiomatic that liability under the Act cannot be premised on speculation or conjecture but must be based solely on the facts contained in the record. Similarly, an award for loss of earnings cannot be based on speculation as to the particular employment level or job classification which a claimant might eventually attain. *Forest City Erectors v. Industrial Commission*, 264 Ill. App. 3d. 436, 441, 636 N.E.2d 969, 973 (1994). For this reason, the Commission and the courts have shown a preference for using actual wages earned by a claimant rather than projected wages established through a vocational expert to determine a claimant's post-accident earning potential. See e.g. *Benedia v. Reed Illinois Corp.*, 96 IIC 1282 where the Commission modified the arbitrator's award and used the earnings rate actually discussed with a potential employer rather than the rate the vocational rehabilitation counselor testified he would be able to earn. Also see *Gallianetti*, infra, where the court reversed the Commission's denial of a wage differential award under a manifest weight standard:

> We emphasize that while the labor market survey listed 21 employers in four types of positions, only one of the employers had openings within claimant's restrictions. We note that there were employers listed on the labor market survey... that paid more than the position that claimant ultimately obtained. However, the survey indicated that no openings were

> available in these positions. Moreover, claimant testified that he contacted these companies and was not offered employment." *Gallianetti* 315 Ill. App. 3d. 721, 730, 732 N.E.2d 482, 490

In this case Petitioner seeks to use his actual wages from Stella's Place as the basis of his award rather than the earnings Respondent's vocational counselor expected him to earn. Ms. Taussig's opinion that Petitioner is able to earn $14.51 an hour is speculative. Based upon the testimony of Petitioner and Ms. Taussig, regarding applications Petitioner filled out, the interviews had with respect to the submitted applications, the actual jobs available and Ms. Taussig's opinion that the Petitioner was very cooperative in the vocational rehabilitation services she supplied, the arbitrator does not find it credible.

Petitioner applied and interviewed for the jobs Ms. Taussig found potentially suitable and was not offered employment. Her opinion that Petitioner is able to earn an average of $14.51 an hour is based on the assumption that he would be employed in one of these jobs. The fact that he was not offered any of these jobs undermines that assumption. Moreover, Ms. Taussig's estimate of the earnings paid for these jobs is based on her Labor Market Survey which is at odds with the figures contained in her Transferable Skills Analysis. The arbitrator finds the wages set forth in the Transferable Skills Analysis to be more reliable than the Labor Market Survey because they are based on a statistical database of all wages paid for those jobs in the Chicago metropolitan region rather than the 10 employers that Ms. Taussig selected for inclusion in her Labor Market Survey. Finally, Petitioner's wages at Stella's Place are within the range of entry level wages for the occupations Ms. Taussig found potentially suitable in her Transferable Skills Analysis. She conceded this point on cross-examination, though she claimed they were at the low end of the wage scale. Petitioner's job at Stella's Place pays more than three of the six jobs Ms. Taussig identified as potentially suitable in her Transferable Skills Analysis.

When an employer directs a claimant to accept a job offer, as Respondent did in this case, the Commission and the courts have found that to be tantamount to a judicial admission that the job is suitable and represents a claimant's real earning capacity. In *Manring v. Continental Plastics*, 95 IIC 1072 the Commission held that the employer was estopped from claiming a job was not suitable when the employer placed the claimant in the job.

> "Suitable" is not defined in the Workers' Compensation Act. However, definitive interpretation is not necessary in this case since the employment Petitioner had at the time of trial is the employment he was placed in by Respondent. It is the employment Respondent expressly determined was best suited for Petitioner and it is the employment Petitioner was required to accept or face losing his benefits on grounds of non-cooperation. The object of vocational rehabilitation is to restore Petitioner to his previous earnings level... Respondent cannot claim to have satisfied its vocational rehabilitation responsibilities by placing Petitioner in a job and then later claim that the job Petitioner was placed in is not "suitable" or does not pay what Petitioner is capable of earning. Respondent is estopped from claiming that the job is not "suitable" for purposes of wage differential claim. Respondent cannot dispute a wage differential when Petitioner remains employed where Respondent placed him. At a minimum, the security job is prima facie a "suitable employment" within the meaning of

§ 8(d)(1) and Respondent presented no affirmative evidence to overcome this prima facie showing.

In *Yellow Freight Systems v. Industrial Commission*, 351 Ill. App. 3d. 789, 796, 814 N.E.2d 910, 915-916 (2004) the court affirmed the circuit court's reversal of the Commission's denial of a wage differential award under a manifest weight standard where the employer approved the claimant's acceptance of a job offer.

> The facts here show that claimant realized he was qualified for few jobs; nevertheless, claimant, on his own volition, applied for a job with a security company after a vocational expert retained by the employer suggested such a position. Claimant was offered the position. He accepted the position only after the employer approved it. Claimant earns $ 7 per hour as a security guard, but earned over $ 19 per hour from the employer. Claimant showed sufficient evidence of impaired earnings. Under these circumstances, the circuit court's determination that the Commission's refusal to award a wage differential was against the manifest weight of the evidence was proper.

The facts of the foregoing cases are strikingly similar to the case at bar and the arbitrator finds them to be controlling. Here, Respondent's counsel approved Petitioner's acceptance of the job offered to him by Stella's Place. Petitioner testified, and Ms. Taussig confirmed that the Petitioner had been instructed to accept a job offer if he received one, then to check with Ms. Taussig to make sure that the job was suitable in the Respondent's opinion and that they would be in agreement that Petitioner accept the employment. Respondent's vocational counselor testified that she checked with counsel for the Respondent and they tacitly agreed with this decision by advising Petitioner to accept the job offer. Moreover, despite its contention that Petitioner could be earning higher wages in other occupations that its vocational counselor found potentially suitable, neither Respondent nor its vocational counselor directed Petitioner to continue his job search. Vocational assistance stopped when Petitioner accepted the position, and began again when the start date was changed to a later date by Stella's Place. All vocational assistance and maintenance benefits were terminated once Petitioner began working at Stella's Place.

For all of the foregoing reasons, the arbitrator finds that Petitioner's job as a manager at Stella's Place is suitable employment under Section 8(d)(1) of the Act and that the average amount he is earning or is able to earn is $360.75 ($9.25 an hour x 39 hours). The arbitrator notes that this amount is greater than the quotient resulting from dividing Petitioner's gross wages by the number of weeks worked ($1,906.80 / 6.714 = $284). Nevertheless, Petitioner had been promoted to manager and was earning $9.25 an hour at the time of trial and, consistent with the mandate of Section 8(d)(1) of the Act, that is the average amount he was "earning."

As such, the arbitrator awards Petitioner wage differential benefits of $957.91 a week ($1,797.61 - $360.75 = $1,436.86 x ⅔) commencing December 11, 2013 and continuing until he reaches age 67 or five years from the date of the final award, whichever is later, because the injuries sustained caused a loss of earnings, as provided in Section 8(d)(1) of the Act. The arbitrator notes that the award does not exceed 100% of the State's average weekly wage in

covered industries under the Unemployment Insurance Act, the maximum wage differential benefit allowed under Section 8(b)4 of the Act.

ORDER OF THE ARBITRATOR

Respondent shall pay Petitioner permanent partial disability benefits, commencing December 11, 2013, of $957.91/week until the Petitioner reaches age 67 or five years from the date of the final award, whichever is later, because the injuries sustained caused a loss of earnings, as provided in Section 8(d)(1) of the Act.

Respondent shall be given a credit of $7,020.29 for permanent partial disability benefits that have been paid.

Respondent shall pay Petitioner compensation that has accrued from May 4, 2012 through February 24, 2014, and shall pay the remainder of the award, if any, in weekly payments.

Deborah L. Simpson
Signature of Arbitrator

April 8, 2014
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

Harvey Norris,

Petitioner,

14IWCC0971

vs.

NO: 13 WC 6826

Lowe's,

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, temporary total disability, prospective medical, nature and extent and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof. The Commission 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 6, 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.

14IWCC0971

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 $47,300.00. 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: NOV 13 2014
KWL/vf
O-11/3/14
42

Kevin W. Lamborn

Thomas J. Tyrrell

Michael J. Brennan

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

14IWCC0971

NORRIS, HARVEY
Employee/Petitioner

Case# **13WC006826**

LOWE'S
Employer/Respondent

On 5/6/2014, 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 0.45% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

1413 BRAD L BAGLEY PC
26 PUBLIC SQ
BELLEVILLE, IL 62220

INMAN & FITZGIBBONS LTD
COLIN M MILLS
201 W SPRINGFIELD AVE SUITE 10
CHAMPAIGN, IL 61820

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)

14IWCC0971

HARVEY NORRIS
Employee/Petitioner

v.

LOWE'S
Employer/Respondent

Case # 13 WC 006826

Consolidated cases: N/A

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **NANCY LINDSAY**, Arbitrator of the Commission, in the city of **HERRIN**, on **March 12, 2014**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

14IWCC0971

FINDINGS

On the date of accident, **08/23/2011**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$28,717.52**; the average weekly wage was **$552.26**.

On the date of accident, Petitioner was **61** 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 **$38,394.98** 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** for any medical bills paid by a group plan for which credit may be allowed under Section 8(j) of the Act.

ORDER

Respondent shall pay Petitioner temporary total disability benefits of $368.14 per week for 128 weeks, commencing September 28, 2011 through March 12, 2014 as provided in Section 8(b) of the Act.

Respondent shall pay reasonable and necessary medical expenses of $105.00 (the outstanding balance owed to Dr. Morgan -- PX 1, 1d) subject to the Medical Fee Schedule. Respondent shall receive credit for any medical bills it has paid.

Petitioner is awarded prospective medical care in the form of a right total knee replacement as recommended by Dr. Morgan.

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

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

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

Signature of Arbitrator

May 1, 2014
Date

ICArbDec19(b)

MAY - 6 2014

FINDINGS OF FACT and CONCLUSIONS OF LAW

This matter proceeded to hearing on March 12, 2014 before the Arbitrator in Herrin, Illinois pursuant to Petitioner's 19(b) Petition. At trial, the following issues were in dispute: (1) medical causal connection of Petitioner's disputed right knee condition (osteoarthritis), (2) Petitioner's entitlement to past and prospective medical benefits (recommended right knee arthroplasty) with regard to Petitioner's disputed right knee condition, (3) Petitioner's entitlement to temporary total disability benefits, and (4) the nature and extent of Petitioner's injuries/permanent partial disability benefits (if Respondent prevailed on causal connection). Petitioner was the sole witness at the hearing.

The Arbitrator finds:

Petitioner, a floor associate for Respondent, was involved in an undisputed accident on August 23, 2011. Petitioner testified that his job duties included assisting customers and stocking shelves. On August 23, 2011 Petitioner had been stocking shelves which required him to go up and down ladders for approximately three hours when he was descending a ladder and noticed his right knee started hurting real bad and he was in a lot of pain. Petitioner was taken to Human Resources where an Incident Report was completed. Petitioner's wife then picked him up and took him to the emergency room at Heartland Regional.

When he presented to the emergency room Petitioner, who was noted to be 5'6" and 324 pounds, reported that he was standing on a ladder and as he stepped down, he felt a "twist/tightening" in his right knee. Petitioner complained of pain with any walking/movement to his anterior knee. He denied any pain prior to the incident on the ladder. X-rays were taken of Petitioner's right knee which were read as revealing moderate degenerative changes of the lateral tibiofemoral joint and mild degenerative changes of the patellofemoral joint. There was no definite fracture or dislocation. Petitioner was diagnosed with a ligamentous sprain of the right knee, given a knee immobilizer and medication, was discharged, and told to follow-up with his primary care physician, Dr. Sean McCain. (PX 2).

On August 26, 2011, Petitioner was seen by Dr. Sean McCain. Petitioner presented with right knee pain "medially constant throbbing" and a "sharper pain" with walking and any weight bearing. Petitioner reported having a hard time using crutches due to his frame. Petitioner provided a consistent history of accident. Petitioner was noted to weigh 343 pounds. Petitioner complained of swelling, tingling, and numbness medially. Petitioner denied any knee locking or giving out. On examination, Petitioner displayed painful range of motion, tenderness on the right knee in the medial aspect, bruising on the superior aspect, and mild swelling and pain with the medial joint. Petitioner was prescribed Vicodin, rest, ice, elevation, and was to begin physical therapy. Petitioner was taken off work for two weeks. (PX 3).

Petitioner underwent physical therapy at the Occupational Performance Rehab Center on September 6 and September 7, 2011. (PX 4).

On September 9, 2011, Petitioner returned to Dr. McCain with complaints of right knee pain, swelling and redness. Petitioner reported that his physical therapy had just been approved in the

past week and his right knee was still painful, but he was able to walk albeit with a limp. Petitioner reported, and the doctor noted on examination, that Petitioner's right knee was still swollen. The doctor told Petitioner he needed conservative care for four weeks before obtaining an MRI. Petitioner was kept off work another 4 weeks. (PX 3).

Petitioner underwent physical therapy on September 12, September 14, September 15, September 19, September 21, and September 22, 2011. (PX 4).

Petitioner saw Dr. McCain on October 4, 2011 with complaints of right knee swelling, popping, pain, and trouble walking long distances. Petitioner's physical examination was unchanged in terms of minimal swelling and tenderness being noted. Negative McMurray's and negative Lachmann's tests were also noted. Noting minimal improvement, an MRI was ordered. There was no mention of Petitioner's work status. (PX 3).

Petitioner underwent physical therapy on October 4, October 5, October 6, and October 10, 2011. (PX 4).

On October 10, 2011, Petitioner underwent an MRI of the right knee which was read as revealing an abnormal appearance suggesting chronic tear of the posterior/body of the medial meniscus with superimposed changes of degenerative osteoarthritis in the medial compartment; no other evidence of meniscal or ligamentous tear; small metal susceptibility artifact anterior to the distal insertion ACL of uncertain etiology; and small joint effusion, small Baker's cyst. (PX 3, 5).

Petitioner returned to Dr. McCain on October 12, 2011. On examination, the doctor noted a tender medial aspect of the knee, no real swelling, and a negative Lachmann's test. The doctor reviewed the MRI and opined that Petitioner should see an orthopedic surgeon and continue with physical therapy. Petitioner was referred to Dr. David Wood. Dr. McCain took Petitioner off work effective October 12, 2011 through November 11, 2011. (PX 3)

Petitioner underwent further physical therapy on October 17, October 19, October 21, October 24, October 26, and October 28, 2011. (PX 4).

Petitioner saw Dr. Richard Morgan at Southern Orthopedic Associates on November 1, 2011 with the chief complaint of right knee pain. Petitioner reported that his symptoms began two months earlier when he stepped off of a ladder while working for Respondent. Petitioner had not worked since the accident and had been using a cane. Petitioner denied any problems with his knee prior to the incident. Plain x-rays showed early medial compartment disease. The MRI showed advanced medial compartment disease, and a chronic tear of the posterior horn and medial meniscus and an ACL deficient knee. Petitioner's weight in excess of 300 lbs. was noted and Petitioner told the doctor he had experienced problems with his left knee previously but did well with Supartz injections and wanted to try them on his right knee. This was agreed to. The doctor noted, "My suspicion is that at some point he'll probably need a total knee replacement." (PX 1b).

Petitioner underwent further physical therapy on November 4, November 7, November 9, and November 10, 2011. (PX 4).

Petitioner underwent further physical therapy on November 14, 2011. Petitioner was still experiencing medial knee pain. Petitioner was to continue physical therapy.[1] (PX 4).

Petitioner underwent Supartz injections into the right knee on November 29, 2011 and December 6, 2011. (PX 1b).

Petitioner had an office visit with Dr. McCain on December 6, 2011. (PX 3)[2]

Petitioner underwent three more Supartz injections into the right knee on December 13, 2011, December 22, 2011, and December 29, 2011. (PX 1b).

Petitioner saw Dr. McCain on January 9, 2012 with complaints of right knee pain, swelling, and bruising above his knee and into his ankle. Petitioner also complained of his knee locking and tingling and numbness extending down to his toes. On exam, he was tender in the medial aspect of his knee and, to some degree, his lower patella. Lachmann's and McMurray's remained negative. Petitioner was to re-evaluate with Dr. Morgan. (PX 3).

Petitioner returned to see Dr. McCain on January 26, 2012 regarding leg edema. The two discussed Petitioner's high cholesterol, hypertension, and diabetes. (PX 3)

Petitioner saw Dr. Morgan on February 2, 2012. Dr. Morgan described Petitioner as "substantially overweight." On exam he noted no effusion and no bruising in the knee. "His knee is pretty large secondary to his obesity." Full extension was estimated at 80-90 degrees of flexion, limited by pain. The injection had helped some but Petitioner was still experiencing a substantial amount of pain. It was also noted that an MRI demonstrated advanced osteoarthritis, a posterior horn tear, and an ACL deficiency of the knee. Petitioner was diagnosed with arthrofibrosis, and posttraumatic arthritis of the knee with exacerbation to exogenous obesity. Petitioner would remain off work and return in 3 to 4 weeks. (PX 1b).

Petitioner saw Dr. McCain on February 7, 2012. It was noted that Petitioner had right knee pain with constant swelling. Petitioner was noted to weigh 355 pounds. (PX 3).

Petitioner saw Dr. Morgan on March 1, 2012. It was noted that Petitioner presented with osteoarthritis of his knees. Petitioner was injured at work "when he was climbing stairs" and had a significant aggravation of degenerative joint disease. Petitioner was not using any assistive devices but was wearing special shoes. X-rays showed a medial compartment narrowing of both knees, with Dr. Morgan noting, "He lost most of the joint space on the left side, and probably half of the joint space on the right." Petitioner was diagnosed with degenerative joint disease. Petitioner wished to be reassessed in a month to see if he could go back in some light duty capacity. (PX 1b).

Petitioner saw Dr. McCain on March 7, 2012 with complaints of right knee pain. Dr. McCain noted that it was difficult to evaluate Petitioner's right knee swelling due to body habitus (Petitioner noted to weigh 348.6 pounds). (PX 3).

Petitioner returned to Dr. Morgan on April 3, 2012. Petitioner was noted as having osteoarthritis of the knees which was aggravated, and being substantially overweight. Therapy had not helped,

[1] This is the last physical therapy visit in the record, however.
[2] Details of the visit are not evident from the record.

and Petitioner did not want to do anything definitive with the knees at that point, but it was noted that he would probably need a knee replacement. Petitioner was noted to have varus habitus of both knees. X-rays showed Petitioner's knee was "bone-on-bone on both sides." Petitioner was taken off work and was to return in one month at which time it was hoped he could return to work part-time. (PX 1b).

Petitioner saw Dr. McCain on April 18, 2012. Petitioner complained of right knee pain, which had become more painful over the last week. It was noted that he was not participating in therapy. Petitioner was noted as weighing 350 pounds. (PX 3).

Petitioner saw Dr. Morgan on May 8, 2012. Petitioner was noted as having osteoarthritis of the knees. Petitioner injured his knee and had a superimposed meniscal tear on the right knee. Petitioner had continuing medial compartment pain. Standing x-rays showed some loss of joint space in the area and osteoarthritis. Petitioner remained off work. (PX 1b).

Petitioner saw Dr. McCain on May 17, 2012. Petitioner complained of right knee pain. It was noted that he was recently seen by Dr. Morgan and was undergoing injections which had provided a slight benefit. Petitioner was noted as weighing 349 pounds. (PX 3).

Petitioner saw Dr. McCain on June 22, 2012. Petitioner complained of right knee pain and noted the August 23, 2011 accident. Petitioner was diagnosed with joint pain and obesity (346 pounds). Weight loss and diet were discussed. (PX 3).

Petitioner returned to Dr. Morgan on July 3, 2012. Petitioner's request for Supartz had been denied and he was reportedly to the point where he couldn't really walk from his car into Wal-Mart without pain. X-rays revealed significant degenerative arthritis and a tear of the meniscus. Petitioner had pre-existing arthritis with a superimposed meniscus tear. The doctor doubted that the arthroscopic procedure would help, and that Petitioner was probably going to need a total knee replacement at some point. Dr. Morgan noted Petitioner really couldn't walk or stand for any length of time and had not made any substantial progress in his weight loss. Petitioner also had not made any substantial progress with maintaining his weight. (PX 1b).

Petitioner presented for his first Supartz injection into the right knee on July 19, 2012. (PX 1b).

Petitioner presented for his second Supartz injection into the right knee on July 26, 2012. (PX 1b).

Petitioner saw Dr. McCain on July 30, 2012. Petitioner complained of right knee pain. It was noted that he was seeing Dr. Morgan and receiving injections. Petitioner was noted as weighing 351.8 pounds, and weight loss was discussed. (PX 3).

Petitioner presented for his third Supartz injection into the right knee on August 2, 2012. (PX 1b).

Petitioner presented for his fourth Supartz injection into the right knee on August 9, 2012. (PX 1b).

Petitioner presented for his fifth Supartz injection into the right knee on August 21, 2012. (PX 1b).

Petitioner saw Dr. McCain on August 21, 2012. This appointment was mainly to address Petitioner's diet, exercise, and medication usage. Petitioner was noted to be 350 pounds. (PX 3).

Petitioner saw Dr. James Stiehl on September 12, 2012 for an independent medical examination ("IME") at the request of Respondent. A report issued on September 18, 2012. By history Petitioner had never had any significant prior "medical episodes" with his knee and on August 23, 2011 he was descending a ladder when he stepped off the bottom rung, twisted, and felt a sudden pain in his right knee. Petitioner then developed anterior knee pain and began a course of treatment (summarized by the doctor). Petitioner added that despite his morbid obesity (Petitioner was 5/6" and 330 lbs.) he really had not had "much trouble" with his knees. On examination Dr. Stiehl noted that while Petitioner was morbidly obese most of it was situated in his trunk. On examination Petitioner had exquisite posterolateral joint line discomfort to palpation and minor anterior discomfort. After his examination of Petitioner and review of his records, the doctor opined that Petitioner probably tore his right medial meniscus after the August 23, 2011 accident and that his condition had not yet resolved and Petitioner was continuing to suffer residuals from the torn meniscus. The finding was substantiated by an MRI scan and a physical exam, which showed persistent fairly severe posteromedial joint line discomfort. However, the doctor opined that Petitioner's early degenerative arthritis was not a result the accident and was an incidental finding which related to his pre-existing morbid obesity. The doctor recommended an arthroscopic medial meniscectomy, and opined that the condition would not respond to physical therapy. Petitioner was to avoid stooping, twisting, bending or climbing activities, and should not lift more than 15 to 20 pounds. Maximum medical improvement was expected four to six weeks after the surgery. (RX 1, Exhibit 2).

Petitioner presented to Dr. Morgan on September 18, 2012. Dr. Morgan noted that Petitioner had osteoarthritis of both knees. Radiographically, Petitioner's left knee actually looked worse but the right knee was more symptomatic. Standing x-rays of his knee showed loss of medial joint space. Petitioner had perhaps half of normal joint space with early reactive osteophytes and subchondral sclerosis. The left side looked a bit worse (same process but essentially bone-on-bone on that side). Both sides hurt but the right was worse. Petitioner had joint fluid therapy a month ago with no improvement. Petitioner was to be set up for a right total knee arthroplasty. (PX 1b).

Petitioner returned to Dr. Morgan on October 30, 2012. It was noted that Petitioner had a torn meniscus on top of degenerative arthritis. Standing x-rays showed narrowing of both medial compartments, essentially bone-on-bone. The MRI demonstrated a torn medial meniscus. Petitioner was unable to work. The doctor did not think that a meniscectomy was going to help as Petitioner already had significant degenerative disease. The doctor did not think the meniscectomy would hurt him, but he did not think that it would help. Petitioner needed a total knee on the right side, according to Dr. Morgan. (PX 1b).

Petitioner saw Dr. McCain on November 21, 2012 with complaints of right knee pain, among other things. The doctor noted that it was hard to evaluate swelling due to "body habitus." It was noted that Petitioner was back to work at four hours per day, per Dr. Stiehl, and that Dr. McCain agreed with this plan. It was noted that Petitioner was unable to use the knee brace, but could not due to his "body habitus." (PX 3).

Petitioner underwent an arthroscopy with debridement of the medial femoral condyle with partial medial meniscectomy on December 5, 2012. Petitioner's diagnosis was listed as osteoarthritis of the right knee. During the procedure Dr. Morgan found grade 3 chondromalacia of the femoral trochlea, a myriad of small cartilaginous flecks in the medial and lateral gutters, a stressed medial compartment, significant grade 4 chondromalacia of the weightbearing portion of the medial femoral condyle, a degenerative tear of the medial meniscus, and grade 2 to 3 chondromalacia changes in the lateral compartment. (PX 1b).

Petitioner returned to Dr. Morgan on December 13, 2012. Dr. Morgan noted that he had schedule Petitioner for a total knee replacement but had proceeded with a scope and debridement per an IME recommendation. Petitioner's wounds looked fine and the doctor described Petitioner's knee as "horrible" as he had eburnation of the bone in the femoral trochlea and almost the same on the medial femoral condyle. Petitioner was walking with a cane. The doctor opined that Petitioner would at least be transiently helped by the arthroscopy, but that his symptoms would probably recur. Petitioner was to begin physical therapy. (PX 1b).

Petitioner underwent physical therapy at the Orthopedic Institute of Southern Illinois through December 2012 and January 2013. (PX 1b).

Petitioner returned to Dr. Morgan on January 31, 2013. The doctor noted that what he found during prior surgery was a "horribly degenerated knee." While Dr. Morgan didn't think the arthroscopy would really help, it was reluctantly performed and while Petitioner had some initial benefit from it any benefits had subsided in the last month or so. Petitioner still had debilitating pain. Petitioner reported he was walking to try and lose some weight but distance was minimal and without Vicodin he really couldn't do it. X-rays showed to significant deterioration of both knees, actually a bit worse on left the right. The doctor believed Petitioner should proceed toward total knee arthroplasty, and was kept off work. (PX 1b).

Petitioner signed his Application for Adjustment of Claim on February 20, 2013. (AX 2)

Petitioner returned to Dr. Stiehl for a follow-up IME on February 25, 2013. In his report Dr. Stiehl noted Petitioner had continued complaints of anterior knee pain and his knee was sore much of the time. Petitioner acknowledged the pain in the posteromedial corner of his knee was now gone but he was having difficulty standing for more than four hours per day or walking any real distance. On examination, the doctor noted that Petitioner was morbidly obese, weighing 345 pounds with a BMI of 345 pounds. The doctor again opined that Petitioner suffered a low-grade twisting injury on August 23, 2011 when he stepped off of a ladder which caused him to aggravate or cause a degenerative meniscus tear. Therefore, the doctor diagnosed him with pre-existing degenerative arthritis of the right knee and a degenerative tear of the right medial meniscus. Otherwise, Petitioner had chronic synovitis of the right knee and evidence of moderate degenerative arthritis. The synovitis was considered "obvious" as Petitioner had chronic anterior pain. The degenerative arthritis related to the fact that Petitioner had an arthroscopic procedure, which showed clear-cut evidence of chondromalacia grade IV involving the medial femoral condyle and tibial plateau and grade III involving the lateral compartment. He did not have bone on bone arthritis and that would be suggested by the prior MRI scan that was done in 2011. (RX 1, Exhibit 3).

Dr. Stiehl opined that the torn medial meniscus clearly could have been caused by the August 23, 2011 incident. Traumatic arthritis would not be a cause as traumatic arthritis usually relies on a

significant traumatic injury that is followed by several years of chronic use, which causes the knee to fail. Petitioner had "advancing arthritis of the knee from the outset on August 23, 2011," and the doctor did not believe that the condition was altered or changed since that time. (RX 1, Exhibit 3).

However, at the time of the examination, Dr. Stiehl did not believe Petitioner had fully recovered from his arthroscopic surgery and he noted Petitioner was continuing to have anterior knee pain, which the doctor indicated could be related to his recent surgery and not necessarily the prior arthritic condition. Therefore, Dr. Stiehl did not believe that Petitioner's meniscal problem, which was causally related to the August 23, 2011 condition, had resolved. (RX 1, Exhibit 3, pp. 3-4/5).

The doctor's opinion was that Petitioner did not require a total knee replacement at that time to cure the effects of the August 23, 2011 injury. At most, Dr. Stiehl believed Petitioner had sustained a torn medial meniscus at that point, and he did not believe that a total knee replacement was needed to correct the condition of a torn meniscus. Dr. Stiehl did not believe Petitioner was at maximum medical improvement (MMI) as he was not quite three months out from the procedure. Additionally, he noted that Petitioner had chronic synovitis of his knee for a long period of time resulting from the torn meniscus and disability which would require several months for that to completely resolve. Furthermore, as the doctor had noted in the past, Petitioner has moderate arthritis, "which will be a confounding problem as well and though that was preexisting, can significantly be aggravated by the arthroscopic procedure and the torn meniscus. (RX 1, Exhibit 3, p. 5/5).

Since Petitioner had not recovered from the arthroscopic procedure, Dr. Stiehl felt Petitioner should not stand for more than four hours a day, nor should he be lifting more than 10-20 pounds on a repetitive chronic basis. The restrictions would apply until his anterior knee pain had resolved which could be over the next one to two months. He further noted that it was also possible that Petitioner's persistent pain related to the moderate degenerative arthritis as well. Dr. Stiehl felt Petitioner would require months of physical therapy before he would be at MMI. (RX 1, Exhibit 3).

Petitioner next saw Dr. Morgan on February 28, 2013. Petitioner had significant degenerative joint disease which was aggravated by an on-the-job injury. The doctor recommended a total knee arthroplasty. It was noted that "an IME" recommended a knee scope. Petitioner indicated he would like to try the knee scope, and it did not help. He went back to see Dr. Stiehl. He recommended physical therapy which did not help. Dr. Morgan still felt like Petitioner needed a total knee replacement, and Petitioner was kept off work. (PX 1b).

On February 28, 2013, Dr. Morgan read x-rays which showed almost complete obliteration of the medial side of the left knee, less so on his right side. (PX 1b).

Petitioner saw Dr. McCain on March 18, 2013. Petitioner was noted as "morbidly obese" and at 342 pounds. There was no treatment rendered with regard to the right lower extremity. (PX 3).

Petitioner saw Dr. Morgan on April 11, 2013. It was noted that Petitioner had injured his knee and torn a meniscus. He already had pretty significant arthritis but it was aggravated to the point that he was unable to work. He was taking Vicodin and using a cane. The doctor opined that Petitioner needed to lose weight, but still needed to proceed with the total knee. (PX 1b).

Petitioner saw Dr. McCain on April 22, 2013. Petitioner was noted as "morbidly obese" and at 339 pounds. There was no treatment rendered with regard to the right lower extremity. (PX 3).

Petitioner saw Dr. Morgan on July 11, 2013. Standing x-rays of both knees demonstrated marked narrowing of the medial compartment and joint spaces. Dr. Morgan again opined that Petitioner needed a total knee replacement. (PX 1b).

Petitioner saw Dr. Stiehl for a third examination on September 11, 2013 and a written report followed. It was noted that Petitioner weighed 335 pounds and had a BMI of 54. Petitioner continued to complain of chronic anterior and medial joint line pain. Dr. Stiehl noted that Petitioner did not have any effusion of his right knee nor did he have ligamentous instability. Petitioner was diagnosed with early to moderate degenerative arthritis of the right knee with severe super obesity. (RX 1, Exhibit 4).

Dr. Stiehl opined that Petitioner's torn meniscus that was aggravated by the August 23, 2011 accident had resolved. Dr. Stiehl did not believe that Petitioner's obesity nor pre-existing arthritis were aggravated or accelerated by the accident. Dr. Stiehl noted Petitioner's long-standing history of obesity that had worsened, as well as other comorbid conditions that were noted with chronic obesity. Petitioner had evidence of progressive degenerative arthritis of the right knee (RX 1, Exhibit 4).

Dr. Stiehl noted that when he reviewed the original MRI scan, it was apparent that Petitioner had osteophytes that had been significant and preexisting by at least a couple of years. The joint spaces on the MRI scan, however, were reasonably well-maintained for the doctor to make a diagnosis of early to moderate arthritis. Dr. Stihel opined that causation of the arthritis related to either a traumatic injury or a severe fracture or severe ligamentous injury or a longstanding degenerative process that has occurred over several years. Simply put, the timeline of the accident and the injury did not allow Dr. Stiehl to attribute the longstanding degenerative condition to the 2001 accident in any manner. (RX 1, Exhibit 4).

Dr. Stiehl also opined that Petitioner had progressive degenerative arthritis and that he would attribute this to the super obesity that exists, which was clearly independent of the work accident. Dr. Stiehl did not believe that Petitioner could walk normally or walk any distance given his condition of super obesity. (RX 1, Exhibit 4).

Dr. Stiehl opined that Petitioner had a temporary aggravation of pre-existing arthritis which had "most likely" returned to pre-injury status. (RX 1, Exhibit 4).

Dr. Stiehl believed that Petitioner had reached maximum medical improvement and that it was unlikely that any additional treatment would change Petitioner's condition. However, all treatment received to that date was reasonable and necessary to treat his work-related injuries. (RX 1, Exhibit 4).

Petitioner was given work restrictions of a sedentary position, and based on the AMA Guidelines for lower extremity impairment using the Sixth Guidelines and Table 16, #3, Mr. Norris has a partial medial meniscectomy for which Dr. Stiehl attributed a 2% disability of the lower extremity, which translated into a 1% whole body impairment based on the AMA Sixth Guidelines. (RX 1, Exhibit 4).

Petitioner saw Dr. Morgan on October 8, 2013. Petitioner was diagnosed with osteoarthritis of the knee. Petitioner had significant degenerative arthritis and significant medial compartment collapse and reactive osteophytes. It was noted that Dr. Stiehl felt that the current inability to work was secondary to the obesity and arthritis and had nothing to do with the accident. Petitioner would remain off work. (PX 1b).

Dr. Richard Morgan was deposed on November 21, 2013. Dr. Morgan, an orthopedic surgeon, testified consistent with his office notes. Dr. Morgan rendered treatment to Petitioner from November 1, 2011 through October 8, 2013. At the initial appointment, Petitioner filled out an intake form and noted that he had complaints of right knee pain after stepping off a ladder at work. Since that time Petitioner had experienced ongoing pain. Petitioner had a history of exogenous obesity, a history of hypertension and a history of diabetes. Petitioner reported a history of problems with the opposite knee, and that he had done viscoelastic therapy for that knee (PX 1). Dr. Morgan believed that this would be an appropriate course of treatment for the advanced medial compartment diseased and tear of the posterior horn that was present on x-ray and MRI. (PX 1).

Dr. Morgan testified about Petitioner's treatment and course of injections. As of October 2012, Petitioner was still having pain in the right knee, and Dr. Stiehl had recommended a right knee arthroscopy and physical therapy. (PX 1). Dr. Morgan opined that he did not believe that the arthroscopy would help long-term; therefore, he recommended a total knee replacement. (PX 1). Nonetheless, Petitioner underwent the arthroscopy on December 5, 2012. Subsequent to the operation, Petitioner still reported pain, and Dr. Stiehl recommended further physical therapy. (PX 1).

Dr. Morgan opined that Petitioner underwent a course of physical therapy after the surgery, though it did not provide Petitioner with any improvement.

Dr. Morgan opined that Petitioner had not reached maximum medical improvement as of October 8, 2013, and that he was not going to improve until he underwent the knee replacement for the diagnosed degenerative arthritis of the right knee. (PX 1).

Dr. Morgan opined that Petitioner's right knee symptoms had "dramatically escalated" since the accident, when asked if he had "an opinion based on a reasonable degree of medical certainty as to whether or not this incident at work accelerated those preexisting degenerative changes to the point symptomatically that surgery was required." (PX 1).

With regard to Petitioner's left knee, of which Dr. Morgan could not opine as to treatment previously rendered, it was Dr. Morgan's opinion that it was essentially the same as the right knee with regard to the degree of the arthritis. (PX 1).

Dr. Morgan opined that there was "honestly nothing" in the right knee that he could structurally relate to the accident when reviewing the October 10, 2011 MRI. (PX 1). Dr. Morgan opined that Petitioner's obesity and diabetic condition were contributing factors to Petitioner's degenerative arthritis. (PX 1).

On cross-examination, Dr. Morgan opined that he would argue with the fact that he treated Petitioner with regard to his left knee beginning in 2008, though he could not find records in this

regard. (PX 1). Dr. Morgan agreed that Petitioner's November 11, 2008 diagnosed osteoarthritis with a superimposed medial meniscal injury to the left knee was the same diagnosis with regard to Petitioner's right knee, subsequent to August 23, 2011. (PX 1).

Dr. Morgan testified that Petitioner, who is significantly obese, reported that he stepped down off of a ladder and injured his knee. There was no report of a fall or a twist provided to him. (PX 1).

Dr. Morgan opined that it is true that morbidly obese individuals, such as Petitioner, are more prone to developing osteoarthritis due to the extra weight adding wear and tear on the joints. Dr. Morgan opined that Petitioner's obesity had significance with regard to his left knee diagnoses prior to 2011, though Petitioner's right knee arthritis was not advancing to a degree that any activity of normal daily living would have rendered it symptomatic. (PX 1). However, Dr. Morgan opined that the objective findings in Petitioner's right knee would "not be much different now than they would have been had he not gone to work on [August 23, 2011], and that they would essentially be the same. (PX 1).

With regard to the objective findings on the 2011 MRI, Dr. Morgan opined that he could not opine as to how long the osteophytes found had been present in the knee, but he opined that the osteophytes were not unusual. (PX 1).

Dr. Morgan agreed that Petitioner could perhaps be a candidate for a total left knee replacement if Petitioner reported symptoms, including pain. In fact, Petitioner's radiographic findings in the left knee were worse than on the right. (PX 1).

With asked about Petitioner's potential recovery from a total knee replacement, given his weight, Dr. Morgan opined that it raised concerns and made it more challenging. He also opined that the vast majority of patients that he performs total knee replacements on are overweight. (PX 1).

Petitioner saw Dr. Morgan on December 17, 2013. The doctor opined that Petitioner "probably" had an aggravation of arthritis, and that Petitioner was waiting to get approval for surgery. Standing x-rays of both knees showed severe osteoarthritis, medial compartment narrowing of both knees. No evidence of fracture or dislocation was noted. Petitioner was kept off work. (PX 1b).

The evidence deposition of Dr. James Stiehl was taken on February 19, 2014. Dr. Stiehl, a Board Certified Orthopedic Surgeon, testified that he is a fellow of the American Academy of Orthopedic Surgeons. He also testified that he is a member of the American Academy of Disability Examining Physicians. Dr. Stiehl testified that only 10% of his practice is devoted to performing independent medical examinations. (RX 1).

With regard to his independent medical examination of Petitioner on September 11, 2012, Dr. Stiehl noted that Petitioner had initially been diagnosed at the hospital with moderate degenerative arthritis, and that Dr. McCain had recommended physical therapy. There was some discrepancy over the October 10, 2011 MRI as Dr. Morgan read that it revealed an torn medial meniscus and an anterior cruciate ligament tear. Dr. Stiehl believed that the anterior cruciate ligament was intact after reviewing the MRI scan. (RX 1).

Dr. Stiehl opined that there were non-occupational risk factors with regard to the osteoarthritis including Petitioner's age (62) and BMI (53) which classified Petitioner as super obese. These

were very, very high risk factors for osteoarthritis and had nothing to do with occupation. (RX 1).

Dr. Stiehl recognized that Petitioner was diagnosed with early osteoarthritis with a superimposed medial meniscal injury, cartilage irregularity and degenerative changes of the left medial and lateral meniscus in 2008, which was "probably" an identical finding to those of the right knee, and consistent with Petitioner's age and body habitus. (RX 1).

Dr. Stiehl testified that it was probable that the right medial meniscus tear could have been aggravated by the August 23, 2011 accident. An arthroscopic procedure was recommended for that diagnosis. The early degenerative arthritis was not caused by the accident, was an incidental finding, and related to pre-existing morbid obesity. There was no treatment recommendation for that diagnosis. (RX 1).

Dr. Stiehl then testified with regard to his February 2013 examination. At that time, Petitioner was post-arthroscopy and still had chronic anterior knee pain. Petitioner was 345 pounds, and was increased ion size from the initial examination. Upon examination of the knee, Petitioner did not have instability, and did not have posterior medial joint line pain, which was found before. (RX 1).

The doctor again opined that the accident could have aggravated a degenerative meniscal tear that may have pre-existed, but was made worse. The degenerative arthritis was pre-existing and was just as bad before the accident as it was after the accident. Dr. Stiehl opined that the pre-existing degenerative arthritis was not caused, aggravated, or accelerated by the accident to the point where Petitioner would require surgery. (RX 1).

Dr. Stiehl based this opinion on the fact there was no traumatic injury that could have caused an injury to the articular surfaces of the knee. Dr. Stiehl gave examples of a traumatic injury – falling off of a 20-foot scaffold, a car accident, a knee fracture with a definite articular surface fracture. Dr. Stiehl explained that there has to be evidence that there was damage to the articular surface, and no MRI scan demonstrated evidence of damage to the knee. When asked if the work-related meniscal injury had resolved by the time of the second exam, Dr. Stiehl responded "Yes." (RX 1, p. 17) He further testified that Petitioner did not require any treatment for work-related injuries at that time. (RX 1).

Dr. Stiehl next testified with regard to his final examination of Mr. Norris on September 11, 2013. Petitioner's weight was the same at this examination. Petitioner again did not have posteromedial joint line discomfort that he found initially, and Petitioner walked without antalgic gait (without a limp). Petitioner was diagnosed with fairly severe chronic obesity and fairly advanced degenerative arthritis of the right knee. Petitioner was also diagnosed with possible a temporary aggravation of pre-existing arthritis, but that aggravation had returned to pre-injury status (RX 1).

Dr. Stiehl testified that Petitioner's diagnosis with regard to the degenerative arthritis would have been the same had he not had the August 23, 2011 work accident. To the point, any normal activity of daily living would have made Petitioner's arthritic condition more symptomatic as Petitioner had all risk factors – age, morbid obesity.

Notwithstanding causation issues, Dr. Stiehl testified that he has done over 2,500 knee replacements and Petitioner would be at the "very very bottom" of the list due to obesity and the risk proposed. (RX 1).

Dr. Stiehl testified that Petitioner would be a candidate for a total right knee replacement had he not had the August 23, 2011 accident and, in fact, even if he had never worked a day in his life for Respodent. (RX 1).

At the arbitration hearing, Petitioner testified consistently with regard to the history of accident and with regard to the nature of his medical treatment. Petitioner testified that he had a temporary improvement following the December 2012 arthroscopic procedure.

Petitioner testified that he had gained 50 pounds since August 2011, and estimated that he currently weighed 335 pounds. Petitioner testified that his right knee felt the same on the date of Arbitration as it did immediately following the accident. Petitioner complained of constant pain and numbness, and that he uses a cane (that was not prescribed or recommended by any medical doctor). Petitioner testified that he could walk 30 minutes at a time before his knee swells, though drives an automobile. Petitioner testified that he attended three independent medical examinations with Dr. James Stiehl.

The Arbitrator concludes:

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

Petitioner's current condition of ill-being in his right knee is causally related to Petitioner's August 23, 2011 accident. This conclusion is based upon a chain of events, the testimony of Dr. Morgan, and the testimony and written reports of Respondent's examining physician, Dr. Stiehl (especially those portions of the reports which were not addressed during the doctor's deposition.) The parties do not dispute that Petitioner's right medial meniscus tear is causally related to the August 23, 2011 accident. Respondent contends Petitioner reached maximum medical improvement for that condition on September 11, 2013 and that Petitioner's right knee condition since then is not causally related to his work accident.

It is well established that if a pre-existing condition is aggravated, exacerbated or accelerated by an accidental injury the employee is entitled to benefits, including prospective medical care. Notwithstanding Petitioner's age of 61, morbid obesity, hypertension and diabetes, Petitioner was regularly employed by Respondent as a floor associate prior to his accident. Petitioner had not previously treated for any injury to, or condition of, his right knee (degenerative or otherwise) prior to his undisputed accident of August 23, 2011.

Following his accident Petitioner experienced the immediate onset of right knee pain which was promptly reported, treated in the emergency room, treated conservatively by Petitioner's family doctor, and more aggressively by Dr. Morgan, an orthopedic surgeon. To a degree, Petitioner's course of treatment has been directed by Respondent vis a vis Dr. Stiehl. Dr. Morgan reluctantly agreed to perform an arthroscopic procedure rather than a total knee replacement as that is what Dr. Stiehl recommended. When that failed, he again recommended a total knee replacement.

It was the opinion of Dr. Morgan that Petitioner's accident aggravated Petitioner's pre-existing degenerative changes in his right knee to the point he now requires a total knee replacement. To

the contrary Dr. Stiehl believed the accident did not cause or aggravate those changes in any way. However, it is important to carefully read all of Dr. Stiehl's written reports and not just his deposition testimony as his written reports tie Petitioner's ongoing condition and complaints together based upon the arthroscopic procedure and its sequale. According to Dr. Stiehl's written report from the February 15, 2013 examination of Petitioner, Petitioner was continuing to deal with residuals of his torn medial meniscus. Petitioner also had chronic synovitis which the doctor opined was due to the arthroscopic surgery. Dr. Stiehl also acknowledged in that report that Petitioner's pre-existing arthritis could be "significantly aggravated" by both the arthroscopic procedure he underwent and the torn meniscus (RX 1, Ex. 3, p. 5/5) After his third examination of Petitioner, Dr. Stiehl solely focused his opinions on the question of causation between the work accident itself and Petitioner's arthritis. He did not follow-up with his causation analysis as discussed in his February 2013 letter -- that is, he didn't address whether Petitioner's condition in September of 2013 might still be related to the torn medial meniscus and arthroscopic procedure. If it was a contributing factor in February of 2013 why wasn't it so in September? Furthermore, while Dr. Stiehl noted a "temporary aggravation" of Petitioner's pre-existing arthritis in his September 2013 letter he never addressed when that temporary aggravation would have resolved.

In summary, ongoing causation is established herein under two theories. The first theory is Dr. Morgan's -- ie., the accident of August 23, 2011 aggravated Petitioner's pre-existing degenerative arthritis and necessitates a total knee replacement. The second theory is that of Dr. Stiehl's -- ie., Petitioner's ongoing problems are not due to the accident but from the arthroscopic surgery necessitated by Petitioner's medial meniscus tear. Either way, Petitioner's current condition of ill-being in his right knee is causally related to his August 23, 2011 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?**

Two bills were submitted into evidence (PX 1, 1c and 1d). The parties stipulated the surgical bill (PX 1, 1c) has been paid. In light of the Arbitrator's conclusion as detailed above with regard to "Issue F," the Arbitrator further concludes that Respondent is liable for the payment of Dr. Morgan's bill as found in PX 1, 1d. It appears there is an outstanding balance of $105.00. Respondent shall receive credit for any medical bills it has paid (RX 2).

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

In light of the Arbitrator's conclusion as detailed above with regard to "Issue F," the Arbitrator further concludes that the recommended right knee arthroplasty by Dr. Morgan is causally-related to injuries suffered as a result of the August 23, 2011 accident and, as such, Petitioner is entitled to prospective medical care in the form of a total knee replacement as recommended by Dr. Morgan.

Issue L: **Is Petitioner entitled to further Temporary Total Disability Benefits**

The parties agree that Petitioner was temporarily totally disabled from September 28, 2011 through September 26, 2013, a period of 104 2/7 weeks. (See AX 1) They further agree that Respondent paid $38,394.98 in temporary total disability benefits from September 28, 2011 through September 26, 2013, representing 104 2/7 weeks. (AX 1). In essence, Respondent's dispute regarding temporary total disability was based upon the causation determination and

based upon that determination as set forth above, as well as the stipulation of the parties (AX 1) the Arbitrator further concludes that that Petitioner is entitled to temporary total disability benefits from September 28, 2011 through March 12, 2014, a period of 128 weeks. Respondent is to receive credit for TTD benefits previously paid. (AX 1)

****

STATE OF ILLINOIS)
) SS.
COUNTY OF)
WILLIAMSON

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Maria Lopez,
Petitioner,
vs.

14IWCC0972

NO: 12 WC 28835

Glister-Mary Lee Corporation,
Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of accident, medical expenses, permanent partial disability 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 17, 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: NOV 13 2014
KWL/vf
O-11/3/14
42

Kevin W. Lamborn

Thomas J. Tyrrell

Michael J. Brennan

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

14IWCC0972

LOPEZ, MARIA
Employee/Petitioner

Case# 12WC028835

GILSTER MARY LEE CORPORATION
Employer/Respondent

On 1/17/2014, 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:

4377 MICHAEL MILES
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PO BOX 907
CARBONDALE, IL 62903

0693 FEIRICH MAGER GREEN & RYAN
PIETER SCHMIDT
2001 W MAIN ST SUITE 101
CARBONDALE, IL 62903

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 14IWCC0972

Case # 12 WC 028835

Consolidated cases: N/A

Maria Lopez
Employee/Petitioner

v.

Gilster-Mary Lee Corporation
Employer/Respondent

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable Molly Dearing, Arbitrator of the Commission, in the city of Herrin, on November 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 _____

14IWCC0972

FINDINGS

On **February 2, 2012,** Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$19,540.65**; the average weekly wage was **$440.10**.

On the date of accident, Petitioner was **38** years of age, ***married*** with **5** dependent children.

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

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

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

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

ORDER

Petitioner did not sustain an accident that arose out of and in the course of her employment with Respondent. Claim is denied. All remaining issues are moot.

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

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

Signature of Arbitrator

January 11, 2014
Date

JAN 17 2014

STATE OF ILLINOIS)
) ss.
COUNTY OF WILLIAMSON)

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Maria Lopez,
Employee/Petitioner,

v.

Gilster-Mary Lee Corporation,
Employer/Respondent.

14IWCC0972

Case No. 12 WC 28835

MEMORANDUM OF DECISION OF ARBITRATOR

FINDINGS OF FACT

At the time of her accident, Petitioner was thirty eight years of age. Arb. X. 1. Petitioner is a machine operator for Respondent, and has been employed with Respondent for the last five years. She has been employed by Respondent for a total of fifteen years.

On February 2, 2012, Petitioner was working the 11:00 p.m. to 7:00 a.m. shift. She is allotted thirty minutes for lunch, from 3:00 a.m. to 3:30 a.m., and she does not clock out to take lunch. Petitioner testified that she took her lunch break on the second floor, as there is no other place on Respondent's premises to take lunch. Her job tasks are located on the first floor. After eating lunch, Petitioner got up, walked outside the door, and began descending the stairs. When she reached the fifth stair, she testified that she slipped, hit her chin and was dizzy. Petitioner hit her knee, and when she was on the very last stair, she grabbed the handle so she would not hit the floor. A co-worker helped her up. Petitioner stood up next to the stairwell by the office, and spoke to her supervisor, Wes Robertson. Mr. Robertson took Petitioner into the office, where she received medicine and a bandage for her knee. She testified that she was not in pain at that time. After approximately one hour, Petitioner testified that she returned to work and completed her shift. She was eventually told to go see the company nurse.

Petitioner testified she reported to the nurse's station, at which time the nurse took the band or wrap off of her knee and instructed her to go see her doctor. She then left the premises.

Petitioner presented to her primary care physician, Dr. Clare Fadden, at the Murphysboro Health Center on February 2, 2012 with a chief complaint of falling down and hurting her left knee. Petitioner reported that she had returned from lunch and fell on the stairs at work. A physical examination revealed that her left leg was tender on palpation. Radiographs of the left femur, left knee, and left lower leg were ordered. The radiograph of the left knee showed a suspected nondisplaced inferior patella fracture, while the other radiographs were unremarkable. PX 2.

On February 6, 2012, Petitioner presented to Dr. Robert Golz at Southern Orthopedic Associates. A social history taken stated that Petitioner "has very limited understanding or speaking of English but the accompanying daughter is very fluent." Petitioner reported to Dr. Golz no knee complaints prior to February 2, 2012 when she fell on the stairs at work. Petitioner stated that she contacted her knee on the stairs and fell down approximately five to six stairs. Her supervisor placed ice on it, and she completed her shift. Petitioner reported an improvement in her pain from a previous level of eight to a current level of two, worsened by activity and bending, and alleviated by rest. Dr. Golz performed a physical examination, which revealed limited range of motion at the left knee due to pain. Full extension was achieved, but a small effusion was noted. Dr. Golz noted a linear abrasion approximately five to six centimeters in length over the patella and some smaller abrasions on the left shin. Petitioner's knee was slightly tender to palpation, without joint line tenderness, and no posterior knee tenderness. Dr. Golz assessed Petitioner with a left inferior nondisplaced patella fracture. She was given a knee immobilizer and a prescription for crutches. Dr. Golz placed Petitioner on light duty with the use of the immobilizer and crutches, and with restrictions of no prolonged standing or walking. Dr. Golz recommended physical therapy and Norco for pain. PX 3.

Dr. Golz's Clinic Notes from that visit indicate that Petitioner "fell off stairs" and landed on knee. It was noted that Petitioner was unsure if she was turning it into work. A Worker's Compensation Information sheet from Dr. Golz's office, which purports to be signed by Petitioner, indicates that the injury occurred on February 1 during Petitioner's work break, and happened when Petitioner's "foot bended [sic] and tripped over the stairs and fell". A Patient Questionnaire completed by Petitioner upon presentation to Southern Orthopedic Associates indicates that Petitioner "fell off stairs" at work on February 2, 2012. PX 3.

Petitioner returned to Dr. Fadden on February 8 for a recheck of her left knee and an "apparent work related injury." Petitioner was ordered to follow up with the orthopedic surgeon, she was advised in the use of crutches, and she was given pain medicine. PX 2.

On February 29, 2012, Petitioner returned to Dr. Golz with her daughter, who served as her translator. Petitioner reported improvement in her left knee. She was still experiencing pain with prolonged standing and some continued swelling. Petitioner was on light duty, but had not received therapy. She had discarded her crutches and was taking Ibuprofen. Radiographs obtained on that date showed the small inferior pole fracture to be in a satisfactory position with no displacement. Dr. Golz placed Petitioner in a knee locked brace, and ordered physical therapy for quadriceps strength. He continued her restrictions at that time. PX 3.

A Nurse's Note from Southern Orthopedic indicates that Petitioner advised not to bill her personal insurance. She reported to the registration staff that she had an attorney, her paper work that was initially completed was incorrect, and that the date of injury was incorrect. The Nurse phoned Respondent, who indicated that no worker's compensation claim had been filed yet for a left leg injury. PX 3. A second Worker's Compensation Information Sheet was completed on February 29, 2012 and appears to have been signed by Petitioner. It indicates that on February 2, 2012 at 3:30 a.m., Petitioner's "left feet bent, went rolling down stairs, hit my chin, got dizzy, kept rolling down stairs, my knee was hitting each stair." PX 3.

On May 9, 2012, Petitioner followed up with Dr. Golz, and reported doing well at that time with little to no pain. Petitioner stated she experienced some discomfort with she stands for greater than eight hours. She indicated that she uses her brace only occasionally, and that she had finished therapy and was performing a home exercise program. Petitioner reported that she had resumed working full duty and had been doing fairly well in that capacity. A family member was present and acted as an interpreter for her during the course of the conversation with Dr. Golz. Radiographs taken revealed continued interval healing. Dr. Golz allowed Petitioner to continue working full duty and released her from his care. PX 3. A referral form from the Murphysboro Health Center to Dr. Golz dated July 30, 2012, contained in the records of Dr. Golz's, notes that Petitioner needs a Spanish interpreter. PX 3.

On July 27, 2012, Petitioner again presented to Dr. Fadden with complaints of left knee pain. Petitioner reported falling in February and worsening knee pain. She also complained of dizziness and abdominal pain. Dr. Fadden noted that Petitioner's left knee was tender, and her diagnosis was knee pain secondary to a patella fracture in February. Radiographs were ordered and she was referred back to Dr. Golz. PX 1.

A Problem Sheet was admitted with Petitioner's primary care records, which indicates the temporary problems and dates of treatment corresponding to the problems. It indicates that on December 9, 2005, Petitioner was treated for dizziness, left carpal tunnel syndrome, and an URI. PX 2.

At Arbitration, Petitioner testified that she has continuing problems with the left knee. She has difficulty bending over to retrieve the empty bags at work, and when she is placed in a stationary job, her pain increases. She also experiences pain with cold weather.

Petitioner testified that when she arrives at work, her supervisor gives her and her crew a note indicating how many boxes to make during that shift. The note is written in English. Petitioner testified that she speaks "just a little" English. She understands some things in English when they are spoken to her. Petitioner indicated that prior to her fall and when she was at the top of the stairs, she did not feel dizzy or have blurred vision. However, she could not remember if she ever felt dizzy or had blurred vision prior to that date. Petitioner testified that she did not tell the company nurse that she was dizzy or had blurry vision, or that that was the cause of her falling down the stairs. She agreed that the company nurse told her to go see her family physician.

Petitioner testified that she does not know the English word for vision, nor can she say "blurry" in English. She understands the English word for dizzy, but she cannot say it, nor can she say "lightheaded".

The Arbitrator notes that Petitioner's testimony was given entirely in the Spanish language, and the questions posed to Petitioner by both her own and Respondent's counsel were communicated to her in Spanish. A professional interpreter was retained to translate from English to Spanish and then Spanish to English.

Buffy Gibbs, an LPN employed by Respondent, testified on behalf of Respondent. She has been employed by Respondent for three years. In her capacity as Respondent's company nurse, she sees injured or sick workers in her office or in the nurse's station. She also screens workers' compensation patients, and performs flu shots. When an employee presents to her, she takes a history of illness from the employee, conducts a physical examination, and triages them accordingly. Ms. Gibbs testified that she may send them for further treatment, or she may call a physician and get medical advice, or in some cases, she makes treatment recommendations. She provides wraps and bandages, but does not generally provide medication, though she may suggest over the counter medications.

Ms. Gibbs saw Petitioner in the nurse's station on February 2, 2012. Ms. Gibbs testified that Petitioner gave her a history of the accident in English, and Ms. Gibbs communicated to her in English. Petitioner told Ms. Gibbs that after she finished her lunch break, Petitioner was walking down the stairs when she got light headed and dizzy, and she fell down the stairs. At the time Petitioner presented to her, Ms. Gibbs made a record of the visit, which was offered and admitted as Respondent's Exhibit 1. Ms. Gibbs testified that if an employee does not speak English well, then it is her practice to call in another worker to serve as an interpreter, and if an interpreter were present, it would be noted in her record. Ms. Gibbs testified that no interpreter was utilized during her visit with Petitioner on February 2, 2012, and she was able to communicate well with Petitioner. Ms. Gibbs also spoke with another individual, not Petitioner, regarding the incident, who indicated to her that Petitioner's blood pressure was too high. Because that information did not come from Petitioner, Ms. Gibbs testified that she does not know if the information is accurate.

During the physical examination performed on February 2, 2012, Ms. Gibbs testified that she found some abrasions and torn skin on Petitioner's knee. She did not find any abrasions or lacerations on Petitioner's chin. Ms. Gibbs referred Petitioner to her primary care physician after she consulted with Respondent's Safety Director, because there was no indication from Petitioner that her injuries were work related, as Petitioner indicated she fainted on the stairs. Had Ms. Gibbs believed the injury to be work related, she testified she would have recommended Petitioner follow up with Midwest Occupational Medicine, one of Respondent's contracted physicians, and that same would be indicated on her note admitted as Respondent's Exhibit 1.

Ms. Gibbs stated that she speaks very little Spanish. Ms. Gibbs testified that she can tell someone in Spanish to wash their hands, to pick up a cup, or when conducting a drug screening, she can say "very good". She stated that her ability to speak some Spanish has been obtained by working for Respondent. Ms. Gibbs testified that she does not know the Spanish words for "vision", "blurred", "blood pressure", or "dizzy".

Wesley Robertson testified on behalf of Respondent. Mr. Robertson testified he is a supervisor for Respondent, and has worked in that capacity for the past fourteen years. He testified that approximately fifty percent of Petitioner's employees are Hispanic, and that approximately half of his work crew is Hispanic. Mr. Robertson indicated that he speaks a little Spanish. Petitioner works on Mr. Robertson's package line crew, and has since Mr. Robertson became a foreman four years ago. He testified that when giving Petitioner directives and orders

for work, he would communicate with her in English. His directives may be short, basic commands, or he may explain to her how to perform a task, like opening packaging for disposal or reuse. Mr. Robertson testified that he never had any difficulty communicating with Petitioner, and he believed she understood his directives given in English. Mr. Robertson likewise did not have any difficulty understanding Petitioner speaking English. He also testified that he and his work crew would have staff meetings oftentimes before or after the conclusion of a shift that may last as long as thirty minutes. Mr. Robertson would indicate where, how and what to clean on cleaning days, or he may communicate a rule to the crew. Mr. Robertson would often utilize Petitioner as an interpreter to communicate his directives to other Hispanic workers who did not understand English well.

Petitioner recalled herself as a rebuttal witness, at which time she testified that Mr. Robertson speaks to her for ten minutes in English during meetings. She acknowledged that she can recite in English what Mr. Robertson tells her. Petitioner also admitted that she understands everything Mr. Robertson says to her, but stated that she cannot speak all of the English language. Petitioner can write in English, and she has family members help her.

Respondent admitted the treatment record from Nurse Buffy Gibbs dated February 2, 2012 as Respondent's Exhibit 1. The record indicates that at 7:10 a.m., Petitioner presented to Ms. Gibbs stating that she had just finished her lunch break and was walking down the stairs when she got blurry vision and dizzy and fell down on the stairs. "She states she thinks it's because her B/P is too high." Ms. Gibbs spoke with Rose Zoellner, safety supervisor for Respondent's plant, who said that Petitioner told her supervisor that she had forgotten to take her blood pressure medicine yesterday. Petitioner complained of left knee pain, pain with walking, and an abrasion on her knee with torn skin. Petitioner denied any present blurry vision or dizziness. A physical examination performed by Ms. Gibbs showed no swelling or discoloration of the knee, but abrasions and torn skin below the knee. Her blood pressure was 140/80. Ms. Gibbs encouraged Petitioner to present to her primary care physician that morning for evaluation of her knee, and to determine the cause of her sudden blurry vision and dizziness. RX 1.

Respondent admitted an Accident/Incident Report as Respondent's Exhibit 2, which indicated that the employee took the stairs from the break room to the production floor and slipped and fell down the stairs. The second page of the Report indicates that the accident occurred when Petitioner got lightheaded, got dizzy and fell down the stairs. The Report purports to be signed by Petitioner and her supervisor, Wesley Robertson. RX 2.

Respondent admitted a treatment record from the Farm Worker Health Center dated September 16, 2004 in which Petitioner's chief complaint was "dizziness, nausea, for one month. Also breast tenderness for 1 wk. Pt. thinks it is [increased] BP." Petitioner's diagnosis, however, was pregnancy, and she was scheduled for an obstetrician workup. RX 3.

CONCLUSIONS OF LAW

In regard to disputed issue (C), to obtain compensation under the Illinois Workers' Compensation Act, a claimant must show by a preponderance of the evidence that he has suffered a disabling injury arising out of and in the course of his employment. 820 ILCS 305/2;

Metropolitan Water Reclamation District of Greater Chicago v. Illinois Workers' Compensation Comm'n, 407 Ill. App. 3d 1010, 1013 (1st Dist. 2011); *Caterpillar Tractor Co. v. Industrial Comm'n*, 129 Ill. 2d 52, 57 (1989). However, the fact that an injury arose "in the course of" the employment is not sufficient to impose liability, for to be compensable, the injury must also "arise out of" the employment. *Id.* at 58.

The "in the course of" component refers to the time, place and circumstances under which the accident occurred. *Illinois Bell Telephone Co. v. Industrial Comm'n*, 131 Ill. 2d 478, 483 (1989). If an injury occurs within the time period of employment, at a place where the employee can reasonably be expected to be in the performance of her duties, and while she is performing those duties or doing something incidental thereto, the injuries are deemed to have been received in the course of the employment. *Caterpillar Tractor Co.,* 129 Ill. 2d at 58. Under the personal-comfort doctrine, an employee who is engaged in the work of her employer may do those things which are necessary to her personal health and comfort, and such acts will be considered incidental to the employment. *Eagle Discount Supermarket v. Industrial Comm'n*, 82 Ill. 2d 331, 339 (1980). Illinois courts have recognized eating to be an act of personal comfort, and have held that where an employee sustains an injury during the lunch break and is still on the employer's premises, the act of procuring lunch has been held to be reasonably incidental to the employment. *Id.*

The "arising out of" component refers to an origin or cause of the injury that must be in some risk connected with or incident to the employment, so as to create a causal connection between the employment and the accidental injury. *Id.* Courts have recognized three general types of risks to which an employee may be exposed: (1) risks distinctly associated with the employment; (2) risks personal to the employee; and (3) neutral risks, which have no particular employment or personal characteristics. *Id.*; *Illinois Institute of Technology v. Industrial Comm'n*, 314 Ill. App. 3d 149, 162 (2000). Injuries resulting from a neutral risk are not generally compensable and do not arise out of the employment, unless the employee was exposed to the risk to a greater degree than the general public. *Metropolitan Water Reclamation District of Greater Chicago,* 407 Ill. App. 3d at 1014.

"Illinois courts have divided workplace falls into distinct origin-based categories. A fall originating from an unknown neutral source is deemed 'unexplained', while a fall originating from an internal and personal condition of the employee is deemed 'idiopathic'". *Builders Square, Inc. v. Industrial Comm'n*, 339 Ill. App. 3d 1006, 1010 (3d Dist. 2003). The "arising out of" requirement is oftentimes satisfied with unexplained falls, but not with idiopathic falls. *Id.*

"To a certain degree, however, the label 'unexplained' is a misnomer" because not only must the claimant prove an inability to explain why a fall occurred, a claimant has the burden of presenting evidence supporting a reasonable inference that the fall stemmed from an employment-related risk. *Id.* In cases in which unexplained falls have been deemed compensable, the Court has consistently identified facts supporting such reasonable inferences. *Id.*, citing *Knox County YMCA v. Industrial Comm'n*, 311 Ill. App. 3d 880 (2000)(claimant could not grab railings on stairway because her hands were holding items related to her work); *General Motors Corp. v. Industrial Comm'n*, 179 Ill. App. 3d 683 (1989)(claimant had to negotiate potholes while driving forklift); *Chicago Tribune Co., v. Industrial Comm'n*, 136 Ill. App. 3d

260 (1985)(floor where claimant slipped and fell could have contained ice and water); *Nabisco Brands, Inc. v. Industrial Comm'n*, 266 Ill. App. 3d 1103 (1994)(claimant had to carry three heavy knives on stairway).

Idiopathic falls may be compensable if the employment significantly contributed to the injury by placing the employee in a position increasing the dangerous effects of the fall. *Elliot v. Industrial Comm'n*, 153 Ill. App. 3d 238, 244 (1st Dist. 1987). It is insufficient to merely show than an injury occurred at the employee's place of work, and the act of walking down the stairs has been found to not establish a risk greater than those faced outside of work. *Id.*

"It is the function of the Commission to judge the credibility of witnesses, determine the weight to be given to their testimony, and to draw reasonable inferences from that testimony." *Nunn v. Industrial Comm'n*, 157 Ill. App. 3d 470, 478 (4th Dist. 1987). The Workers' Compensation Act is a remedial statute and should be liberally construed to effectuate its main purpose – providing financial protection for injured workers. *Interstate Scaffolding, Inc. v. Illinois Workers' Compensation Comm'n*, 236 Ill.2d 132, 149 (2010).

Significant testimony was elicited at Arbitration regarding whether Petitioner speaks and understands English, and to what degree. The totality of evidence suggests that while she may be able to understand and speak English at work for basic communications, she may require more assistance communicating in other matters. Although Ms. Gibbs and Mr. Robertson may have had no issue with speaking with and understanding Petitioner at work, the objective records of Dr. Fadden and Dr. Golz both note Petitioner's limited ability to understand English and the necessity of an interpreter for her medical care. It is, therefore, reasonable to assume that Petitioner's utilization of an interpreter at Arbitration was necessary, and not merely a ploy.

With regard to the "in the course of" component, the evidence established that Petitioner had concluded her lunch break and was descending the stairs from the break room on Respondent's premises when she was injured. Petitioner testified that the break room located on the second floor was the only place to eat lunch, and she did not clock out. Because Petitioner was injured on Respondent's premises after having been engaged in an act of personal comfort, the Arbitrator finds that Petitioner was performing duties incidental to her employment at the time of her injury. Therefore, Petitioner sustained injuries in the course of her employment.

Concerning the "arising out of" component, the Arbitrator is unpersuaded by the record of Ms. Gibbs and Respondent's Accident/Incident Report, or the histories of accident contained therein. The Arbitrator notes that Ms. Gibbs' record and the Accident/Incident Report are the only evidence to suggest that Petitioner fell down the stairs as a result of her becoming dizzy, lightheaded, or having blurry vision. In accepting the liberal interpretation of the evidence to effectuate the Act's purpose, the Arbitrator declines to accept those histories of accident when the same are subject to error. Not only did the record admitted as Respondent's Exhibit 1 originate from Respondent's company nurse, but it reasonable to infer that there may have been a miscommunication between Ms. Gibbs and Petitioner due to a language barrier when the history of the accident was taken, considering both Dr. Fadden's and Dr. Golz's records indicate Petitioner required the use of an interpreter during her medical treatment (PX 3), and no interpreter was present when Ms. Gibbs took the history on February 2, 2012. It is reasonable to

infer that Petitioner's report of becoming dizzy prior to falling was merely a miscommunication, given that the history contained in the Worker's Compensation Information Sheet completed on February 29, 2012 for Southern Illinois Orthopedics indicates that Petitioner became dizzy after she fell down the stairs. PX 3.

Further, the two histories contained in the Accident/Incident Report are inconsistent with one another. The front page states Petitioner "slipped and fell", whereas the second one indicates the accident occurred when Petitioner got lightheaded, got dizzy and fell down the stairs. RX 2. It is unclear from whom or where the history contained in the Report originated. Similarly, Ms. Gibbs' record indicates Petitioner became dizzy and her vision became blurry before she fell, whereas the Accident Report states that Petitioner became dizzy and lightheaded. RX 1, 2. The histories enumerated in Ms. Gibbs' record and Mr. Robertson's Report are inconsistent with those contained in the objective medical records of Dr. Fadden and Dr. Golz, which the Arbitrator deems to be more credible, in light of the aforementioned inconsistencies and because an interpreter was present for discussions between Petitioner and Dr. Golz. PX 3.

Dr. Fadden and Dr. Golz both noted almost identical histories of accident, which indicate that Petitioner simply fell down the stairs at work, and struck her left knee. PX 2, 3. A Worker's Compensation Information Sheet for Southern Illinois Orthopedics signed by Petitioner and dated February 29, 2012 indicates that Petitioner's "left feet bent, went rolling down stairs, hit my chin, got dizzy, kept rolling down stairs, my knee was hitting each stair." PX 3. Petitioner did not proffer any medicals records or opinions indicating a condition that would cause Petitioner's foot or ankle to bend, roll or otherwise give way so as to support a finding of an idiopathic fall. Instead, Petitioner testified that she slipped on the fifth stair. Absent from all of the histories in the record is any evidence as to what caused her foot to bend, why or upon what Petitioner slipped, or why she fell, yielding it within the purview of an unexplained fall.

However, Petitioner has failed to tender any evidence for which this Arbitrator could draw a reasonable inference of a special hazard or risk connected to Petitioner's employment, as Petitioner did not present any evidence regarding slipping on a foreign substance or falling as the result of a defect on the stairs. Petitioner likewise did not testify that she was in a hurry or carrying anything in her hands while descending the stairs, which in other cases, has supported a finding of accident. *See supra.* The Arbitrator finds, therefore, that Petitioner's injury did not arise out of her employment.

Even if the Arbitrator were to find Petitioner's fall to be an idiopathic one, Petitioner has nonetheless failed to show that her employment significantly contributed to the injury. Petitioner presented no evidence that the stairs themselves were unique, increased the danger of her injury, or that descending the stairs was unique to her work. As *Elliot* instructs, merely walking down the stairs does not establish a risk greater than those outside of work. *Elliot*, 153 Ill. App. 3d at 244. Therefore, even if she had suffered an idiopathic fall, Petitioner has failed to prove that she sustained an injury arising out of her employment with Respondent.

Petitioner's claim is denied, and all remaining issues are moot.

STATE OF ILLINOIS)
) SS.
COUNTY OF MADISON)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Stanley Wright,
Petitioner,
vs.

14IWCC0973
NO: 12 WC 19212

Southwestern Sprinkler Corporation,
Respondent.

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed March 6, 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: NOV 13 2014
KWL/vf
O-11/3/14
42

Kevin W. Lamborn

Thomas J. Tyrrell

Michael J. Brennan

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

14IWCC0973

WRIGHT, STANLEY
Employee/Petitioner

Case# 12WC019212

SOUTHWESTERN SPRINKLER CORPORATION
Employer/Respondent

On 3/6/2014, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

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

1727 LEE & WENDT
KEVIN MORRISON
1101 S SECOND ST
SPRINGFIELD, IL 62704

2396 KNAPP OHL & GREEN
DAVID GREEN
6100 CENTER GROVE RD BOX 446
EDWARDSVILLE, IL 62025

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 14IWCC0973

Stanley Wright
Employee/Petitioner

v.

Southwestern Sprinkler Corporation
Employer/Respondent

Case # 12 WC 19212

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 N. Lee**, Arbitrator of the Commission, in the city of **Herrin, Illinois**, on **February 7, 2014**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

14IWCC0973

FINDINGS

On **May 17, 2012**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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 **$61,048.72**; the average weekly wage was **$1174.01**.

On the date of accident, Petitioner was **46** years of age, ***married*** with **3** children under 18.

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

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

Respondent shall be given a credit of **$N/A** for TTD, **$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

Petitioner failed to prove a compensable claim. Therefore, Petitioner's claim for compensation is denied.

See attached Addendum and Statement of Facts.

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

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

Edwin Zee
Signature of Arbitrator

3/1/14
Date

MAR 6 - 2014

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

STANLEY WRIGHT, Petitioner, vs. SOUTHWESTERN SPRINKLER CORPORATION, Respondent.	)	14IWCC0973 No. 12 WC 19212

ADDENDUM TO ARBITRATION DECISION

STATEMENT OF FACTS

THE ARBITRATOR HEREBY MAKES THE FOLLOWING FINDINGS OF FACT

Petitioner filed an Application for Adjustment of Claim alleging an accident on May 17, 2012 when he lost his balance and fell resulting in injuries to the left foot and back.

At trial, Petitioner testified that he worked for Respondent until May 17, 2012. At the time of this alleged accident, he was working with his son, Brett Wright, at a job in Carbondale, Illinois installing sprinkler heads. He testified that he stepped on a pile of pipe and the pipe pile rolled, causing him to fall and twisting his left ankle. The accident happened between 10:00-10:30 a.m. Some time after the accident, he received a phone call from Respondent's superintendent, Kenny Sturgeon, who told Petitioner to load up the company truck with his tools and come to Respondent's shop in Evansville, Indiana for a safety meeting. Petitioner claimed he told Mr. Sturgeon at that time that he had slipped and fallen.

Petitioner loaded the company truck and traveled with Brett from the worksite in Carbondale, Illinois to Respondent's office in Evansville, Indiana, a trip of approximately two hours. Petitioner drove the company truck since he was the only one authorized to do so.

When he arrived at Respondent's office in Evansville, Indiana, he was met by Mr. Sturgeon who told Petitioner and Petitioner's son to take their personal belongings off the company truck and that Mr. Sturgeon would give Petitioner and his son a ride to their personal vehicle located approximately 45 minutes away from Respondent's office. Petitioner claimed he telephoned Mr. Sturgeon again later that night to again inform Mr. Sturgeon that he had injured himself. He also testified that he telephoned his business agent, Brian Fischer, on May 17, 2012 to tell Mr. Fischer that he had injured himself.

Petitioner testified that the pain in his left foot did not increase until later that night Petitioner thought he could "just shake it off and go ahead". (Trial Transcript P. 35). As the day progressed, his left foot became more symptomatic. (Trial Transcript P. 36).

Petitioner claimed he had no idea what procedure to follow when reporting an accident and he had no instruction that he was to report an accident to Respondent's office manager, Anne Wood, in order to fill out an accident report. He claimed that, when he returned with his son to Respondent's office in the middle of the afternoon on May 17, 2012, the only person at the office was Mr. Sturgeon. He did not know what time they returned to the office although he then testified he did not believe it was 3:00 p.m. on Thursday afternoon. (Trial Transcript P. 41). Petitioner "did not know" if he had any trouble walking when he returned to the Respondent's office that afternoon. (Trial Transcript P. 42).

Petitioner explained that he did not go to the hospital that night since his left foot was not very painful until later that night or first thing the next morning. He claimed he did not realize that he was fired by Respondent until the following Monday. However, he admitted that the procedure for termination or layoff was that the employer was required under union rules to provide the workers with pay up to the date of the termination. (Trial Transcript P. 52). He was given checks by Mr. Sturgeon paying him up to May 17, 2012 when Mr. Sturgeon dropped Petitioner and his son off at his son's truck in Ferdinand, Indiana. (Trial Transcript P. 53).

Petitioner was seen at a local emergency room on May 18, 2012 at approximately 10:00 a.m. Petitioner's complaints and history at the emergency room was "fell while walking across pile of pipes yesterday...pain to all over back, left foot/ankle...also pain to back of neck". Interestingly, Petitioner did not testify at trial of having any pain to any body part other than the left leg. In any event, X-rays of the cervical, thoracic, and lumbar spine showed no evidence of an acute injury. An X-ray of the left foot showed no evidence of an acute injury.

Petitioner was next seen by Dr. Jon Ellison on May 22, 2012, who diagnosed a left foot sprain. Dr. Ellison gave him a walking boot and prescribed pain medication. Petitioner testified Dr. Ellison kept him off work through July 17, 2012.

Petitioner worked for Ohio Valley Sprinklers from July 18, 2012 through January 9, 2013 performing the same work as he performed for Respondent which included climbing ladders (Respondent Exhibit 7-29; Trial Transcript P. 59). He worked for a brief period of time for Fireline Sprinkler Corporation (Respondent's Exhibit 8) and then started working for his current employer, Midwest Sprinkler on September 20, 2013 to the present time (Respondent's Exhibit 9; Trial Transcript P. 8-9). He performs the same work for Midwest Sprinkler as he performed for Respondent, including hanging pipe, standing on concrete, and climbing ladders.

Petitioner testified that he has had pain and swelling of his left leg since September of 2012 (Trial Transcript P. 59). He further claimed that he still has pain in the left foot and is on Hydrocodone for his foot pain prescribed by Dr. Ellison. However, he had taken no Hydrocodone the morning of the trial and had "no idea" how often he had taken Hydrocodone over the past two months. While the pharmacy records show that he was prescribed 196 doses of Hydrocodone over a 30 day period of time from October 30, 2013 through November 30, 2013, he testified he probably had those tablets "at home in the medicine cabinet". (Trial Transcript P. 67-68)

The medical records show that Dr. Ellison evaluated Petitioner on August 7, 2012 at which time Petitioner had no complaints of the left leg and Dr. Ellison noted that the foot sprain had resolved. Petitioner claimed he did not recall this evaluation (Trial Transcript P. 60).

Petitioner was seen at the Perry County Memorial Hospital on November 11, 2012 for sinus complaints. Petitioner was on no medications and there were no complaints noted of the left lower extremity. (Respondents Exhibit 3).

While Petitioner testified on direct examination that he telephoned his business agent, Brian Fischer, on May 17, 2012 and told him he had had a work accident, Petitioner denied that he spoke with Brian Fischer on May 17, 2012 on redirect examination. (Trial Transcript P. 12; 69-70).

Brett Wright testified at trial. He is Petitioner's son and testified he was with Petitioner at the time of this accident. He saw Petitioner fall and knew Petitioner was injured at the time of the fall. (Trial Transcript P. 76). Contrary to Petitioner's testimony, Brett testified that Petitioner complained about his ankle when he returned to Respondent's shop that afternoon and could not help unload his personal items from the company truck since he was injured. (Trial Transcript P. 80). Brett and Mr. Sturgeon unloaded Petitioner's and Brett's personal items from the service truck to Mr. Sturgeon's personal vehicle. They were then handed two paychecks which "usually means that we were laid off". (Trial Transcript P. 77). Brett testified that he and Petitioner filed a grievance with the union over a "tool dispute" since they were not given the tools which they were supposed to have been given when they began working for Respondent. (Trial Transcript P. 78). This is contradicted by Petitioner's testimony that the union grievance was a dispute over being required to work out of town without being paid per diem expenses. (Trial Transcript P. 51).

Petitioner's testimony also conflicts with Brett's testimony since Petitioner testified that Petitioner and Brett each unloaded approximately half of their personal items from Mr. Sturgeon's car (Trial Transcript P. 46-47) while Brett testified that Brett and Mr. Sturgeon unloaded their personal items. (Trial Transcript P. 80). Contrary to Petitioner's trial testimony that he had no significant discomfort or problems until the evening of May 17, 2012, Brett testified that when they returned to Respondent's shop on the afternoon of May 17, 2012, Petitioner "hurt all over" and was limping to the extent that he could not assist Brett in unloading their personal items from the company truck. (Trial Transcript P. 79-80).

Brett testified that he did not tell his father to fill out an accident report when they returned to Respondent's facility since he did not know an accident report was to be completed when one has a work accident. (Trial Transcript P. 80-81).

Petitioner's office manager, Anne Wood, testified at trial. She has been Respondent's office manager for 18 years. Ms. Wood testified that Petitioner and Brett were aware of the proper procedure when reporting an accident since Brett had an accident in December of 2011 and he followed the procedure for reporting an accident to Ms. Wood. (Trial Transcript P. 85).

Ms. Wood testified this project was behind schedule. On May 14, 2012, Mr. Sturgeon and another of Respondent's representatives traveled to the worksite and found that the job was far behind schedule and the decision was made to terminate Petitioner. (Trial Transcript P. 87). She was at Respondent's facility when Petitioner and his son returned to Respondent's shop on May 17, 2012 but Petitioner did not speak to her. Petitioner called Ms. Wood on the afternoon of May 18, 2012 and asked for insurance information and reported that he was injured on the job. Ms. Wood told Petitioner that she would have to notify the insurance company and requested the appropriate form from Respondent's insurance broker. (Respondent's Exhibit 6-11, 6-12). On the following Monday (May 21, 2012), Ms. Wood called Petitioner and told him that she needed an accident report completed. Petitioner told Ms. Wood that he would have to consult his attorney. (Trial Transcript P. 92-93).

Ms. Wood testified that Petitioner and his son were given checks on May 17, 2012 to pay them for their work up to that point since payment was required upon termination of an employee. The checks were prepared approximately two hours before Petitioner and his son returned to Respondent's facility on the day of the alleged accident.

Kenny Sturgeon testified for Respondent. He is currently laid off from Respondent's employment.

The project Petitioner was working on at the time of this alleged accident was installing sprinkler heads in the aviation building at Southern Illinois University in Carbondale, Illinois. Problems arose about the pace of the work in late 2011 and continued into 2012. On May 14, 2012, Mr. Sturgeon and another representative of Respondent inspected the worksite and found the work to be far behind schedule. The decision was made to terminate Respondent.

On May 17, 2012, Mr. Sturgeon called Petitioner and told him to return to the shop. Petitioner did not state that he had injured himself during that phone call. (Trial Transcript P. 100). When Petitioner and his son returned to Respondent's shop that afternoon, Mr. Sturgeon was waiting for him in the parking lot. Ms. Wood was in the office. When Petitioner and his son arrived in the parking lot, Mr. Sturgeon told Petitioner that he was going to have to "let you guy's go". Petitioner began making phone calls to find a ride home but was not able to reach anyone. Mr. Sturgeon then decided that he would give Petitioner and Brett a ride to Brett's personal truck in Mr. Sturgeon's personal car. Petitioner and Brett began unloading their personal items from the service truck into Mr. Sturgeon's car. Neither Petitioner nor Brett said anything about Petitioner being injured at that time. Petitioner, Brett, and Mr. Sturgeon all took part in unloading the personal items from the service truck to Mr. Sturgeon's car. Petitioner had no problems walking or unloading those items.

Mr. Sturgeon then drove Petitioner and Brett in his personal car to Ferdinand, Indiana. with Petitioner in the front seat of the car. (Trial Transcript P. 104). At no time during the 45-minute ride did Petitioner tell Mr. Sturgeon that he was in pain or had been injured.

Mr. Sturgeon is familiar with the jobs Petitioner held with Ohio Sprinkler and Midwest Sprinkler. These jobs require ladder climbing, standing on concrete, and carrying various items.

Mr. Sturgeon was familiar with the union grievance that Petitioner and Brett filed against Southwestern Sprinkler, which dealt with the alleged failure to provide them with hand tools. There is a receipt that Petitioner and his son received for these hand tools in June of 2011 (Respondent Exhibit 6-1). Respondent decided to provide Petitioner and Brett with an additional set of tools in order to close out the grievance. (Respondent Exhibit 6-6).

Dr. Jon Ellison testified by deposition for Petitioner. He first saw Mr. Wright after this accident on May 22, 2012 at his office in Huntingburg, Indiana. He had previously reviewed the emergency room records from Memorial Hospital located in Jasper, Indiana as well as the actual X-rays. There was no fracture although he did have a severe sprain of the left foot. Dr. Ellison believed the employee was on crutches (this is incorrect in that the employee was actually in a walking boot). He was prescribed Lortab for pain relief and told Petitioner to do weight bearing as tolerated and to use Ibuprofen for an anti-inflammatory medication.

Dr. Ellison saw Mr. Wright again on June 5, 2012. The tenderness of the left foot was over the medial or outside portion of the foot and the front of the foot. On July 10, 2012, Dr. Ellison thought that Mr. Wright may have had a stress fracture since he still had pain in the foot. Dr. Ellison admitted that it was unusual for a foot sprain to be painful for this time frame. The X-rays obtained in July of 2012 showed nothing different than the initial X-rays obtained on May 18, 2012 in that, again, there was no fracture on either of the X-rays. In addition, the degenerative changes noted by the radiologist were pre-existing and would have not been caused by this accident.

Dr. Ellison returned Petitioner to work on July 18, 2012 (although he was not seen on that date). Dr. Ellison next saw Petitioner on August 7, 2012. At that time, Dr. Wright noted that his "foot sprain had resolved". Dr. Ellison admitted he examined the foot and that there was no tenderness, discoloration, unusual temperature, or anything abnormal about the appearance of the left foot. He specifically testified that the left foot was a normal appearing left foot.

He did not see Petitioner again until February 25, 2013 at which time his nurse notes that the employee was there to "discuss diet pill...discuss left foot fracture 5/2012". Dr. Ellison admitted that the employee did not have a foot fracture and that part of that note was written by his nurse. He examined the foot on that visit and noted that there was no deformity to the left foot meaning that there was no objective clinical abnormality he saw at the time of that visit. He did not restrict Petitioner's activities at that time and has not seen Petitioner since then.

Dr. Ellison took Petitioner off work from May 22, 2012 until July 18, 2012.

Dr. Ellison testified he did not know what time of day the accident occurred on May 17, 2012 and also did not know what Petitioner did between the time he was seen at the emergency room on May 18, 2012 at 11:00 a.m. and the time that he presented to Dr. Ellison's office on May 22, 2012.

Dr. Ellison admitted that there is a podiatrist in Huntingburg, Indiana, as well as some orthopedic surgeons, all to whom he has referred patients in the past. Here, he did not refer Mr. Wright to any of these physicians.

Dr. Ellison has been Mr. Wright's family physician since 2007. If Mr. Wright had telephoned Dr. Ellison's office any time prior to May 22, 2013 asking for an appointment to be seen due to this work injury, Dr. Ellison may not have been able to fit him in but his nurses would have made a note in the patient's telephone log. During the deposition Dr. Ellison reviewed his telephone log and confirmed there was no telephone call from Mr. Wright asking for an appointment between May 17, 2012 and May 22, 2012.

Regarding the March 13, 2013 letter, Dr. Ellison admitted that Petitioner asked him to write that letter at the time of his February 25, 2013 visit. While Dr. Ellison stated the employee had a "chronic" foot injury, Dr. Ellison was asked when the left foot sprain became "unresolved" since Dr. Ellison noted in August of 2012 that it had resolved. Dr. Ellison admitted that he had no idea when it became "unresolved". In addition, Dr. Ellison admitted that the work Petitioner performed as a pipefitter after August 2012 could be the cause of the complaints Petitioner made on February 25, 2013.

Dr. Ellison admitted Petitioner was obese when he saw him in 2012 and that weight also could have been the cause for the complaints which the employee presented with in February of 2013.

Petitioner did not testify at trial of any current problems regarding any body part other than his left lower extremity although he claimed he injured his back on his Application for Adjustment of Claim.

Therefore, the Arbitrator makes the following findings as to "C" and "F" regarding accident and causal connection:

Petitioner failed to prove a compensable claim. First, Petitioner's testimony about the onset of his complaints and why he did not complete an accident report is contradicted by both his own testimony and the testimony of his son, Brett. Petitioner testified that while he had only some minor discomfort when returning to Respondent's facility, Brett testified that Petitioner was in pain and limping at that time. Petitioner testified that he assisted in unloading personal items from Respondent's service truck into Mr. Sturgeon's personal vehicle while Brett testified that Petitioner was in too much discomfort to assist in the unloading and that the personal items were unloaded by Mr. Sturgeon and Brett. Both Petitioner and Brett testified that they unaware of the procedure to be followed in reporting an accident although Brett had an accident in December of 2011 and followed Respondent's procedure in reporting an accident although he testified at trial that he was unaware of any such procedure.

Petitioner was contradictory as to whom he reported an accident and when. He testified at trial on direct examination that he called his business agent, Brian Fischer, on May 17, 2012 and informed Mr. Fischer that he had had an accident that day but then later in his testimony on re-direct examination by his own attorney denied that he spoke to Mr. Fischer on May 17, 2012. He also claimed that he told Kenny Sturgeon of his accident when Kenny Sturgeon called that afternoon but he then tried to call Mr. Sturgeon that evening.

14IWCC0973

In addition, Petitioner's testimony regarding the left lower extremity complaints is not consistent with other parts of his testimony or the medical records. His testimony as to when his left foot became symptomatic was confusing at best. Also, Petitioner claimed at trial that he had pain and swelling of the left lower extremity since September of 2012 although he was seen at a clinic in November 2012 with no left lower extremity complaints being noted. He was seen by his family physician on August 7, 2012 at which time his foot sprain was noted to have resolved and did not see Dr. Ellison again until February 25, 2013. He has not seen Dr. Ellison since February 25, 2013 although he, apparently, continues to receive prescriptions for Hydrocodone from Dr. Ellison. If Petitioner does not take the Hydrocodone but simply puts the pills in his bathroom cabinet as he testified at trial, one wonders why he is filling prescriptions for Hydrocodone on a regular basis. In addition, there is no explanation why Petitioner has not returned to Dr. Ellison since February of 2013 if Petitioner is, in fact, having continuing complaints.

The Arbitrator makes the following findings as to "J" and "K" regarding medical benefits and temporary total disability benefits:

Having found that Petitioner failed to prove a compensable claim, he has also failed to prove the right to medical benefits and temporary total disability benefits.

The Arbitrator makes the following findings as to "L" regarding the nature and extent of the injury:

Having found that Petitioner failed to prove a compensable claim, he also failed to prove the nature and extent of the injury. In addition, Petitioner's left foot sprain resolved according to his own family physician on August 7, 2012. Dr. Ellison admitted that Petitioner's work for subsequent employers was just as likely a cause for any claimed continuing discomfort as this accident. Dr. Ellison gave no opinion on the degree of any impairment. There is no evidence of permanent partial disability.

Accordingly, Petitioner's claim for compensation is denied.

DATE

ARBITRATOR

14IWCC0973

STATE OF ILLINOIS)
) SS:
COUNTY OF WILLIAMSON)

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

STANLEY WRIGHT,)
)
Petitioner,)
)
vs.) No. 12 WC 19212
)
SOUTHWESTERN SPRINKLER,)
)
Respondent.)

February 7, 2014
Herrin, Illinois

TRANSCRIPT OF EVIDENCE
ON ARBITRATION

I N D E X

WITNESSES	DIRECT	CROSS	RDX	RCX
Stanley Wright	7	26	69	-
Brett Wright	73	78	-	-
Anne Wood	84	93	-	-
Kenneth Sturgeon	96	109	112	113

STATE OF ILLINOIS)
) SS.
COUNTY OF KANE)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Nancy Kay Jones,

Petitioner,

vs.

NO: 10 WC 26855

14IWCC0974

Toyota Motor Sales USA,

Respondent.

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed March 25, 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.

14IWCC0974

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $57,500.00. 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: NOV 13 2014
TJT:yl
o 10/6/14
51

Thomas J. Tyrrell

Michael J. Brennan

Kevin W. Lamborn

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

JONES, NANCY KAY
Employee/Petitioner

Case# **10WC026855**

TOYOTA MOTOR SALES USA
Employer/Respondent

14IWCC0974

On 3/25/2014, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

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

4642 O'CONNOR & NAKOS
MATT WALKER
120 N LASALLE ST 35TH FL
CHICAGO, IL 60602

0766 HENNESSY & ROACH PC
QUINN M BRENNAN
140 S DEARBORN 7TH FL
CHICAGO, IL 60603

14IWCC0974

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
NATURE AND EXTENT ONLY

NANCY KAY JONES
Employee/Petitioner

v.

Toyota Motor Sales, USA,
Employer/Respondent

Case # 10 WC 26855

Consolidated cases: none

The only disputed issue is the nature and extent of the injury. An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Peter M. O'Malley**, Arbitrator of the Commission, in the city of **Geneva**, on **1/24/14**. By stipulation, the parties agree:

On the date of accident, **5/18/06**, Respondent was operating under and subject to the provisions of the Act.

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

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

Timely notice of this accident was given to Respondent.

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

In the year preceding the injury, Petitioner earned $**55,744**, and the average weekly wage was $**1,072.00**.

At the time of injury, Petitioner was **51** years of age, ***married*** with **0** dependent children.

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

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

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

14IWCC0974

ORDER

Respondent shall pay Petitioner the sum of **$591.77** per week for a further period of **101.2** weeks, as provided in Section **8(e)10** of the Act, because the injuries sustained caused **the loss of use of 22.5% (of the left arm 56.925 weeks) and 17.5% of the right arm (44.275 weeks)**.

Respondent shall pay Petitioner compensation that has accrued from **5/19/06** through **1/24/14**, and shall pay the remainder of the award, if any, in weekly payments.

The parties agreed that Respondent shall hold petitioner harmless for payments made by Aetna Insurance to Valley West Hospital in the amount of $2,347.55. (Arb.Ex.#1).

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

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

Signature of Arbitrator

3/17/14
Date

ICArbDecN&E p.2

MAR 25 2014

STATEMENT OF FACTS:

The parties stipulated that the Petitioner, Nancy Kay Jones, was injured in the course and scope of her employment on May 18, 2006. She first sought care and treatment with Dr. John Showalter on December 11, 2006. Dr. Showalter noted that Petitioner was a 52 year old, left handed warehouse associate. Dr. Showalter recorded that Petitioner's right elbow began bothering her in May when she was pulling a cart out of storage. He also charted complains that had developed with the left elbow. The pain had slowly worsened over time. Dr. Showalter diagnosed Petitioner with mild bilateral elbow pain and prescribed anti-inflammatories.

Petitioner was seen by Dr. Gregory Markarian at the request of her employer. Dr. Markarian initially served as Respondent's Section 12 examining physician, but took over Petitioner's medical treatment. Dr. Markarian diagnosed Petitioner with bilateral elbow medial epicondylitis and ulnar neuritis, and opined that Petitioner's condition was causally related to her work accident.

Petitioner treated conservatively with Dr. Markarian, and eventually sought another opinion from Dr. Thomas Kiesler at Orthopedic Associates of DuPage. Dr. Kiesler first saw the Petitioner on October 4, 2010. He noted that Petitioner had been treating with Dr. Markarian for nearly four years with therapy only. Dr. Kiesler wrote that the right elbow was worse than the left, particularly with respect to numbness and tingling. He recorded night time numbness and tingling every night in the ring and small fingers. The pain was so severe that Petitioner had difficulty even shutting off her alarm clock in the morning.

Dr. Kiesler diagnosed Petitioner with bilateral medial epicondylitis, and bilateral cubital tunnel syndrome, right greater than left. On December 7, 2010, Dr. Kiesler performed surgery consisting of a right ulnar nerve anterior intermuscular transposition, right medial tennis elbow debridement with partial ostectomy, and a left medial tennis elbow injection with Celestone and Marcaine.

Dr. Kiesler attempted to treat Petitioner's left elbow conservatively. Ultimately, Petitioner opted to undergo surgery and on July 26, 2012 she underwent a left ulnar nerve anterior intramuscular transposition and left medial tennis elbow debridement with partial ostectomy. Petitioner was released to return to work without restrictions on October 17, 2012.

Currently, Petitioner notices that her left hand will still cramp up and that pain shoots up to her elbow. She indicated that she has no real problems with her right hand. Petitioner testified that she is left handed and that she does not have the strength she needs to grab and pull with her left arm. She noted that she uses both hands and that she asks for help on the job now depending on the situation. She indicated that it is also harder to make her quotas now to some extent, but that they have revised the program to make it a little easier to make the rate. However, she noted that she has received many write-ups in the past for not making quota. In addition, she stated that she cannot do certain hobbies like she used to anymore, such as gardening, painting and fishing, given that her arms cramp up. She also indicated that she has good days and bad days, depending on the job. However, she noted she is not scheduled to see any doctors again at this point, although she feels she will see doctors in the future for her condition.

WITH RESPECT TO THE ISSUE OF THE NATURE AND EXTENT OF THE INJURY, THE ARBITRATOR FINDS AS FOLLOWS:

Petitioner was diagnosed with bilateral medial epicondylitis, and bilateral cubital tunnel syndrome. She treated with the company physician for four years doing solely physical therapy as noted by Dr. Kiesler's office note dated October 4, 2010. By the time Petitioner sought another opinion, her pain was so severe that she had

difficulty even shutting off her alarm clock in the morning. Petitioner underwent two surgeries. During the first surgery, which was performed on the right elbow, Dr. Kiesler also administered an injection into the left elbow.

Dr. Kiesler attempted to treat Petitioner's left elbow conservatively. Ultimately, Petitioner opted to undergo surgery and on July 26, 2012 she underwent a left ulnar nerve anterior intramuscular transposition and left medial tennis elbow debridement with partial ostectomy. Petitioner was released to return to work without restrictions on October 17, 2012.

Currently, Petitioner notices that her left hand will still cramp up and that pain shoots up to her elbow. She indicated that she has no real problems with her right hand. Petitioner testified that she is left handed and that she does not have the strength she needs to grab and pull with her left arm. She noted that she uses both hands and that she asks for help on the job now depending on the situation. She indicated that it is also harder to make her quotas now to some extent, but that they have revised the program to make it a little easier to make the rate. However, she noted that she has received many write-ups in the past for not making quota. In addition, she stated that she cannot do certain hobbies like she used to anymore, such as gardening, painting and fishing, given that her arms cramp up. She also indicated that she has good days and bad days, depending on the job. However, she noted she is not scheduled to see any doctors again at this point, although she feels she will see doctors in the future for her condition.

Based on the above, and the record taken as a whole, the Arbitrator finds that Petitioner sustained permanent partial disability to the extent of 22.5% loss of use of left arm and 17.5% of the right arm, pursuant to §8(e)10 of the Act.

Furthermore, the Arbitrator notes that the parties stipulated at the time of the hearing that the Respondent would hold the Petitioner safe and harmless for payments made by Aetna to Valley West Hospital in the amount of $2,347.55.

14IWCC0975

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

Christopher Jarzab,

Petitioner,

vs.

NO: 07 WC 19251

Natura Products Inc and
Chicago Cutting Die Co,

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed February 14, 2014, is hereby affirmed and adopted.

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

14IWCC0975

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: NOV 13 2014
o10/22/14
RWW/rm
046

Ruth W. White

Charles J. DeVriendt

Daniel R. Donohoo

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

14IWCC0975

JARZAB, CHRISTOPHER
Employee/Petitioner

Case# 07WC019251

NATURA PRODUCTS INC AND
CHICAGO CUTTING DIE CO
Employer/Respondent

On 2/14/2014, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.11% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

4788 HETHERINGTON KARPEL BOBBER ET AL
PETER BOBBER
161 N CLARK ST SUITE 2810
CHICAGO, IL 60602

0210 GANAN & SHAPIRO PC
MELISSA McENDREE
210 W ILLINOIS ST
CHICAGO, IL 60654

STATE OF ILLINOIS)
)SS.
COUNTY OF COOK)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION 19(b)

14IWCC0975

Christopher Jarzab
Employee/Petitioner

v.

Natura Products Inc. and Chicago Cutting Die Co.
Employer/Respondent

Case # **07** WC **19251**

An *Application for Adjustment 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 **November 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: Is Petitioner entitled to vocational rehabilitation?

FINDINGS 14IWCC0975

On the date of accident, **January 4, 2007**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$21,902.92**; the average weekly wage was **$421.21**.

On the date of accident, Petitioner was **40** 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 **$20,019.72** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$20,019.72**.

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 **$280.81**/week for **321 3/7^{ths}** weeks, commencing **January 26, 2007** through **March 24, 2013**, as provided in Section 8(b) of the Act.

Respondent shall pay Petitioner the temporary total disability benefits that have accrued from **January 26, 2007** through **March 24, 2013**, and shall pay the remainder of the award, if any, in weekly payments.

Respondent shall be given a credit of **$20,019.72** for temporary total disability benefits that have been paid.

Respondent shall pay Petitioner maintenance benefits of **$280.81**/week for **34 1/7th** weeks, commencing **March 25, 2013** through **November 18, 2013**, as provided in Section 8(a) of the Act.

Respondent shall pay reasonable and necessary medical services, pursuant to the medical fee schedule, of **$18,819.20** to **ATI Physical Therapy**, **$15,599.87** to **Hinsdale Orthopedics**, and **$1,187.50** to **IWP**, as provided in Sections 8(a) and 8.2 of the Act.

Respondent shall authorize and pay for vocational rehabilitation services by a vocational rehabilitation specialist chosen by Petitioner, as provided in Section 8(a) of the Act.

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

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

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

Milton Black
Signature of Arbitrator

February 13, 2014
Date

FEB 14 2014

Petitioner was 40 years old at the time of his January 4, 2007 work accident. Petitioner testified that he has a tenth grade education and he never obtained a high school diploma or GED. Petitioner testified that he never had any prior injury to, or medical problem with, his low back. On July 12, 2005, Petitioner passed a pre-employment physical exam.

Petitioner testified that on January 4, 2007 he was lifting a pallet when he noticed pain in his spine and left hip. Petitioner testified he returned to work but that that his pain persisted. Respondent sent Petitioner to Northbrook Occupational Medicine Center. He was placed on light duty. On January 26, 2007, Petitioner was assessed with lumbrosacral spine strain, left S1 joint sprain, and "nucleus pulp herniation". Petitioner was taken off work. An MRI revealed a small mass at L1-L2 disc and a left sided herniated disc at L5-S1.

Petitioner treated conservatively until he was referred to Dr. Richard Mannion of Northwest Orthopedic Surgery. Dr. Mannion found an unrelated discitis at the L1-L2 level and a work-related L5-S1 disc herniation. The discitis was treated with antibiotics, inpatient, at Northwest Community Hospital. EMG testing for the disc herniation was not approved by Respondent.

Petitioner then reqested an orthopaedic referral from his primary care physician, Dr. David Feerst. Petitioner was referred to Dr. David Schafer of Suburban Orthopedics. Dr. Schafer ordered and Petitioner underwent three epidural steroid injections at St. Alexius Medical Center. Petitioner testified that he that he had limited relief. Dr. Schafer recommended that Petitioner be seen by a spine surgeon and remain off work.

On April 7, 2008, Petitioner was examined by Dr. Charles Slack. Dr. Slack diagnosed persistent lumbar radiculopathy with an L5-S1 disc protrusion and degenerative disc changes. He opined that Petitioner's present condition was causally related to his work injury and indicated that the low back pain with radicular complaints into the left leg were consistent with the L5-S1 disc herniation which was traumatically caused by the work accident rather than being related to the L1-L2 discitis. Dr. Slack indicated that Petitioner could work lifting a maximum of 20 pounds with no repetitive bending, twisting or prolonged sitting or standing without a change of position.

Dr. Slack's referred Petitioner to Dr. Theodore Fisher, who recommended L5-S1 surgical decompression and posterior spinal fusion with an interbody fusion. Dr. Fisher performed the surgery at St. Joseph Hospital once workers' compensation authorization was obtained. Petitioner initially improved, however, as his activity level increased, he noted increased pain between L4 and S1 as well as bilateral heel pain. Dr. Fisher recommended an injection around the hardware. Dr. Fisher felt that if the hardware caused the pain, Petitioner would be a candidate for hardware removal.

Petitioner obtained a second opinion from Dr. Michael Zindrick. Dr. Zindrick diagnosed post-spine fusion and low back pain with retained hardware at L5-S1. Dr. Zindrick indicated that Petitioner's current and present condition of low back pain was related to the January 2007 work accident and felt it was reasonable to consider hardware injection and hardware removal.

On March 27, 2012, Dr. Zindrick performed surgical removal of the hardware. Petitioner underwent a course of physical therapy and work conditioning. On March 20, 2013, Dr. Zindrick placed petitioner on a 20 pound lifting restriction with no repetitive bending, twisting, or lifting and position changes as comfort allows. Dr. Zindrick also indicated petitioner had reached MMI and that the restrictions were permanent. Petitioner last saw Dr. Zindrick on August 15, 2013, at which time he noted that Petitioner continued with chronic back pain and would require pain medications going forward and reiterated the need for the same permanent restrictions.

Petitioner has not worked anywhere since his last day of light duty work for respondent on January 25, 2007. Respondent has never offered petitioner light duty work since that day.

Petitioner testified that he did obtain a temporary job offer to be a bell ringer for the Salvation Army during the holiday season. Respondent has not offered vocational rehabilitation services. Petitioner has requested vocational rehabilitation. Petitioner testified to his ongoing symptoms.

Joel Greenberg, Petitioner's supervisor, testified on behalf of Respondent. Mr. Greenberg identified photos showing punch press work and the types of skids that Petitioner was moving at the time of the injury. Mr. Greenberg testified that the punch press operator portion of Petitioner's job is relatively light and not very physically demanding but that other duties can exceed the weight restrictions. Mr. Greenberg testified that there are no workers for Respondent on permanent light duty.

Dr. Jay Levin performed Respondent Section 12 examinations, issued reports, and found no causal connection.

CAUSATION

Petitioner testified that he never sustained any prior condition of ill-being or injury to his low back. The sequence of events is consistent. The records and opinions of the treating physicians are corroborative. Dr. Levin's contrary opinion is not persuasive.

Based upon the foregoing, the Arbitrator finds that Petitioner's current condition of ill-being regarding his low back is causally related to the work injury.

MEDICAL

Respondent's dispute on this issue is premised on causation, which has been resolved in favor of Petitioner.

Therefore, the claimed medical bills shall be awarded.

TEMPORARY TOTAL DISABILITY BENEFITS AND MAINTENANCE

Petitioner was kept off full duty work by his treating physicians from January 26, 2007 through his MMI date March 20, 2013.

Therefore, Petitioner is entitled to the claimed temporary total disability benefits.

Petitioner's physical restrictions were then made permanent restrictions, but he was not accommodated by Respondent.

Therefore, Petitioner is entitled to the claimed maintenance benefits.

VOCATIONAL REHABILIATION

Petitioner has requested vocational rehabilitation. Respondent has not accommodated the physical restrictions. Petitioner testified that he would welcome vocational rehabilitation services and that he wants to work.

Therefore, Respondent shall authorize and pay for vocational rehabilitation services by a vocational rehabilitation specialist chosen by Petitioner.

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

Laura Alanis,

Petitioner,

14IWCC0976

vs.

NO: 09 WC 30810

Woodstock Christian Life Services,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner and Respondent herein and notice given to all parties, the Commission, after considering the issues of medical expenses, 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 December 30, 2013, is hereby affirmed and adopted.

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

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

14IWCC0976

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

DATED: NOV 13 2014
o10/22/14
RWW/rm
046

Ruth W. White

Charles J. DeVriendt

Daniel R. Donohoo

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

ALANIS, LAURA
Employee/Petitioner

Case# **09WC030810**

WOODSTOCK CHRISTIAN LIFE SERVICES
Employer/Respondent

14IWCC0976

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:

0247 HANNIGAN & BOTHA LTD
KEVIN D BOTHA
505 E HAWLEY ST SUITE 240
MUNDELEIN, IL 60060

1408 HEYL ROYSTER VOELKER & ALLEN
BRAD ANTONACCI
120 W STATE ST SUITE 201
ROCKFORD, IL 61105

14IWCC0976

STATE OF ILLINOIS)
)SS.
COUNTY OF McHENRY)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

LAURA ALANIS
Employee/Petitioner

v.

WOODSTOCK CHRISTIAN LIFE SERVICES
Employer/Respondent

Case # **09** WC **30810**

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 **Woodstock**, on **11/06/13**. 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 **10/21/08**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$13,694.72**; the average weekly wage was **$263.36**.

On the date of accident, Petitioner was **30** years of age, ***married*** with **4** dependent children.

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 **$1,033.35 as a PPD advance, and $10,522.16 for medical benefits**, for a total credit of **$11,555.51**.

Respondent is entitled to a credit of **$439.30** under Section 8(j) of the Act.

ORDER

Credits

Respondent shall be given a credit of $0 for TTD, $0 for TPD, $0 for maintenance, and $1,033.35 as a PPD advance, and $10,522.16 for medical benefits, for a total credit of $11,555.51.

Respondent is entitled to a credit of $439.30 under Section 8(j) of the Act.

Temporary Total Disability

Respondent shall pay Petitioner temporary total disability benefits of $0/week for 0 weeks, commencing N/A through N/A, as provided in Section 8(b) of the Act.

Medical Benefits

Respondent shall pay reasonable and necessary medical services of $0, as provided in Section 8(a) of the Act, as the Arbitrator finds the Respondent has paid all reasonable and necessary medical services.

Permanent Partial Disability: Person as a Whole

Respondent shall pay Petitioner permanent partial disability benefits of $263.36/week for 30 weeks, because the injuries sustained caused the 6% loss of the person as a whole, as provided in Section 8(d)2 of the Act.

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

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

Edward Lee
Signature of Arbitrator

12/27/13
Date

DEC 30 2013

14275-S5393
BAA/vlb

ARBITRATION DECISION

ATTACHMENT

14IWCC0976

Laura Alanis v. Woodstock Christian Life Services
Case No. 09 WC 30810

FINDINGS OF FACT

Petitioner worked as a housekeeper for the Respondent on 10/21/08. On that date, Petitioner was pushing a cart into the storage room when she slipped on some water on the floor and fell. She experienced pain in the center of her lower back and reported this to her supervisor, Jackie Starver.

The Respondent referred the Petitioner to Centegra Occupational Health for medical treatment. (Petitioner's Exhibit No. 1.) She was diagnosed with an acute lumbar sprain, prescribed Naproxen and Flexeril, and restricted to light-duty work. Petitioner testified that the Respondent accommodated her light-duty restrictions. Petitioner continued to follow up at Centegra through 11/25/08. At that time, the Petitioner advised her physician that she was 80 percent improved. (Respondent's Exhibit No. 4.) She noted mild, occasional pain in the lower back with excessive bending and lifting. Her examination was normal with no evidence of radicular pain, and she was diagnosed with an improved lumbar strain. Her physician released her to return to regular work duties starting 12/01/08. She was instructed to stop taking Naproxen and Flexeril and to discontinue physical therapy. She was released from treatment at that time. She underwent physical therapy at Majercik physical therapy during November 2010 as well. Petitioner was noted to have improved range of motion and mobility following physical

therapy and was also noted to have almost no pain on 11/24/08. She additionally denied numbness, tingling, or leg pain, according to the physical therapy records. (Petitioner's Exhibit No. 2.) As Petitioner testified, she noted significant improvement in her condition during her treatment at Centegra. She also confirmed that she returned to work full duty on 12/01/08.

Petitioner continued to work her regular duties and regular hours as a housekeeper for the Respondent from December 2008 through March 2010, a period of approximately 16 months. Petitioner received medical treatment for unrelated conditions at Mercy Health System. There is no reference to Petitioner's back until 4/06/09, even though she treated before that date at Mercy Health System on 2/24/09 and 3/20/09. On 4/06/09, she noted "mid" back pain "on/off x 2 days." (Petitioner's Exhibit No. 3.) There is no reference to the Petitioner's 10/21/08 work injury to her lower back at that time. She was not provided with a diagnosis with respect to her back, neither with respect to her mid back or lower back. It is noted throughout the records that the Petitioner is morbidly obese.

The Petitioner next received chiropractic treatment at Strelcheck Chiropractic Clinic on 5/23/09. (Petitioner's Exhibit No. 8.) She treated on one occasion for treatment of her lower back, groin, upper back, neck, jaw, and ringing in her ears. The records fail to mention or refer to the Petitioner's 10/21/08 work injury.

The Petitioner then presented to Mercy Health System on 8/23/09 and complained of back pain from an injury at work. (Petitioner's Exhibit No. 3.) She was requesting to treat with a chiropractor. She was diagnosed with chronic low back pain and morbid obesity. She was referred to physical therapy and psychology. The Petitioner then received a referral from Mercy Health System on 2/05/10 to treat with pain management.

The Petitioner treated with Dr. Kelly, a pain management physician, from 3/01/10 through 3/14/11. (Petitioner's Exhibit No. 4.) Petitioner was now complaining of pain radiation from her lower back into her hips and left leg. With respect to her lower back, Dr. Kelly diagnosed symptomatic left-greater-than-right L5-S1 lumbosacral radiculopathy with evidence of decreased Achilles reflexes and mild weakness of the left tibialis anterior muscle. He also diagnosed a superimposed mildly symptomatic tarsal tunnel syndrome. He recommended an EMG, which was performed on 3/15/10. The EMG revealed bilateral left-greater-than-right L5-S1 lumbosacral radiculopathy with evidence primarily of chronic axonal involvement, as well as bilateral left-greater-than-right compression/entrapment distal tibial mononeuropathy (tarsal tunnel syndrome), along with other unrelated findings.

Dr. Kelly performed a lumbar epidural steroid injection at L5-S1 on 3/22/10. Petitioner testified she noted no improvement after the injection. Dr. Kelly restricted the Petitioner from work on 3/29/13. Despite a lack of relief from the first injection, Dr. Kelly performed a second lumbar epidural steroid injection on 4/12/10. Dr. Kelly claimed that the Petitioner exacerbated her lower back symptoms after returning to work following the first injection. On 6/14/10, Dr. Kelly recommended a trial of Duragesic patches. On 7/19/10, he performed right-sided L3, L4, and L5 medial branch blocks. He then performed left-sided L3, L4, and L5 medial branch blocks on 7/26/10. He claimed the Petitioner responded well to the right-sided medial branch blocks but not the left-sided medial branch blocks. He therefore recommended radiofrequency ablation on the right side. He diagnosed left-sided-greater-than-right L5-S1 lumbosacral radiculopathy with persistent symptoms, particularly on the left, and a right-sided localized back pain that did respond very well to L3, L4, and L5 medial branch blocks, indicating a facet component to her back pain only on the right but not on the left.

Dr. Kelly performed a right-sided L3, L4, and L5 radiofrequency ablation on 10/07/10. He claimed this procedure significantly helped Petitioner's lower back pain, but the pain returned by 11/08/10. He felt the Petitioner's problem was chronic at that point. Dr. Kelly felt the Petitioner had reached MMI for nonsurgical treatment by 12/06/10 and for the first time recommended an MRI of the lumbar spine. The MRI was performed on 12/13/10, which revealed slight bulging of the disc material at the L4-L5 level without significant impingement upon the thecal sac or nerve roots. Dr. Kelly noted that there were no overt surgical lesions present. He referred the Petitioner to Dr. Dudar for consideration for a spinal cord stimulator.

The Petitioner presented to Dr. Dudar on 2/11/11. He diagnosed severe chronic low back pain with right leg lumbosacral radiculopathy left greater than right; degenerative disc disease; mild bulging disc, multilevel; severe myofascial syndrome; muscle spasm of lumbar spine; and neuropathic pain in the lower extremities. Dr. Dudar felt the Petitioner was a candidate for a possible spinal cord stimulator trial and also possibly suggested discography to rule out discogenic pain. The Petitioner did not follow up with Dr. Dudar.

When the Petitioner last treated with Dr. Kelly on 3/14/11, Dr. Kelly noted the Petitioner did not wish to seek the additional treatment recommended by Dr. Dudar. Dr. Kelly indicated the Petitioner reached maximum medical improvement.

The Petitioner has not treated with any physician since 3/14/11. She admitted that Dr. Kelly advised her to follow up with him, but she has not followed up with him. She also has no follow-up appointments scheduled with any physician. The Petitioner admitted that she never followed up with Dr. Dudar even though he was recommending additional medical treatment in February 2011.

The Petitioner testified that she moved to Guadalajara, Mexico, in April of 2011. She has been living in Mexico for the past two years and only recently returned to the United States, approximately one month prior to the hearing. Petitioner claimed that she looked for employment in Mexico but provided no documentation or specific information regarding this alleged job search. She testified that she currently resides in Mexico.

The Petitioner testified that she currently experiences pain in the center of her lower back that radiates to her sides. She also claimed that she experiences pain in both of her legs, left greater than right. She is currently not taking any prescription pain medications but takes Tylenol for pain. The Petitioner testified to some difficulty with performing some activities of daily living.

The Petitioner presented Dr. Kelly for his evidence deposition. (Petitioner's Exhibit No. 5.) Dr. Kelly testified that his diagnoses with respect to the Petitioner's lower back were causally related to the 10/21/08 work injury. He claimed the Petitioner's treatment has been reasonable, necessary, and causally related to the work injury. He indicated the Petitioner is restricted to sedentary work. On cross-examination, Dr. Kelly admitted there was a gap in treatment following the Petitioner's initial treatment at Centegra. When Dr. Kelly was questioned about the lack of any significant findings on the MRI, he claimed the MRI is not completely accurate. He admitted there were no findings on the MRI that require surgical intervention. Dr. Kelly admitted the Petitioner is obese, and obesity can aggravate lower back symptoms and issues. He also admitted he is only assuming that the Petitioner exceeded her light-duty restrictions when she returned to work following the first lumbar epidural steroid injection. He also admitted he did not review the utilization review report on this case. Dr. Kelly admitted the

Petitioner has not treated with him in over two years despite the fact that she was supposed to continue to follow up with him for ongoing pain medications.

Dr. Jay Levin performed a Section 12 examination at the request of the Respondent on 5/3/10. (Respondent's Exhibit No. 2.) The Respondent also presented Dr. Levin for his evidence deposition. (Respondent's Exhibit No. 1.) After performing an extensive examination, thoroughly reviewing the Petitioner's medical records, and obtaining an extensive history from the Petitioner, Dr. Levin diagnosed the Petitioner with a lumbar strain. He testified the Petitioner suffered no other injuries as a result of the alleged accident. His clinical findings did not match the Petitioner's subjective complaints. The only treatment he found to be reasonable, necessary, and related to the work accident was the treatment that occurred at Centegra Health Systems. He did not feel the Petitioner required any additional treatment after 12/01/08. According to Dr. Levin, the Petitioner could return to work full duty as of 12/01/08, consistent with the Centegra records. He also felt the Petitioner reached maximum medical improvement on that date as well. On cross-examination, Dr. Levin confirmed that any findings of potential radiculopathy on examination were contradicted by other physical findings he made, which would indicate the Petitioner was not suffering from radiculopathy. Dr. Levin noted that the 3/15/10 EMG findings needed to be correlated with an MRI. The MRI had not been performed at the time of Dr. Levin's examination. The Arbitrator notes the MRI reveals benign findings with no significant impingement.

Rising Medical Solutions performed a utilization review at the request of the Respondent on 11/09/10. (Respondent's Exhibit No. 3.) According to Dr. McCoy, the pain management physician who performed the utilization review, the Petitioner's lumbar epidural steroid injections were not reasonable or necessary. He indicated that one epidural injection should

have been performed given the patient's unresponsiveness to conservative therapy, but after minimal pain reduction and transient relief, a second injection should not have been performed. He also indicated that only one selective nerve root block was reasonable and necessary. According to Dr. McCoy, the EMG findings did not warrant the right L3, L4, and L5 selective nerve root blocks.

The Petitioner placed into evidence Petitioner's Exhibit No. 7, which purports to be the alleged outstanding medical bills on this claim. Respondent's Exhibit No. 5 documents the payments made on this claim, by the Respondent's workers' compensation carrier, for medical benefits as well as a PPD advance in the amount of $1,033.35.

14IWCC0976

CONCLUSIONS OF LAW

In support of the Arbitrator's decision relating to (F), whether the Petitioner's current condition of ill-being is causally related to the work injury, the Arbitrator finds the following:

The Arbitrator finds that the Petitioner suffered a lumbar strain as a result of the work injury, which resolved by 12/01/08. The Petitioner's current condition of ill-being is not causally related to that lumbar strain.

The medical records from Centegra Occupational Health illustrate that the Petitioner experienced a lumbar strain as a result of the work injury. As the Petitioner testified, and as the records from Centegra illustrate, the Petitioner noted significant improvement during the month of treatment she received at Centegra. She noted 80 percent improvement in her condition by 11/25/08. Her examination was normal with no evidence of radicular pain at that time. Her physician released her to return to regular work duties starting 12/01/08. She was released from treatment at that time. Her condition had resolved at this time.

Petitioner continued to work her regular duties and regular hours as a housekeeper for the Respondent from December 2008 through March 2010, a period of approximately 16 months. If the Petitioner was suffering from something beyond a lumbar strain, she would not have been able to complete her work duties and work for 16 months.

The Petitioner's medical records from Mercy Health System demonstrate that she was making no additional complaints with respect to her lower back in the spring of 2009, which further support the Arbitrator's conclusion. Petitioner received medical treatment for unrelated conditions at Mercy Health System. There is no reference to Petitioner's back until 4/06/09, even though she treated before that date at Mercy Health System on 2/24/09 and 3/20/09. On

4/06/09, she noted "mid" back pain "on/off x 2 days." (Petitioner's Exhibit No. 3.) This record clearly illustrates that the Petitioner was not experiencing back pain until around 4/04/09. It is also clear that the Petitioner was complaining of mid-back pain on 4/06/09. The only complaints she made with respect to her back following the work accident were in the lower back. There was never any mention of pain in the mid back. These complaints of back pain on 4/06/09 are clearly unrelated to the work injury. There is no reference to the Petitioner's 10/21/08 work injury to her lower back at that time. She was not provided with a diagnosis with respect to her back, neither with respect to her mid back or lower back. When the Petitioner received one chiropractic treatment at Strelcheck Chiropractic, she treated for numerous body parts and failed to mention or refer to the 10/21/08 work injury. It is not until 8/23/09 that the Petitioner attempts to claim that she continued to experience lower back pain from the 10/21/08 work injury. The Arbitrator finds that this significant gap in medical treatment and gap in complaints regarding the lower back breaks the causal connection chain.

These records support Dr. Levin's conclusion that the Petitioner suffered nothing more than a lumbar strain on 10/21/08 and suffered no other injuries as a result of the alleged accident. These records also support Dr. Levin's conclusion that the Petitioner reached maximum medical improvement on 12/01/08 as well.

It also appears that the Petitioner was not making any radicular complaints when she treated during the month following the work injury. She made no radicular complaints when she received physical therapy, and she denied radicular complaints when she treated with Mercy Health System and made back complaints in August of 2009. It is not until she began treating with Dr. Kelly in March of 2010 that there is notation of radicular complaints of pain. These

radicular complaints of pain are clearly inconsistent with the complaints the Petitioner was making in the month following the work injury and are not causally related to the work injury.

Petitioner's obesity is a causative factor with respect to her current lower back complaints. It is noted throughout the records that the Petitioner is morbidly obese. She was noted to have a body mass index of 44 in the medical records. She was recommended to undergo weight-loss treatment and at one point was recommended for bariatric surgery. Dr. Levin testified that obesity has a negative effect on the lumbar spine. This is due to more weight being applied across the lumbar spine from the total body weight above that area, in addition to comorbidities of other medical conditions that can occur with obesity. Dr. Kelly admitted in his deposition that the Petitioner is obese, and obesity can aggravate lower back symptoms and issues.

The MRI, which was performed on 12/13/10, revealed slight bulging of the disc material at the L4-L5 level without significant impingement upon the thecal sac or nerve roots. The Arbitrator notes that the MRI findings do not correlate with the EMG findings. The EMG findings were noted to be at the L5-S1 level, not the L4-L5 level. Dr. Kelly noted that there were no overt surgical lesions present. The radiographic findings do not support the Petitioner's continued complaints of pain. Even if the Petitioner's current complaints of pain are to be believed, the evidence is clear that these complaints are in no way causally related to the lumbar strain that occurred on 10/21/08.

The Arbitrator does not find Dr. Kelly's opinions to be credible. Dr. Kelly's opinions regarding causal connection ignore the gap in medical treatment following the Petitioner's release and return to regular work duties in December of 2008. His opinions also fail to recognize the lack of radicular complaints until one and a half years after the work injury. Dr.

Levin's opinions, however, are consistent with the medical evidence, and the Arbitrator therefore adopts his opinions.

The Petitioner suffered a lumbar strain as a result of the work injury. The evidence demonstrates that this condition resolved by 12/01/08. The Petitioner failed to provide evidence of continued lower back complaints or treatment to her lower back. This significant gap in treatment and complaints broke the causal connection chain between the Petitioner's 10/21/08 work injury and her current condition of ill-being. The fact that the Petitioner then began making radicular complaints of pain one and a half years later is inconsistent with her initial pain complaints following the work injury. Finally, the Petitioner's morbid obesity has played a causative role with respect to the Petitioner's current complaints of pain. Based on the above, the Arbitrator finds that the Petitioner suffered a lumbar strain as a result of the work injury.

In support of the Arbitrator's decision relating to (J), whether the medical services that were provided to Petitioner were reasonable and necessary, and whether the Respondent has paid all appropriate charges for reasonable and necessary medical services, the Arbitrator finds the following:

Based on section (F) above, the Arbitrator finds that any medical treatment that occurred after 12/01/08 is causally unrelated to the 10/21/08 work injury. The Arbitrator adopts the opinions of Dr. Levin and finds that the Petitioner was at MMI as of 12/01/08 and required no additional medical treatment. The only treatment that was reasonable and necessary was the treatment that occurred at Centegra Occupational Health. According to Petitioner's Exhibit No. 7, and Respondent's Exhibit No. 5, the Respondent's workers' compensation carrier paid all medical bills from Centegra Occupational Health. Therefore, the Respondent has paid all appropriate charges for reasonable and necessary medical services.

In support of the Arbitrator's decision relating to (K), temporary total disability benefits, the Arbitrator finds the following:

Based on section (F) above, the Arbitrator finds that the Petitioner reached maximum medical improvement as of 12/01/08. The Petitioner was released to return to full work duties at that time and did return to full work duties. Dr. Levin additionally indicated the Petitioner could return to full work duties at that time and required no work restrictions. (Respondent's Exhibit No. 1.) The Petitioner is claiming that she was temporarily totally disabled from 3/29/10 through 3/14/11, the period in which Dr. Kelly restricted her from work. However, even if the Petitioner required these work restrictions, as noted in section (F) above, these work restrictions are causally unrelated to the 10/21/08 work injury. Therefore, the Arbitrator finds that the Petitioner failed to prove entitlement to TTD benefits and denies all requests for TTD.

191WCC0976

In support of the Arbitrator's decision relating to (L), the nature and extent of the injury, the Arbitrator finds the following:

The Arbitrator finds that the Petitioner's 10/21/08 work injury resulted in a lumbar strain, which improved with conservative treatment. On 11/25/08, the Petitioner advised her physician that she was 80 percent improved. (Respondent's Exhibit No. 4.) She noted mild, occasional pain in the lower back with excessive bending and lifting. Her examination was normal with no evidence of radicular pain at that time, and she was diagnosed with an improved lumbar strain. Her physician released her to return to regular work duties starting 12/01/08. She was instructed to stop taking Naproxen and Flexeril and to discontinue physical therapy. She was released from treatment at that time. She underwent physical therapy at Majercik Physical Therapy during November 2010 as well, and Petitioner was noted to have improved range of motion and mobility following physical therapy. She was also noted to have almost no pain on 11/24/08. Petitioner additionally denied numbness, tingling, or leg pain, according to the physical therapy records. (Petitioner's Exhibit No. 2.) As Petitioner testified, she noted significant improvement in her condition during her treatment at Centegra. She also confirmed that she returned to work full duty on 12/01/08, and continued to work her regular hours and regular duties as a housekeeper for the Respondent.

Based on the above, the Arbitrator finds that the Petitioner is entitled to permanent partial disability benefits of $263.36 per week for 30 weeks, because the injuries sustained caused the 6 percent loss of the person as a whole, pursuant to Section 8(d)2 of the Act. Pursuant to Respondent's Exhibit No. 5, the Respondent is entitled to a credit in the amount of $1,033.35 for the prior PPD advance.

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

Evangelina Diaz,

Petitioner,

14IWCC0977

vs.

NO: 11WC0163

Elite Staffing,

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

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

14IWCC0977

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $13,500.00. 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: NOV 13 2014
o10/21/14
RWW/rm
046

Ruth W. White

Charles J. DeVriendt

Daniel R. Donohoo

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

DIAZ, EVANGELINA
Employee/Petitioner

Case# **11WC000163**

14IWCC0977

ELITE STAFFING
Employer/Respondent

On 4/8/2013, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

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

2553 LAW OFFICES OF JAMES P McHARGUE
MATTHEW C JONES
100 W MONROE ST SUITE 1605
CHICAGO, IL 60603

4866 KNELL & O'CONNOR
KAROLINA ZIELINSKA
901 W JACKSON BLVD SUITE 301
CHICAGO, IL 60607

STATE OF ILLINOIS)
)SS.
COUNTY OF COOK)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Evangelina Diaz
Employee/Petitioner
v.
Elite Staffing
Employer/Respondent

Case # **11 WC 163**

14IWCC0977

An *Application for Adjustment 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 **February 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: Whether prospective medical should be awarded?

FINDINGS

14IWCC0977

On **October 26, 2010**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

Petitioner's current condition of ill-being regarding her right hand and wrist only *is* causally related to the accident.

In the year preceding the injury, Petitioner earned **$8,973.91**; the average weekly wage was **$309.45**.

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

Petitioner ***has*** received all reasonable and necessary medical services for her right hand and wrist.

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

Respondent shall be given a credit of **$3268.21** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$3268.21**.

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 **$309.45**/week for **23** weeks, commencing **October 28, 2010** through **November 7, 2010**, from **December 4, 2010** through **February 13, 2011**, from **June 16, 2011** through **July 14, 2011**, and from **August 22, 2011** through **October 13, 2011**, as provided in Section 8(b) of the Act.

Respondent shall pay Petitioner the temporary total disability benefits that have accrued from **October 28, 2010** through **February 26, 2013**, and shall pay the remainder of the award, if any, in weekly payments.

Respondent shall be given a credit of **$3268.21** for temporary total disability benefits that have been paid.

Respondent shall pay reasonable and necessary medical services for Petitioner's right hand and wrist injury, as provided in Sections 8(a) and 8.2 of the Act.

Respondent shall pay Petitioner permanent partial disability benefits of **$309.45**/week for **30.75** weeks, because the injuries sustained caused the **15%** loss of use of the **right hand**, as provided in Section 8(e) of the Act.

Respondent shall have credit for all amounts paid, if any, to or on behalf of the petitioner, on account of said accidental injury.

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

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

14IWCC0977

Signature of Arbitrator

April 5, 2013
Date

APR 8- 2013

FINDINGS OF FACT

On October 28, 2010, Petitioner presented to Concentra Medical Center in Chicago, Illinois. Petitioner indicated that she twisted the radial aspect of her forearm two days earlier when winding up a cord from a machine at work. Petitioner reported stiffness in her right wrist and hand and described her pain as moderate and aching. The assessment states forearm strain/sprain. Petitioner was prescribed ibuprofen and was scheduled for physical therapy. Petitioner was assigned modified duty with a lifting restriction of 20 pounds and restricted use of her right hand. She received follow up treatment at Concentra and was assessed with right de Quervain's tendonitis. Petitioner was given work limitations and was to continue with physical therapy, wrist splinting, and medication. (Px 1).

Petitioner was referred to an orthopedic surgeon, Dr. Charles Mercier. Petitioner was diagnosed with de Quervain's, received a cortisone injection to her wrist, and was told to follow up. Dr. Mercier recommended a de Quervain's release and a continuation of the work restrictions pending surgical approval.

Petitioner presented to Dr. John Fernandez, for a Section 12 examination. Dr. Fernandez agreed that Petitioner had de Quervain's tenosynovitis, he opined that it was work related, and he recommended surgical intervention including a right wrist first dorsal compartment release and a possible right wrist carpal tunnel release. (Px 3).

Petitioner returned to Dr. Mercier. He noted that Dr. Fernandez's report indicated a diagnosis of possible carpal tunnel syndrome. Dr. Mercier opined that any potential carpal tunnel symptoms were not related to the alleged accident. Petitioner was told to continue modified work duties and to follow up. Surgery and EMG testing had not been approved. (Px 2).

On March 30, 2011, Petitioner presented to Dr. Fernando Perez, a chiropractor, at Marque Medicos. Petitioner complained of right wrist pain, right elbow pain, right shoulder and neck pain. She indicated that on October 26, 2010 she was performing repetitive and forceful work with her right hand and arm when she suddenly experienced a cramp in her right shoulder, then forcefully pulled her right arm out and experienced a popping sensation in her right wrist with immediate pain. Radiology and EMG and studies were performed. Petitioner was referred to Dr. Andrew Engel, a pain specialist, Dr. Ellis Nam, an orthopedic surgeon, Dr. Richard Shin, a hand surgeon, and physical therapists at Marque Medicos. Petitioner was treated for right upper extremity and neck symptoms. (Px 5).

On June 16, 2011, Petitioner underwent dorsal compartment of wrist tendon release on her right wrist performed by Dr. Shin. Petitioner followed up with Dr. Shin and underwent physical therapy. She was eventually released from treatment and returned to regular work regarding her right hand. (Px 11).

Dr. Nam prescribed cortisone injections. He eventually released her for any further right shoulder treatment and placed her at full duty, noting that he did not feel there was much he could do for her. (Px 10, Pg. 6).

Petitioner returned to Dr. Engel, who administered right C4, C5, and C6 medial branch blocks on two

occasions. Dr. Engel then referred Petitioner to Dr. Robert Erickson, a neurosurgeon. (Px 6).

Petitioner presented to Dr. Erickson. He recommended anterior cervical discectomy and fusion at C5-C6." (Px 12, Pg. 5). On November 18, 2011, Petitioner underwent surgery performed by Dr. Erickson. Petitioner underwent an anterior cervical discectomy and fusion C5-C6, anterior cervical discectomy and fusion C4-C5. Intravertebral devices were placed at both levels (PEEK cages) and anterior cervical plates at C4 through C6 were also placed. (Px 12, Pgs. 8-9).

Petitioner returned to Dr. Engel, and underwent postoperative physical therapy at Marque Medicos. (Px 6). Petitioner was advised to remain off work. (Px 5). Dr. Erickson wrote a letter to Dr. Engel stating that Petitioner recovered well from surgery and recommended that Petitioner can return to work as a factory seamstress on or February 18, 2012. He further wrote that Petitioner's treatment had been medically reasonable and necessary. On March 16, 2012, Dr. Engel released Petitioner to full work duty and discharged her from treatment. (Px. 12, Pg. 12-13). Dr. Erickson testified at an evidence deposition and reiterated his opinions. (Px 17).

Petitioner presented to Dr. Carl Graf, an orthopedic spinal surgeon, for a Section 12 examination. Dr. Graf opined that the care and treatment regarding the cervical spine was not reasonable, not necessary, not medically indicated, and not causally related. (Rx 3).

Petitioner testified, through a Spanish speaking interpreter, that following her wrist surgery her pain went away but she still had numbness in her fingers. (Tr. 30). Petitioner testified that she decided to take time off work on her own while on light duty restrictions in July of 2011. (Tr. 36). Petitioner testified that she was supposed to call Respondent to return to light duty work on April 15, 2011, but that she did not call until August 22, 2011 and August 25, 2011, and that she was not offered light duty work at that time because none was available. (Tr. 37).

On cross examination, Petitioner admitted that the contact person for returning to work was Lisa Ontiveros from Alava. (Tr. 71). Petitioner admitted that she never contacted Lisa again after calling Marisol Arroyo on August 22, 2011 regarding return to work. (Tr. 71-72).

On cross examination, Petitioner admitted that she filled out a patient form when she first presented to Concentra Medical Centers on October 28, 2010. (Tr. 50). Petitioner admitted that the form indicated that she was sewing a cord and felt a cramp in her hand. (Tr. 51). Petitioner admitted that in the portion of the form where it asks to fill in what body part was injured she filled in "right hand" and did not say anything about her shoulder or her neck. (Tr. 51).

Petitioner testified that Dr. Erickson recommended a fusion at C5-C6 and that she was aware she was going to undergo surgery at this level. (Tr. 68). Petitioner further testified that before undergoing surgery she was not aware that Dr. Erickson was going to perform a two level fusion. (Tr. 68-69).

CONCLUSIONS OF LAW

Regarding Issues "C" and "F," whether Petitioner's current condition of ill-being is causally related to an accident which arose out of and in the course of Petitioner's employment with Respondent, the Arbitrator finds the following:

The Arbitrator concludes that Petitioner's current condition of ill-being as it relates to her right hand and wrist is causally related to the October 26, 2010 work accident. This conclusion is based on the medical histories contained within the treatment records as well as the opinions of Dr. Shin and Dr. Fernandez.

The Arbitrator further concludes that Petitioner's current condition of ill-being, as it relates to all other claimed body parts, is not causally related to the October 26, 2010 work accident. Petitioner's testimony lacks credibility regarding these injuries. The histories of accident contained within the treatment records are inconsistent with one another as well as with Petitioner's testimony. The Arbitrator is not persuaded by Dr. Erickson's opinions. The Arbitrator is persuaded by Dr. Graf's opinions.

Regarding Issue "J," whether the medical services provided to Petitioner were reasonable and necessary and whether Respondent has paid all appropriate charges for reasonable and necessary medical services, the Arbitrator finds the following:

Based upon the conclusions for accident and causation, Petitioner's claims for medical benefits pertaining to treatment for her right hand and wrist are awarded. Those medical bills are to be paid pursuant to the medical fee schedule.

Petitioner's claims for medical benefits pertaining to all other claimed body parts are denied.

Regarding Issue "K," whether temporary total disability (TTD) benefits are due, the Arbitrator finds the following:

Based upon the conclusions for accident and causation, Respondent's liability for temporary total disability benefits is awarded for time off work due to the right hand and wrist injury only. Compensation was properly paid for that injury.

Regarding Issue "L," whether Petitioner is entitled to permanent partial disability benefits, the Arbitrator finds the following:

Based upon the medical evidence and medical opinions, Petitioner has sustained a 15% loss of use of the right hand.

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

Araceli Martinez,
Petitioner,

vs. No. 10 WC 23904

Aramark Business Facilities LLC,
Respondent.

14IWCC0978

DECISION AND OPINION ON REVIEW

Petitions for Review having been timely filed by Respondent and Petitioner, and notice given to all parties, the Commission, after considering the issues of benefit rates, medical expenses, causal connection, temporary total disability, nature and extent, and penalties and fees, and being advised of the facts and law, modifies the March 1, 2013 Decision of Arbitrator Kelmanson as stated below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

After considering the entire record, the Commission affirms and adopts the Arbitrator's findings with respect to all issues. However, the Commission modifies the Arbitrator's Decision by striking the following language, found on page 7 of the Arbitrator's Findings of Fact and Conclusions of Law:

> Should the parties in the future disagree as to whether Respondent has properly satisfied the award of medical expenses, section 19(g) of the Act provides Petitioner with enforcement mechanism in the circuit court.

All else is affirmed and adopted.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed on March 1, 2013 is hereby modified.

IT IS FURTHER ORDERED BY THE COMMISSION that the language contained in the Arbitrator's Findings of Fact and cited above be stricken from the Arbitrator's Decision.

14IWCC0978

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay all reasonable, necessary, and related medical bills for the treatment of Petitioner's right knee in Petitioner's Exhibits 6 through 11 and for the treatment of Petitioner's neck and back conditions in Petitioner's Exhibits 6 and 7, subject to Dr. Wehner's opinion that no more than 12 physical therapy or chiropractic sessions were medically necessary, pursuant to the medical fee schedule, in accordance with and subject to §§8(a) and 8.2 of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay Petitioner temporary total disability benefits of $267.03 per week for 44-3/7 weeks commencing May 4, 2010 through October 19, 2010, and from January 24, 2011 through June 14, 2011, as provided in Section 8(b) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay Petitioner permanent partial disability benefits of $245.33 per week for 47.3 weeks, because the injuries sustained caused Petitioner the loss of use of 22% of the right leg, as provided in Section 8(e) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay Petitioner further permanent partial disability benefits of $245.33 per week for 15 weeks, because the injuries sustained caused Petitioner the loss of use of 3% of the person as a whole, as provided in Section 8(d)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 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 $30,000.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: NOV 14 2014

Daniel R. Donohoo

Kevin W. Lamborn

Thomas J. Tyrrell

o-11/5/13
drd/dak
68

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

MARTINEZ, ARACELI
Employee/Petitioner

Case# **10WC023904**

ARAMARK BUSINESS FACILITIES LLC
Employer/Respondent

14IWCC0978

On 3/1/2013, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.13% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

1922 SALK, STEVEN B & ASSOC LTD
DAMIAN R FLORES
150 N WACKER DR SUITE 2570
CHICAGO, IL 60606

2337 INMAN & FITZGIBBONS LTD
TERRENCE DONOHUE
33 N DEARBORN SUITE 1825
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

Araceli Martinez
Employee/Petitioner

v.

Aramark Business Facilities, LLC
Employer/Respondent

Case # **10** WC **23904**

Consolidated cases: _____

14IWCC0978

An *Application for Adjustment 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 **January 14, 2013**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **5/3/2010**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$20,828.60**; the average weekly wage was **$400.55**.

On the date of accident, Petitioner was **47** years of age, ***married*** with **0** dependent children.

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

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

Respondent shall be given a credit of **$7,060.34** for TTD benefits, for a total credit of **$7,060.34**.

ORDER

Respondent shall pay Petitioner temporary total disability benefits of **$267.03**/week for **44 3/7** weeks, commencing **May 4, 2010**, through **October 19, 2010**, and from **January 24, 2011**, through **June 14, 2011**, as provided in Section 8(b) of the Act.

Respondent shall pay the medical bills pertaining to the right knee in Petitioner's Exhibits 6 through 11 pursuant to sections 8(a) and 8.2 of the Act. Further, Respondent shall pay the medical bills pertaining to the neck and back conditions in Petitioner's Exhibits 6 and 7, subject to Dr. Wehner's opinion that no more than 12 physical therapy or chiropractic sessions were medically necessary. Respondent shall be given a credit for the sums it paid toward the medical bills.

Respondent shall pay Petitioner permanent partial disability benefits of **$245.33**/week for **47.3** weeks, because the injuries sustained caused the **22%** loss of use of the **right leg**, as provided in Section 8(e) of the Act.

Respondent shall pay Petitioner further permanent partial disability benefits of **$245.33**/week for **15** weeks, because the injuries sustained caused the **3%** loss of the person as a whole, as provided in Section 8(d)2 of the Act.

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

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

Signature of Arbitrator

3/1/2013
Date

MAR 1 - 2013

14IWCC0978

FINDINGS OF FACT AND CONCLUSIONS OF LAW

Petitioner testified via a Spanish interpreter that she worked for Respondent Aramark Business Facilities for two years, performing housekeeping and cleaning duties on site at Corn Products. Petitioner explained that she cleaned the production floor using a power hose to spray the floor, the tanks and the tubes with hot water. She worked eight hour shifts and was on her feet between five and a half and six hours a day. As part of her cleaning duties, Petitioner went up and down the stairs of the three story building where she worked. Petitioner estimated that she went up and down the stairs 15 to 20 times a day. Petitioner denied prior problems with her neck, low back or right knee.

Petitioner further testified that on May 3, 2010, she slipped and fell on wet floor while cleaning a hallway, landing on her back and striking her head against the floor and her right knee against a tube. An ambulance transported Petitioner to MacNeal Hospital, where the staff diagnosed contusions to the back, neck and right knee and released Petitioner to return to work on sedentary duty.

On May 6, 2010, Petitioner sought treatment at Marque Medicos for complaints of severe pain in the neck, mid and low back, and right knee. She also complained of headaches, dizziness, nausea and vomiting. On physical examination by Chiropractor James, Petitioner exhibited very poor gait and posture, inability to walk without help, and "obvious distress." She complained of extreme pain with many diagnostic maneuvers. Dr. James recommended chiropractic treatment, physical therapy and an MRI, and took Petitioner off work. An MRI of the cervical spine showed a 2 mm central disc protrusion at C3-C4 and C5-C6, without stenosis. An MRI of the lumbar spine showed a 1.5 mm disc bulge at L4-L5 and L5-S1, without stenosis. An MRI of the right knee was interpreted by the radiologist as showing a small effusion and a 1 cm area of "cartilaginous blistering" along the superior aspect of the patellar ridge. Dr. James referred Petitioner to Dr. Engel for pain management and Dr. Nam for orthopedic care.

On May 24, 2010, Petitioner saw Dr. Nam, complaining of persistent right knee pain, swelling, catching and giving way. Dr. Nam diagnosed knee contusion "with probable osteochondral lesion [of the] patellar surface," opining the condition was causally connected to the work accident. He recommended continuing physical therapy and kept Petitioner off work.

On May 27, 2010, Petitioner saw Dr. Engel, rating her right knee pain a 9/10 and her neck and low back pain a 10/10. Physical examination was notable for a restricted range of motion with a negative straight leg raise test. Dr. Engel prescribed medication, recommended continuing physical therapy, and kept Petitioner off work.

On June 2, 2010, Dr. Wehner, a spine surgeon, examined Petitioner at Respondent's request primarily with respect to the neck and back conditions. Dr. Wehner testified via evidence deposition on March 11, 2011, that Petitioner was ambulating with a cane and requested to be provided with a walker or a wheelchair. Petitioner described the work accident consistently with her testimony and complained that she was feeling worse than on the date of the accident. She complained of mid back pain, which she rated a 10/10, and neck and right knee pain, which she rated a 9/10. Physical examination was notable for poor effort and multiple

pain behaviors. Dr. Wehner reviewed the cervical and lumbar MRI studies, which she interpreted as being within normal limits for Petitioner's age, and diagnosed soft tissue injuries of the neck and low back, noting marked symptom magnification and histrionic behavior. Dr. Wehner opined the reasonable course of treatment would include a total of 12 chiropractic or physical therapy visits, noting that Petitioner had already attended 10 chiropractic or physical therapy sessions. Dr. Wehner opined Petitioner would reach maximum medical improvement and could return to work full duty after completing two more sessions.

On June 16, 2010, Petitioner followed up with Dr. Engel's physician's assistant, rating her neck pain a 4/10 and low back pain a 6/10. On physical examination, she exhibited a restricted range of motion, tenderness to palpation and diminished strength. The physician's assistant adjusted Petitioner's medications, recommended continuing physical therapy, and kept her off work.

On June 21, 2010, Petitioner followed up with Dr. Nam, complaining of persistent right knee pain. Dr. Nam recommended an MR arthrogram and continuing physical therapy, and kept Petitioner off work. The MR arthrogram, performed June 23, 2010, was interpreted by the radiologist as showing chondromalacia patella and osteoarthritic changes, without a focal chondral defect.

On July 1, 2010, Petitioner followed up with Dr. Engel, rating her pain a 5/10 overall. On physical examination, she had a full cervical range of motion and improved lumbar range of motion. Dr. Engel recommended lumbar medial branch blocks and continuing medication management and physical therapy, and kept Petitioner off work.

On July 19, 2010, Petitioner followed up with Dr. Nam, who interpreted the MR arthrogram as showing a probable osteochondral lesion in the lateral facet of the patella. He recommended a cortisone injection, which Petitioner declined, continuing physical therapy, and kept Petitioner off work.

On July 30, 2010, Dr. Wehner issued an addendum report after reviewing additional medical records. Dr. Wehner testified in her evidence deposition that her opinions remained unchanged.

On August 12, 2010, Petitioner followed up with Dr. Engel and rated her pain a 3/10 overall. Physical examination of the cervical and lumbar spine was normal. Dr. Engel discontinued physical therapy, recommended a functional capacity evaluation, and released Petitioner to return to work on restricted duty in the interim.

On August 16, 2010, Petitioner followed up with Dr. Nam and complained of persistent pain in the right knee. Dr. Nam performed a cortisone injection and kept Petitioner off work.

On or about August 24, 2010, Dr. Hole, an orthopedic surgeon, conducted a retrospective record/utilization review. Dr. Hole opined the chiropractic treatment, physical therapy and medications Petitioner received were appropriate and related to the work accident. Dr. Hole disagreed that Petitioner should be off work and recommended a functional capacity evaluation.

On September 9, 2010, Dr. Evans, an orthopedic surgeon, examined Petitioner at Respondent's request regarding her right knee condition. Petitioner described the mechanism of injury consistently with her testimony and reported no significant improvement in the symptoms since the work accident. Dr. Evans diagnosed a patellar contusion and exacerbation of preexisting osteoarthritis, which he causally connected to the accident. Dr. Evans opined that Petitioner had received appropriate medical treatment and reached maximum medical improvement, and could return to work on light duty. He recommended a functional capacity evaluation to delineate Petitioner's work capabilities.

On September 20, 2010, Petitioner followed up with Dr. Nam, reporting no improvement with the injection. Dr. Nam recommended surgery and kept Petitioner off work. Respondent's Exhibit 6 is a light duty offer, effective September 29, 2010.

A functional capacity evaluation, performed October 4, 2010, placed Petitioner at the light physical demand level.

On October 7, 2010, Petitioner presented for an appointment with Dr. Engel, reporting no improvement. Dr. Engel was busy attending to another patient, and Petitioner became upset and left without rescheduling. Dr. Engel discharged Petitioner from care and referred her to another pain management physician.

In a narrative report dated October 8, 2010, Dr. Nam opined the proposed surgery was medically necessary and causally connected to the work accident, explaining that he relied on the mechanism of injury and the chain of events.

Petitioner underwent physical therapy at Marque Medicos from May 6, 2010, through October 11, 2010. Contemporaneously, she also underwent some chiropractic treatment at Marque Medicos.

On October 18, 2010, Petitioner followed up with Dr. Nam, who reviewed the results of the functional capacity evaluation and released her to return to work on light duty. Dr. Nam discontinued physical therapy in anticipation of authorization for the surgery.

Petitioner testified that on October 20, 2010, she returned to work for Respondent and was asked to sort papers.

On December 6, 2010, Petitioner followed up with Dr. Nam, reporting that she had to do a lot of walking at work, even though she was on light duty. She complained of pain and was afraid her knee was going to give out. Dr. Nam restricted Petitioner to sedentary duty.

Petitioner testified that Respondent mostly had her sort papers until January of 2011, when Eva Delgado, an assistant to Carl Hill, the site manager at Corn Products, asked her to pick up garbage outside for two days. Petitioner testified that during those two days, she spent five hours a day walking outside, picking up garbage with a "pincher" and putting it in a container. She felt a great deal of pain in her back and right knee as a result.

On January 24, 2011, Petitioner followed up with Dr. Nam, complaining of persistent knee pain and reporting that Respondent made her walk outside. Dr. Nam reiterated his recommendation for surgery and took Petitioner off work.

On February 23, 2011, Dr. Wehner issued a second addendum report after reviewing additional medical records and a surveillance video. Dr. Wehner testified in her evidence deposition that her opinions remained unchanged, and disagreed that Petitioner should be under a lifting restriction with respect to her neck and back conditions.

Dr. Nam testified via evidence deposition on February 25, 2011, that his review of the MR arthrogram confirmed the suspicion of a lesion or abnormality involving the cartilage surface of the patella. Based on Petitioner's history, the mechanism of injury, clinical presentation and diagnostic studies, Dr. Nam opined the lesion represented an acute change from the work accident. Dr. Nam maintained the proposed surgery was medically necessary. Dr. Nam opined that, with respect to the right knee condition, Petitioner was unable to work from May 24, 2010, through October 18, 2010, because she had "too much difficulty ambulating." On January 24, 2011, Dr. Nam took Petitioner off work because Petitioner complained Respondent was not honoring her restrictions. Dr. Nam opined the physical therapy Petitioner underwent for the right knee condition had been reasonable and necessary. Dr. Nam denied prescribing Petitioner a cane.

On March 7, 2011, Dr. Evans issued an addendum report after reviewing additional medical records and a surveillance video, which he noted was of poor quality. Regarding the surgery recommended by Dr. Nam, Dr. Evans stated: "[I]f there is no evidence of pre-injury pain with her patellofemoral arthritis and she is having enough pain to require surgery then the surgery would be referable to the work related injury."

On April 5, 2011, Dr. Nam performed arthroscopic abrasion arthroplasty of the patella, chondroplasty of the lateral tibial plateau, and synovectomy of the medial plica. Intraoperatively, he diagnosed a chondral lesion of the patella, a chondral flap lesion of the lateral tibial plateau, and synovitis of the medial patellofemoral joint space. Petitioner testified she did not work or seek light duty work from January 24, 2011, through April 5, 2011, and postoperatively. Petitioner's postoperative recovery was unremarkable. She underwent physical therapy at Marque Medicos from April 14, 2011, through July 22, 2011. Contemporaneously, she also underwent some chiropractic treatment at Marque Medicos.

On June 13, 2011, Petitioner followed up with Dr. Nam, complaining of right knee pain and difficulty going up and down the stairs. On physical examination, she had pain with patellofemoral compression. Dr. Nam recommended continuing physical therapy and released Petitioner to return to work on sedentary duty. Petitioner testified she returned to work on sedentary duty on June 15, 2011. When she attended physical therapy on June 16, 2011, she rated her knee pain a 2/10.

On June 20, 2011, Dr. Brecher, an orthopedic surgeon, performed a prospective utilization review at Respondent's request. Dr. Brecher opined additional postoperative physical

therapy for the right knee was not medically necessary, although he acknowledged decreased strength in the knee. On July 7, 2011, Dr. Humberstone, a chiropractor, reviewed and agreed with Dr. Brecher's opinion. On January 4, 2012, Dr. Brecher performed a retrospective utilization review, reiterating his opinion that physical therapy after June 20, 2011, was not medically necessary.

On July 25, 2011, Petitioner followed up with Dr. Nam, complaining of knee pain with climbing stairs. Dr. Nam prescribed work conditioning and modified Petitioner's restrictions to no stair climbing or lifting more than 10 pounds.

On August 2, 2011, Dr. Evans reexamined Petitioner. Petitioner reported the right knee pain was usually a 1.5/10, increasing to 3-4/10 after physical therapy or a misstep. Objective physical examination findings were near normal. Dr. Evans also recommended work conditioning, followed by a functional capacity evaluation.

From August 1, 2011, through September 9, 2011, Petitioner underwent work conditioning at Elite Physical Therapy. Petitioner testified that she noticed additional improvement in her right knee with work conditioning.

On September 12, 2011, Petitioner followed up with Dr. Nam and complained of persistent knee pain. Dr. Nam discontinued work conditioning, recommended a functional capacity evaluation, and continued Petitioner's restrictions. The functional capacity evaluation, performed September 19, 2011, placed Petitioner at the light to medium physical demand level, consistent with her job description. On September 26, 2011, Petitioner followed up with Dr. Nam, who released her to return to work full duty and discharged her from care.

Petitioner testified that she has returned to work for Respondent full duty. She rated her current neck pain a 1/10, her back pain a 2/10 and her right knee pain also a 2/10, explaining that she notices the pain at the end of the workday. Regarding her right knee condition, Petitioner testified that the knee is not the same. It is weaker than it was before the accident and hurts a lot during cold weather. It also hurts with kneeling. Petitioner described the pain as "pinching." Likewise, Petitioner mentioned "pinching" pain in her low back during cold weather, and testified to low back pain with prolonged sitting. Petitioner further testified that she has become a restless sleeper and now puts a pillow between her legs to sleep better. She takes over-the-counter Tylenol approximately twice a week. Petitioner admitted she has not treated for her injuries or missed work since September of 2011.

Carl Hill, Respondent's site manager at Corn Products, testified that his job duties include making light duty assignments after reviewing work restrictions. According to Mr. Hill, Respondent accommodates light duty restrictions "100 percent of the time." Mr. Hill explained that the facility at Corn Products was large, with lots of sedentary work to be done. When Petitioner returned to work on restricted duty on October 20, 2010, Mr. Hill assigned her to filing and handling paperwork and assisting Ms. Delgado. Between October 20, 2010, and January 24, 2011, Petitioner's assignments were based on the restrictions recommended by Dr. Evans. At some point in January of 2011, Petitioner complained to Mr. Hill about being assigned to work outside. Mr. Hill explained that Petitioner was sent outside to pick up some trash, but was not

expected to work outside all day. When Petitioner complained, Mr. Hill told her she would need to see her doctor about modifying the restrictions.

Mr. Hill further testified that currently Petitioner continues to work at the entity formerly known as Corn Products, performing her regular duties of cleaning the production floor. Petitioner is now assigned only to the first floor, and needs to walk up and down the stairs no more than a couple of times a day.

In support of the Arbitrator's decision regarding (F), is Petitioner's current condition of ill-being causally related to the injury, the Arbitrator finds as follows:

The Arbitrator finds Petitioner's right knee, neck and low back conditions are causally connected to the work accident.

In support of the Arbitrator's decision regarding (J), were the medical services that were provided to Petitioner reasonable and necessary, and has Respondent paid all appropriate charges for all reasonable and necessary medical services, the Arbitrator finds as follows:

Petitioner's Exhibits 6 through 11 contain medical bills. The parties dispute the proper medical fee schedule amounts under the Act, particularly with respect to Petitioner's Exhibits 6 and 10, each side having arrived at different fee schedule amounts. Petitioner's Exhibit 6 contains physical therapy and chiropractic bills from Marque Medicos, showing charges in the sum of $52,368.00 and corresponding fee schedule amounts in the sum of $37,151.99. Petitioner's Exhibit 10 is a "Facility Fees" bill in the sum of $40,505.40, discounted to $30,784.10 pursuant to the medical fee schedule, from Ambulatory Surgical Care Facility, LLC., where Dr. Nam performed the right knee surgery on April 5, 2011. The Arbitrator notes that even at a glance, the claimed facility fee by far exceeds the operating room bills generally charged by Chicago's best hospitals. Respondent's Exhibit 3 contains the fee schedule calculations performed by Bunch & Associates on March 30, 2012 and April 2, 2012, determining the fee schedule amount for the physical therapy and chiropractic treatment at Marque Medicos to be $9,681.05, and the fee schedule facility charge from Ambulatory Surgical Care Facility to be $15,342.96. Respondent's Exhibit 4 contains "amended" fee schedule calculations performed by Bunch & Associates on January 5, 2012, determining the fee schedule facility charge from Ambulatory Surgical Care Facility to be $11,507.22, revised from the Bunch & Associates previous calculation of $7,671.48.

As noted, the parties dispute each other's fee schedule calculations. Yet no foundation has been laid establishing the accuracy of *any* of the fee schedule calculations. The Arbitrator is not persuaded by the medical fee schedule calculations performed by Marque Medicos and Ambulatory Surgical Care Facility. Regarding the remainder of Petitioner's medical bills, it is unclear who performed the fee schedule calculations on Petitioner's behalf. The Arbitrator is also not persuaded by the fee schedule calculations performed by Bunch & Associates. The Arbitrator notes two major revisions to the fee schedule facility charge from Ambulatory Surgical Care Facility. On this record, the Arbitrator is unable to resolve the fee schedule dispute.

In Tower Automotive v. Workers' Compensation Comm'n, 407 Ill. App. 3d 427 (2011), the appellate court explained that the purpose of the Act is satisfied when the employee and her family are relieved of the costs and burdens of reasonable and necessary medical care. Thus, the employer's liability for medical expenses is limited to the amounts accepted by the providers to satisfy the medical bills or to the fee schedule amounts under section 8.2 of the Act. The Arbitrator finds that a "boilerplate" award of medical expenses is the correct remedy under the circumstances.

Relying on the opinions of Dr. Nam, Dr. Evans and Dr. Hole, the Arbitrator finds the entire treatment for Petitioner's right knee injury has been reasonable and necessary. With regard to Petitioner's neck and back conditions, the Arbitrator notes significant symptom magnification and adopts the opinions of Dr. Wehner. The Arbitrator awards the medical bills pertaining to the right knee in Petitioner's Exhibits 6 through 11 pursuant to sections 8(a) and 8.2 of the Act. With respect to the neck and back conditions, the Arbitrator awards the medical bills in Petitioner's Exhibits 6 and 7, subject to Dr. Wehner's opinion that no more than 12 physical therapy or chiropractic sessions were medically necessary. The Arbitrator gives Respondent credit for the sums it paid toward the medical bills.

Should the parties in the future disagree as to whether Respondent has properly satisfied the award of medical expenses, section 19(g) of the Act provides Petitioner with enforcement mechanism in the circuit court.

In support of the Arbitrator's decision regarding (K), what temporary benefits are in dispute, the Arbitrator finds as follows:

The Arbitrator awards temporary total disability benefits from May 4, 2010, through October 19, 2010, and from January 24, 2011, through June 14, 2011, a period of 44 3/7 weeks.

In support of the Arbitrator's decision regarding (L), what is the nature and extent of Petitioner's disability, the Arbitrator finds as follows:

Having carefully considered the entire record, the Arbitrator finds the injuries sustained caused loss of use of the right leg to the extent of 22 percent thereof and permanent disability to the extent of 3 percent of the person as a whole.

In support of the Arbitrator's decision regarding (M), should penalties or fees be imposed upon Respondent, the Arbitrator finds as follows:

The Arbitrator finds that penalties and attorney fees are not warranted.

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

Michelle D. Hansen,

Petitioner,

14IWCC0979

vs.

NO: 11 WC 29177

Barrington Transportation,

Respondent.

DECISION AND OPINION ON REMAND

This matter comes before the Commission on remand from the Circuit Court of Cook County. In a February 28, 2014 Order the honorable Robert Lopez Cepero remanded this case to the Commission "for it to explain the basis for its decision regarding the medical condition of the Plaintiff and the credibility of the doctors who addressed said medical condition." On March 29, 2011 the Petitioner, a 45-year-old bus driver, experienced a sudden loss of consciousness while driving; the bus left the roadway and reportedly came to a stop in a wooded area. Petitioner alleged that she was struck in the head by items falling out of an overhead compartment, causing her to lose consciousness. The preponderance of the evidence proved that Petitioner lost consciousness merely as a result of an episode of syncope of indefinite origin. In a decision dated October 15, 2012, the Arbitrator found that Petitioner's accident did not arise out of her employment and that her current condition of ill-being is not causally related to the accident. The Arbitrator found that Petitioner's testimony was inconsistent and not credible, and that Petitioner's allegation that head trauma caused her to lose consciousness was not supported by the evidence. The Commission reversed on the issue of whether Petitioner sustained a compensable accident. In a decision dated May 28, 2013 the Commission found that Petitioner's employment as a bus driver placed her at a significantly greater risk of injury, citing *Oldham v. Industrial Comm'n*, 139 Ill. App. 3d 594, 487 N.E.2d 693 (2nd Dist. 1985). The Commission further found that as a result of the accident Petitioner sustained a temporary cervical strain

14IWCC0979

superimposed on her pre-existing degenerative disc disease and that the strain resolved by May 24, 2011. We hereby clarify and explain the basis for our decision in accordance with the Order of the Circuit Court.

Findings of Fact and Conclusions of Law

The March 29, 2011 accident occurred as Petitioner was driving an empty bus to Respondent's lot. Petitioner testified at the 19(b) hearing that she regularly drove the same bus, known as Van 26. The bus had six rows of seats and a supply compartment with a plastic door over her head. Inside the compartment, she kept various items including a bucket of "kitty litter" type substance that was used to absorb fluids. Petitioner offered photographs taken April 4, 2011 depicting the items within Van 26. Petitioner's husband, Charles Hanson, also works for Respondent as a bus driver. Mr. Hanson testified that he took the photographs. Respondent's Secretary and Treasurer, Mr. Pahlke, testified for Respondent and identified three photographs offered into evidence by Respondent. He testified that these photographs were taken subsequent to Petitioner's accident and showed that the bucket measured approximately five inches wide and six inches tall and weighed approximately one pound and six ounces. Petitioner testified that that latch on the supply compartment door previously opened in December of 2010 and items fell out; she testified that she submitted an incident report to maintenance. Petitioner testified that prior to losing consciousness she recalled hearing the items shifting with the compartment. The Arbitrator noted that Petitioner's testimony with respect to the condition of the compartment door was not corroborated.

The Barrington Fire Department responded to the scene of the March 29, 2011 accident. Records show that Petitioner was found in driver's seat, restrained in a seat belt, and that the airbag had not deployed. Petitioner was disoriented and unable to remember what had happened; she had been incontinent of urine and had bitten her tongue. Petitioner testified that she was unable to recall what she told emergency personnel about the accident. Petitioner was transported to Advocate Good Shepherd Hospital and remained there until March 31, 2011. An emergency room nurse noted that Petitioner was slightly confused at the time of her admission and did not remember the accident. Dr. Collins evaluated petitioner in the emergency room, took a history, and physically examined her. He noted that she was by then awake, alert, and oriented, and had no head trauma or facial tenderness and no back or extremity tenderness or evidence of acute injury. Dr. Collins noted that Petitioner denied any headache or head injury, and that she denied any neck, back or extremity pain. She reported taking her Tramadol and Adderall according to her prescriptions and denied abusing drugs or drinking. Petitioner testified that she was very confused at the time and did not know what she told the doctors at the hospital about the accident. She did not recall being asked about headaches; she remembered that she told hospital personnel that she was hurting in the neck, shoulders, arms, and back and that she generally hurt all over. On cross-examination, Petitioner agreed that she did not recall telling any of the emergency room staff about the noise that she claims she heard in the overhead compartment before her accident or that she believed she had been hit in the head.

Tests performed in the hospital, including an electrocardiogram, cardiac stress test, chest x-ray, CT and MRI of the brain, were either normal or essentially unremarkable. However, Petitioner's toxicology screen was positive for amphetamines, opiates and phencyclidine (PCP). Dr. Collins noted that he was uncertain as to the relevance of the toxicology findings to the event. His diagnosis of Petitioner was syncope and collapse with a cervical strain. Dr. Collins noted that he was uncertain as to the exact etiology of the episode of syncope but he believed that inpatient hospitalization was indicated for further monitoring. Petitioner was noted to suffer from chronic hypertension, attention deficit disorder with hyperactivity, irritable bowel syndrome, hyperlipidemia, and bipolar disorder.

On March 30, 2011 while in the hospital Petitioner was further examined by Dr. Goode and Dr. Katsamakis, a neurologist. Dr. Goode noted that Petitioner reported feeling discomfort in her head including lightheadedness and a "feeling of fullness" ten minutes before she lost consciousness. Petitioner testified that she did not recall giving a history of experiencing these symptoms prior to the accident. She agreed that she did not tell any doctors who treated her in the hospital that she suspected she was hit in the head. Dr. Goode noted that Petitioner's syncopal episode could have been secondary to medication use. Dr. Goode noted that the amphetamines and opioids found in her toxicity screen results probably correlated with her attention deficit disorder and pain medications, but that Petitioner had also tested positive for phencyclidine while denying using any drugs. Dr. Goode referred Petitioner to Dr. Katsamakis for a neurological consultation. Dr. Katsamakis noted that Petitioner did not recall any events between driving the bus and being extricated by paramedics. He noted "again, there were no injuries, no apparent head trauma, although she did injure her shoulder." He noted that Petitioner lost bladder control and had some subsequent confusion after the accident, but no symptoms of weakness or numbness. She had no history of seizures and denied any changes in her medication usage for at least the last year or two. Dr. Katsamakis cleared Petitioner for discharge and released Petitioner from a neurological standpoint to return to her regular work duties. Petitioner testified that she did not recall telling Dr. Katsamakis that she had no head trauma or that she remembered nothing between dropping off her last child and being attended to by the paramedics. She testified that she was regularly receiving morphine in the hospital for her pain and that she did not remember "a lot of things."

Petitioner sought treatment with her primary care provider, Dr. Kamholz, on April 4, 2011. Dr. Kamholz noted that Petitioner did not recall the events of the accident but "suspects she got hit in the back of the head by a tub of chemicals used to clean up chemical spills. She notes after the accident she has had pain in the back of head/scalp and it has been burning, especially when she brushes her hair. She also has pain on the left back of shoulder and left neck." Petitioner complained of a stiff and sore neck and pain at the left posterior shoulder that goes down the back of the left side of her neck and thorax. Dr. Kamholz noted that Petitioner tested positive for amphetamines, opioids and PCP. Dr. Kamholz noted that the etiology of the syncope was unclear although it seemed possible that Petitioner was hit in the back of the head as she described. Dr. Kamholz diagnosed syncope and shoulder and neck pain. Petitioner testified that Dr. Kamholz was the first physician that she talked to about something falling on

her head. Dr. Kamholz referred Petitioner to Dr. Perlmutter at Lake Cook Orthopedics for her musculoskeletal pain complaints.

Petitioner testified that she explained to Dr. Perlmutter everything that had happened to the best of her knowledge. Dr. Perlmutter's April 6, 2011 record indicates that Petitioner reported that while driving the bus a bucket of sand and a hard folder fell out of an overhead compartment, hit her on the head and knocked her out. Dr. Perlmutter noted that Petitioner was not complaining of any headaches and had no significant backaches, but complained of pain in her cervical spine radiating to her left upper arm, most severe in the trapezial area; she had no symptoms numbness or tingling. On exam, her cervical spine range of motion was restricted by pain and turning her head to the left and looked upward exacerbated her pain. Petitioner's left shoulder x-rays were normal, but Dr. Perlmutter interpreted cervical x-rays as showing some degenerative disc disease at C4-5, C5-6 and C6-7. He noted that Petitioner complained of radicular symptoms into her left shoulder, although she did not have any obvious neurologic findings. He further noted "given the magnitude of the injury and given the fact that this all happened while she was unconscious, I think a cervical MRI scan is indicated. Dr. Perlmutter placed Petitioner off work until after the MRI. The radiologist reviewing the April 11, 2011 cervical MRI noted disc degeneration, especially in the lower cervical spine, with minimal retrolisthesis of C5 on C6 and mild straightening of the cervical spine, and canal and foraminal stenosis at C4-5 and C6-7, and especially at C5-6. On April 18, 2011 Petitioner returned to Dr. Perlmutter, who reviewed the MRI and found degenerative disc disease at C4-5 and worse at C5-6. He recommended an epidural steroid injection at C5-6, which was approved by Respondent's workers' compensation insurance carrier.

Petitioner saw her psychiatrist, Dr. Balkin, on April 28, 2011. Petitioner had been seeing Dr. Balkin since 1997. Dr. Balkin's notes read "Had an accident? R unconscious at the wheel – hit in the head??" Petitioner testified that she continues to see Dr. Balkin and that Dr. Balkin had made no changes to her medications.

On May 5, 2011 Petitioner underwent a right C5-6 transforaminal epidural injection and epidurography administered by Dr. Schneider at Advocate Good Shepherd Hospital. Petitioner returned to Dr. Perlmutter on May 23, 2011 and reported that the injection did not help. She also reported increased pain now in her *right* shoulder, with throbbing pain in her right forearm and tingling in her fingers. Dr. Perlmutter noted a positive Phalen's test, positive Tinel's test and limited range of motion in the neck. He ordered physical therapy and an EMG/NCV to determine whether Petitioner's complaints could be attributed to cervical radiculopathy or carpal tunnel syndrome. Dr. Perlmutter continued to keep Petitioner off work for four more weeks. The report of the May 31, 2011 EMG study of the bilateral upper extremities indicated that Petitioner's results were consistent with mild to moderate carpal tunnel but that there was insufficient evidence of cervical radiculopathy.

Petitioner participated in two weeks of physical therapy and returned to Dr. Perlmutter on June 20, 2011. Petitioner testified that the physical therapy did not help her and actually caused

her to have more pain. Petitioner reported to Dr. Perlmutter complaints of right shoulder pain and paresthesias in her right hand. Dr. Perlmutter diagnosed cervical spondylosis, biceps tendinitis, and carpal tunnel syndrome. He noted in his records that he was sure that that her cervical spondylosis was aggravated by the accident. He administered an injection into Petitioner's right shoulder and kept her off work for two more weeks. He indicated that operative treatment should be discussed if the injection did not help her. On July 8, 2011 Petitioner reported no improvement from the injection and continued neck and right shoulder pain. Dr. Schneider at Dr. Perlmutter's office noted that Petitioner had some carpal tunnel syndrome that he believed was difficult to explain. He opined that Petitioner's shoulder pain and periscapular pain was related to the degenerative disc disease in the cervical spine at C5-6, C6-7 and C4-5. Dr. Schneider recommended an anterior cervical discectomy and fusion at three levels. Petitioner was kept off of work until further notice and was prescribed a cervical collar.

On July 29, 2011, Petitioner had a Section 12 examination by Dr. Delheimer at the request of Respondent. Petitioner complained of severe pain in her neck and right arm. She reported that she felt she needed to prop up her head while sitting. She only rarely experienced any left arm pain. Dr. Delheimer reviewed Petitioner's medical records and opined that Petitioner sustained, at most, soft tissue injuries as a result of the work accident. He relied on the records of Dr. Collins who examined Petitioner on March 29, 2011 in the emergency room, and he further relied on Petitioner's subsequent workup in the hospital which was negative. Dr. Delheimer noted that during Petitioner's hospital stay there was no documented evidence of any acute injury, no evidence of edema or cyanosis, and that her sensory, motor and orientation skills were normal. He found Petitioner's pain to be myofascial and muscular in type, consistent with a soft tissue injury or strain which would be reasonable considering the events of Petitioner's accident. Regarding Petitioner's loss of consciousness, Dr. Delheimer opined that the etiology was likely related to an episode of syncope, noting that she had no findings of face or head trauma at the hospital that would have been consistent with Petitioner's description of having been struck in the head hard enough to cause her to lose consciousness. Ultimately, Dr. Delheimer opined that Petitioner had cervical degenerative disc disease prior to the accident with no evidence of any acute pathology, aggravation, or acceleration beyond the normal progression of the condition. He did not believe that Petitioner was a candidate for an anterior cervical discectomy and fusion at C4-5 and C6-7 given the minor findings at those levels, but that she was a candidate for a C5-6 anterior cervical discectomy and fusion to treat her pre-existing condition. Dr. Delheimer noted that soft tissue injuries generally resolved with or without treatment within approximately eight weeks and that, given the absence of objective findings during that period, he opined that Petitioner had reached maximum medical improvement by May 24, 2011 and he saw no reason that any work restrictions would be necessary. Regarding Petitioner's shoulder pain, he believed that this was likely referred pain from the neck and that her shoulder symptoms were not consistent with a shoulder injury. Regarding Petitioner's carpal tunnel syndrome, Dr. Delheimer opined that it was an incidental finding and not related to the accident.

On September 14, 2011 Petitioner returned to Dr. Perlmutter. She complained of

increased pain in both shoulders and burning pain down both upper extremities, more severe on the right side. She reported difficulty standing, that she had increased her pain medication and was now taking up to ten Norco per day. Dr. Perlmutter ordered a repeat cervical MRI and anticipated performing a three level anterior cervical discectomy and fusion. On September 28, 2011, Dr. Perlmutter's progress notes include, in handwriting, "heavy folder – kitty litter – plastic quart size can of Lysol, window" and further "compartment opened – set it all in motion – bus off road – no kids – down ditch – up incline [illegible] bus totaled." Dr. Perlmutter reviewed the MRI and interpreted it as showing degenerative disc disease of varying degrees at C4-5, C6-7, and the worse at C5-6. Dr. Perlmutter also reviewed the report of the IME by Dr. Delheimer. Dr. Perlmutter stated that he would probably agree with Dr. Delheimer that a one level C5-6 discectomy and fusion would be sufficient. Dr. Perlmutter noted "I cannot say whether the accident caused that disc protrusion or whether it was just something that was aggravated as a pre-existing condition, but in any event, at least from a time standpoint, according to the patient, her symptoms started at the time of the accident and have persisted from that time until now. Is there any way to say that the disc did not predate the accident? There is no way of saying that. All I can talk about is her symptoms."

Petitioner underwent a C5-6 discectomy and fusion by Dr. Perlmutter on January 10, 2012. Her pre-operative and post-operative diagnoses were the same; cervical spondylosis at C5-6. On January 23, 2012 Petitioner reported to Dr. Perlmutter that she noted neck pain and left shoulder pain when not wearing her collar. She estimated she had 70% improvement in the symptoms radiating into both upper extremities. Dr. Perlmutter kept Petitioner off of work and restricted her from driving, lifting, bending, and twisting. On February 22, 2012 Petitioner complained of some neck pain and discomfort in the left shoulder. She began post-operative physical therapy on March 1, 2012. On April 4, 2012 Petitioner reported to Dr. Perlmutter complaints of pain in the right periscapular area with spasms and some pain in her right triceps area. Dr. Perlmutter diagnosed right shoulder rotator cuff bursitis or tendinitis and administered a steroid injection into Petitioner's right shoulder. Dr. Perlmutter noted that Petitioner had cancelled some of her physical therapy appointments; Dr. Perlmutter advised Petitioner that she needed physical therapy to strengthen her neck muscles to help with the reported spasms which he believed were at least in part caused by fatigue. On May 15, 2012 Petitioner reported some mild posterior neck pain but severe pain in the right shoulder which radiated down her arm to her thumb. She reported that physical therapy helped, that she felt pretty good for a few hours, but then the problem came back again. She complained of a constant throbbing feeling in her right arm. She testified at hearing that her right shoulder symptoms never improved with physical therapy, but that she noticed the sharp pains going down her arm and the numbness and tingling went away. Dr. Perlmutter ordered an MRI of the right shoulder and the report indicated acromioclavicular joint degenerative change, rotator cuff tendonitis without a tear, a small glenohumeral joint effusion and subacromial subdeltoid bursitis.

Petitioner saw Dr. Anderson, a shoulder specialist and partner of Dr. Perlmutter, on June 13, 2012. Dr. Anderson noted that Petitioner was a patient of Dr. Perlmutter's and had sustained a work injury "when something fell on her head while driving a bus." He noted that Petitioner

had severe pain in her right shoulder as well as cervical spine issues since that time resulting in a cervical fusion with some symptom improvement, but continued constant and severe right shoulder and trapezius pain which was worse with use, especially overhead activities. Dr. Anderson noted that Petitioner was on narcotic pain medication essentially full-time since her injury. Dr. Anderson diagnosed right shoulder pain, rotator cuff and biceps tendinitis, and acromioclavicular joint pain. He believed that the right shoulder MRI was positive for acromioclavicular joint spurring and he recommended arthroscopic surgery consisting of a subacromial decompression, biceps tenodesis and distal clavicle excision. Dr. Anderson performed surgery on June 21, 2012. Post-operatively Petitioner followed up with Dr. Anderson, and participated in physical therapy. Petitioner testified at hearing that she remains under the care of Dr. Perlmutter for pain management and that he has continued to keep her off of work. She takes Flexeril every eight hours and Norco every six hours. Petitioner testified that she has not driven since the accident and testified that she has difficulty performing all activities and no longer cleans her house or walks her dogs. She testified that her husband does the shopping, although she will accompany him and sometimes she wears a sling when she has to do significant amounts of walking.

While we reversed the decision of the Arbitrator on the issue of whether Petitioner sustained a compensable accident, we agreed with the Arbitrator's findings of fact, the Arbitrator's credibility judgment and furthermore the Arbitrator's conclusions with respect to the mechanism of injury, causal connection to Petitioner's current condition of ill being and the nature of the injury sustained during the accident. The Arbitrator observed Petitioner's demeanor during her testimony and throughout trial and found Petitioner's testimony not credible and repeatedly inconsistent with the medical records and internally inconsistent with her own testimony on direct and cross-examination. The Arbitrator noted that from the time Petitioner was extricated from the bus by paramedics through her discharge from the hospital there was no history or findings consistent with a blow to the head. Instead, multiple evaluations and a battery of tests pointed overwhelmingly to an idiopathic episode of syncope and collapse related to Petitioner's personal medical status. We agree with the Arbitrator's reliance on the treatment records of the paramedics, Dr. Collins, Dr. Goode, Dr. Katsamakis and the nurses and physical therapists who evaluated Petitioner while she was in the hospital. These records, taken separately and in conjunction, reveal that Petitioner was alert and oriented during her hospital stay, that she had no evidence of head trauma and exhibited no evidence of acute injury other than a neck strain related to the motor vehicle accident. The Arbitrator noted that Petitioner's history to Dr. Kamholz on April 4, 2011 of posterior head and scalp pain and a "suspicion" that she was hit in the back of the head in the accident is not a reliable history where it is different from and contradictory to the hospital records. By the time Petitioner saw Dr. Perlmutter on April 6, 2011, she again reported this new history.

After considering all of the evidence, the Arbitrator found that the credible record supported the opinions of Dr. Delheimer and not Dr. Perlmutter with respect to accident and causal connection. The Arbitrator's decision to accept one medical opinion over the other was based on the record as a whole and the completeness and veracity of the foundation of facts upon

14IWCC0979

which each doctor based their opinions. The credibility of Dr. Perlmutter was not explicitly or implicitly challenged by the Arbitrator in her decision finding the opinion of Dr. Delheimer to be more consistent with the evidence. The Arbitrator noted that neither physician provided testimony in this case. In our decision dated May 28, 2013 we agreed with the Arbitrator that the Petitioner's current condition of ill being is not related to the accident. Although we found that Petitioner's employment placed her at a greater risk of injury and that therefore the accident was compensable, we agreed with the Arbitrator that Petitioner sustained no more than a cervical strain. We further found that Petitioner's cervical strain injury resolved by May 24, 2011 per the opinion of Dr. Delheimer and we remanded the case to the Arbitrator for further proceedings for a determination of medical expenses and temporary total disability benefits to be awarded consistent with our decision.

THEREFORE, the Commission hereby clarifies and explains its Decision dated May 28, 2013 as stated above and pursuant to the February 28, 2014 remand order from the Circuit Court of Cook County.

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

DATED: NOV 17 2014
RWW/plv
o-6/25/14
46

Ruth W. White

Charles J. DeVriendt

Daniel R. Donohoo

STATE OF ILLINOIS)
)
COUNTY OF PEORIA)

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

RON LEONARDSON,

14IWCC0980

Petitioner,

vs. No: 10 WC 20926

CATERPILLAR,

Respondent

DECISION ON PETITION UNDER SECTIONS 8(a) & 19(h)

This matter comes before the Commission on Petitioner's petition for relief pursuant to sections 8(a) and 19(h), even though Petitioner was found to be permanently totally disabled and only asks for prospective medical treatment in the instant petition. At arbitration, the parties stipulated to accident, causation, medical expenses, temporary total disability, and that Petitioner was permanently and totally disabled. There were no findings of fact in the Decision of the Arbitrator by stipulation of the parties. The decision was issued on June 12, 2012. The issue now before the Commission is prospective treatment of Petitioner's right hip and sacroiliac ("SI") joint conditions. A hearing was held on March 12, 2014 before Commissioner White in Peoria. There was no live testimony adduced at the hearing and only exhibits were submitted into evidence.

On April 2, 2009, Petitioner went to the company clinic after a work accident and reported pain in his lower back radiating down his left hip, left knee, left calf, and numbness in the toes. In the accident report, Petitioner indicated he felt "strong pain hit [his] back, left hip area causing" him to 'buckle.' He further wrote "ER doc thinks SI main problem. Had laminectomies in '89 and 96." Petitioner reported no improvement with physical therapy. He wanted to go to Illinois Neurological Institute. Respondent provided a referral.

On May 5, 2009, Petitioner presented to Dr. Kube for the first time complaining of back and left leg pain. His pain diagram showed pain in the low back, left hip, posterior thigh and calf. It also showed some pain in the right hip and posterior thigh on the right side with the notation "less than left side." The new patient questionnaire mentioned only pain in the lower back, left thigh, left leg, and right thigh. Petitioner reported he had left leg and hip pain since the summer of 2008. Petitioner's current condition developed when he was pulling some linkage at work and it got stuck. He pulled hard and went down to the floor in excruciating back pain radiating down his left leg. Only left-sided symptoms are noted in Dr. Kube's treatment notes. An MRI showed acute fracture at T12, herniated disc at L3-4 on the left, a previous laminectomy defect at L4-5, and multilevel degenerative disc disease.

On May 22, 2009, Dr. Kube performed "revision decompression with partial facetectomy and extreme scar take down, and T12 vertebroplasty for T12 compression fracture, abundant scar and epidural scarring with herniated disc at L4-5." On July 29, 2009, Petitioner began physical therapy for his lumbar condition on referral from Dr. Kube. At the initial evaluation he noted he had low back pain that radiated into his hips bilaterally. That appears to be the only reference to the right hip in the exhibit.

On July 14, 2009, Dr. Kube referred Petitioner for evaluation of Petitioner's left hip. On August 21, 2009, Petitioner presented to Dr. Capecci on referral from Dr. Kube for evaluation of left hip pain. Petitioner reported the work accident and indicated he did "recall specifically that his left hip was bothering at that time, but thinks it may have been related to that injury." He has had pain in his left hip since that time. X-rays of the left hip were unremarkable except for some mild joint space narrowing compared to the right hip. Dr. Capecci wanted an MRI to determine whether Petitioner had a torn labrum. On October 7, 2009, Petitioner had an injection into his left hip.

On December 3, 2009, Petitioner returned to Dr. Kube and reported he was still having pain in his left hip. He also had "scant pain in the right SI joint." Dr. Kube noted they were "still having come difficulty getting him setup with some long-term treatment for his hip. Petitioner was frustrated with the treatment he has had so far and "the ability to get access to a physician." Petitioner had an MRI that "discusses a labral tear." In February 2010, Dr. Rhode performed a left labral tear repair.

On September 27, 2010, Petitioner returned to Dr. Capecci complaining of increased pain in his left hip. He had an injection that provided relief for about a week. Dr. Capecci noted Petitioner had unsuccessful labral repair by Dr. Rhode in February 2010. X-rays showed significant interval progression of the arthritis in the left hip. Dr. Capecci noted Petitioner had severe osteoarthritis and his symptoms were consistent with degenerative joint disease of the hip. Dr. Capecci recommended a total hip replacement due to his debilitating pain. They would have to get approval from Respondent. Total left hip replacement surgery was performed on November 1, 2010.

On December 8, 2010, Petitioner reported he had the same pain as before the surgery. He knew he was not doing as well as other artificial hip recipients. He reported a great disparity in the length of his legs with the left considerably longer. Dr. Capecci noted there was some discrepancy, which he would have expected, but it was not as severe as Petitioner reported. He recommended a ¼" lift. He found nothing clinically that would explain the extent of his significant disability. Petitioner had weakness in his left calf, which could be caused by his lumbar condition. He advised Petitioner he should consult Dr. Kube about that.

On January 26, 2011, Dr. Capecci noted that an MRI showed Petitioner still had multiple areas of pathology in his lumbar spine that could be causing his nerve pain, particularly at L4-5. Dr. Capecci again recommended the ¼" lift for the right foot and released Petitioner from the strict hip precautions. He would see him in another 9 months and take additional x-rays. There are no more notes indicating any later visits.

On January 27, 2011, Petitioner returned to Dr. Kube. He told Dr. Kube he did not want to have any more major surgical interventions. Dr. Kube thought that was very reasonable and was not even certain it would provide much benefit regarding his chronic conditions, likely including neuritis. Dr. Kube thought intervention at L4-5 may be appropriate if Petitioner's pain worsened. On September 27, 2011, Dr. Kube indicated Petitioner had "really about now finally had it." His main complaint seemed to be the left leg. Dr. Kube wanted a CT and would determine the least invasive procedure possible.

There was no additional records until October 1, 2012, when Petitioner presented to Florida neurosurgeon, Dr. DeSilva, presumably for the first time. His chief complaint was 7/10 low back pain radiating to the left leg. Dr. DeSilva noted that his problem had been going on for many years, but he was concerned that it was getting worse. Petitioner's medical history included total left hip replacement, vertebroplasty, anterior discectomy and fusion, and two lumbar discectomies. Dr. DeSilva indicated Petitioner had chronic problems with his low back and SI joints. Dr. DeSilva did not know what percentage of his pain was from his lumbar spine and how much was from the SI joints. He recommended SI injections, if that relieved the pain Petitioner would be a candidate for a SI joint fusion. If it did not he could be a candidate for a spinal cord stimulator.

On October 18, 2012, Petitioner returned and complained of the same symptoms. Dr. DeSilva noted the MRI showed multilevel degenerative disc disease from L2 to S1 with multilevel foraminal stenosis. Petitioner indicated he did not want a spinal cord stimulator, but Dr. DeSilva told him the pain may be from the SI joint and he would go ahead with the injection. The injection provided Petitioner with significant pain relief for a week, but then the pain returned. Petitioner was "keen to proceed with [SI joint fusion] surgery." They would seek authorization.

Petitioner was deposed on October 22, 2013, he testified he had arthroscopic surgery on his left hip and then a total left hip replacement on October 25, 2010. He moved to Florida and sought medical treatment for his back and hips. He initially went to Dr. DeSilva because his hips "were killing [him] all the time." He has had pain in his hips ever since the accident on April 2, 2009. The pain is around the SI joint on both sides, but the right side is worse. He had injections in both SI joints; "within 10 minutes it almost like no pain." However, the pain gradually returned. Dr. DeSilva has offered him an SI joint fusion on the right. Dr. DeSilva discussed with Petitioner the pros and cons of the surgery. and Petitioner wanted to proceed with the surgery. Petitioner's medical bills are paid through both WC and Medicare. WC has not approved the surgery and Dr. DeSilva would not bill Medicare because of the pending litigation. He was scheduled to see Dr. Weiss for an IME at Respondent's request later that day.

On cross examination, Petitioner testified he had been offered prescription pain medication but he has refused them because they do not do much good and he does not want to become dependent on narcotics. Petitioner denied Dr. DeSilva recommended additional injections in his back and that Petitioner refused them. Petitioner agreed that he refused a stimulator. He did not specifically remember telling a Dr. Kornblatt [presumably a section 12 medical examiner] that his hip pain was limited to his left hip, but he did remember that his left hip hurt more than the right at that time.

On December 5, 2013, Dr. Weiss issued an addendum report of a medical examination performed pursuant to section 12 of the Act. Dr. Weiss noted that he performed a previous section 12 medical examination and prepared a report. He was asked to review the case again to offer opinions regarding whether Petitioner's current conditions and need for surgery were the result of the April 2009 work accident.

Dr. Weiss noted that Petitioner had multilevel laminectomies and disc excisions in around 1999. On April 2, 2009, Petitioner was pulling on a heavy linkage at work and felt a sudden sharp pain in his back which ran down his left leg to the foot. In May 2009, he underwent a vertebroplasty of T12 and decompression at L3-4. That surgery helped his radicular left leg pain. In July 2009, Petitioner began treating for his left hip. In February 2010, he had an arthroscopic labral tear repair. Petitioner continued to have symptoms and a total left hip replacement was performed in late 2010. Following the hip replacement Petitioner was believed to still have L5 radiculopathy. Dr. Kube opined that he had L4-5 stenosis and started Petitioner on Lyrica. In May 2012, Petitioner had bilateral SI joint injections and facet joint injections bilaterally at L3-S1. In July 2012, he declined diagnostic median block injections. In October 2012, Dr. DeSilva recommended an SI injection to determine whether the lumbar spine or SI joints were the source of Petitioner's pain. After the injection, Dr. DeSilva recommended an SI joint fusion on the right.

Dr. Weiss noted that Dr. Kube's May 5, 2009 treatment record clearly indicated Petitioner's complaints involved back pain and left-sided radicular symptoms. There was no mention of an SI complaints or any evidence of any SI pathology at that time. In July 2009, Petitioner began to complain of catching in his left hip. Dr. Capecci's treatment note of August 21, 2009 specified there was no irritability with palpitation of the SI joint, "which would further support Dr. Kube's findings." An MRI showed osteoarthritis of Petitioner's left hip with an associated small partial thickness labral tear. The MRI report makes no mention of the SI joint. "It was not until 2012 that [Petitioner] began treatment for bilateral SI joint complaints and Dr. DeSilva is now recommended a right SI joint fusion."

Dr. Weiss opined that Petitioner's SI joint problems "clearly" were not secondary to his work accident. It was not for several years after the accident that he began to complain of SI joint and right hip pain. Dr. Weiss underscored that the bilateral nature of his SI complaints supported the opinion that the SI conditions were degenerative in nature and not associate with the work accident. He also pointed out that it would require a significant trauma, such as a high-speed motor vehicle accident to cause an SI joint injury, which was not consistent with the fact that he did not seek treatment for such a long period of time.

Petitioner attacks the section 12 medical report of Dr. Weiss and stresses that his characterization that Petitioner did not complain of SI pain until 2012 is incorrect. He points to the May 5, 2009 pain diagram in which he circled the right hip as a source of pain and the physical therapy note of July 29, 2009 in which the therapist noted low back pain radiating into his hips bilaterally. Finally, he notes a treatment note from Dr. Kube and a December 28, 2010 pain diagram in which right hip pain is reported.

The Commission finds that Petitioner has not sustained his burden of proving that his current condition of his hips and SI joints are causally related to his accident of April 2, 2009. There is really scant evidence to support the proposition that Petitioner's right hip and SI joint conditions are related to the accident. Petitioner relies on a single physical therapy report of low back pain radiating into the hips bilaterally, two pain diagrams, and a single reference in Dr. Kube's treatment records about "scant pain" in the right SI joint. The failure of Dr. Weiss to address those references does not affect his premise that there would have to be a significant trauma, such as a high-speed motor vehicle accident, to cause an SI joint injury. While the yanking experienced in his work accident could have caused Petitioner's disc problems, especially considering his previous history of serious back pathology, it would not seem to be of such a traumatic nature so as to injure the SI joints. Dr. Weiss makes a good point that the fact that he has the condition in both SI joints would militate against a traumatic cause and support a degenerative cause. The Commission also notes that there is no medical opinion supporting causation.

In addition, in the initial treatment note of Dr. Kube on May 5, 2009, Petitioner indicated he had hip pain since 2008, which obviously predated the April 2009 accident. In any event, the fact that Petitioner had some right hip/SI joint pain around the time of his accident does not prove anything regarding causal connection between the hip/SI joint condition and the work accident. Petitioner had severe osteoarthritis which could cause some pain before the SI dysfunction diagnosis was made. Finally, it would appear extremely probable that if Petitioner had substantial right-sided hip/SI joint pain he would have mentioned that to Dr. Capecci who was treating his left hip. There is no such notation in his records. For these reasons the Commission denies the instant petition

IT IS THEREFORE ORDERED BY THE COMMISSION that Petitioner's Petition Pursuant to §8(a) and §19(h) is hereby denied.

DATED: NOV 17 2014

Ruth W. White

Daniel R. Donohoo

Charles J. DeVriendt

RWW/dw
O-10/21/14
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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 Down	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

JON LUCHSINGER,

Petitioner,

14IWCC0981

vs.

NO: 11 WC 20569

STATE OF ILLINOIS – DWIGHT CORRECTIONAL CENTER,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issue of the propriety of the imposition of 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 Arbitrator found that Petitioner proved the stipulated work-related accidents caused a current condition of ill-being of his arms bilaterally. He awarded Petitioner $10,894.98 in outstanding medical bills, 25.3 weeks of permanent partial disability benefits, representing 5% loss of the use of each arm, and $5,447.49 in penalties under section 19(k) and $3,268.49 in "penalties" under section 16. The Arbitrator did not award penalties pursuant to section 19(l). The Commission agrees with the determination of the Arbitrator regarding the issues of causation, total temporary disability and permanent partial disability and affirms and adopts those portions of the Decision of the Arbitrator.

The Arbitrator awarded penalties under section 19(k) because he found the Respondent, the State of Illinois, did not offer any explanation for not paying outstanding medical bills associated with the undisputed April 7, 2011 and April 11, 2011 accidents. The Commission notes that there was no outstanding temporary total disability benefits due Petitioner.

Section 19(k) of the Act provides 820 ILCS 305/19(k) (emphasis added):

> In case where there has been any unreasonable or vexatious delay of payment or intentional underpayment of compensation, or proceedings have been instituted or carried on by the one liable to pay the compensation, which do not present a real controversy, but are merely frivolous or for delay, then the Commission **may** award compensation additional to that otherwise payable under this Act equal to 50% of the amount payable at the time of such award. Failure to pay compensation in accordance with the provisions of Section 8, paragraph (b) of this Act, shall be considered unreasonable delay.

Section 19(l) of the Act provides 820 ILCS 305/19(l):

> In the case of demand for payment of medical benefits under Section 8(a), the time for the employer to respond shall not commence until the expiration of the allotted 30 days specified under Section 8.2(d). In case the employer or his or her insurance carrier **shall without good and just cause fail, neglect, refuse, or unreasonably delay the payment of benefits under Section 8(a) or Section 8(b), the Arbitrator or the Commission shall allow to the employee additional compensation** in the sum of $30 per day for each day that the benefits under Section 8(a) or Section 8(b) have been so withheld or refused, not to exceed $10,000.

The above language provides that the imposition of penalties under section 19(k) is discretionary because the section specifies that the Arbitrator or Commission "may" award additional compensation if a delay in payments of benefits is unreasonable or vexatious. On the other hand, under section 19(l), there is less discretion in the imposition of penalties for the unreasonable delay of payment of medical bills because the section provides that the Commission "shall" allow additional compensation for such delay.

In the current controversy, the Commission concludes that the imposition of penalties under section 19(l) is more appropriate than the imposition of penalties under section 19(k). First, as noted above, there is no total temporary disability benefits due Petitioner and the only issue is the delay of payment of medical bills. Second, the State did present vouchers at arbitration indicating that there was some effort to pay the medical bills in a more timely manner. Therefore, the Commission finds that the delay in payment of medical bills was sufficiently unreasonable to allow the imposition of penalties under section 19(l), but not of such an egregious nature as to allow the imposition of penalties under section 19(k).

The Commission notes the Petitioner filed his penalty petition on August 15, 2012. The Commission finds that date to be a suitable date to be the requisite date of demand of payment. The date of arbitration was October 16, 2013. Therefore, the Commission finds that the award of penalties in the amount of $30 a day for 63 days is appropriate. Accordingly, the Commission awards a total of $1,890.00 in penalties under section 19(l). The Commission also notes that the imposition of fees under section 16 for penalties imposed under section 19(l) is not appropriate. Therefore, the Commission vacates the fees awarded under section 16 as well as the penalties awarded under section 19(k).

14IWCC0981

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $1,890.00 in penalties pursuant to §19(l) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that the award of penalties pursuant to §19(k) and the award of fees pursuant to §16 are vacated.

DATED: NOV 17 2014

Ruth W. White

Daniel R. Donohoo

Charles J. DeVriendt

RWW/dw
O-10/22/14
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ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

LUCHSINGER, JON
Employee/Petitioner

Case# **11WC020570**

ILLINOIS DEPARTMENT OF CORRECTIONS
Employer/Respondent

14IWCC0981

On 12/9/2013, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

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

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

5120 ASSISTANT ATTORNEY GENERAL
DAVID PAEK
100 W RADNOLPH ST 13TH FL
CHICAGO, IL 60601

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

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

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

DEC 9 2013

KIMBERLY B. JANAS Secretary
Illinois Workers' Compensation Commission

14IWCC0981

STATE OF ILLINOIS)
)SS.
COUNTY OF Will)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Jon Luchsinger
Employee/Petitioner

v.

Case # 11 WC 20570

Consolidated cases:

Illinois Department of Corrections
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 **George Andros**, Arbitrator of the Commission, in the city of **New Lenox**, on **October 16, 2013**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **April 7, 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 **$100,453.60**; the average weekly wage was **$1,931.80**.

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

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

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

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

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

ORDER

Respondent shall pay reasonable and necessary medical services of $10,894.98, as provided in Sections 8(a) and 8.2 of the Act.

Respondent shall pay Petitioner permanent partial disability benefits of $669.64/week for 12.65 weeks, because the injuries sustained caused the 5% loss of the right arm , as provided in Section 8(e) of the Act.

Respondent shall pay Petitioner permanent partial disability benefits of $669.64/week for 12.65 weeks, because the injuries sustained caused the 5% loss of the left arm, as provided in Section 8(e) of the Act.

Respondent shall pay to Petitioner penalties of $3,268.49, as provided in Section 16 of the Act; $5,447.49, as provided in Section 19(k) of the Act; and $0, as provided in Section 19(l) of the Act.

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

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

/s/ George J Gorelick

Signature of Arbitrator

December 6th, 2013

Date

ICArbDec p. 2

DEC 9 - 2013

STATEMENT OF FACTS

On April 7, 2011 and April 11, 2011, the petitioner, Jon Luchsinger was employed by the respondent, Illinois Department of Corrections as the chief engineer at the Dwight Correctional Center in Dwight, Illinois.

As chief engineer, the petitioner worked with 5 employees under his supervision, including electricians, carpenters and plumbers. The petitioner's staff was shorthanded, so the petitioner would work with each of the tradesmen when needed. As part of his work duties, the petitioner replaced processed piping and recharge lamps, changed toilets, rodded out drains and performed any other task as necessary. The petitioner's job also required that he lift furniture such as beds and tables, and equipment like rodders and boxes of hand tools. The lifting involved in the petitioner's position could range anywhere from 5 to 80 pounds. The petitioner's job duties further required him to climb ladders and scaffold, crawl into tight spaces and work frequently overhead.

On April 7, 2011, the petitioner was working to fix a roof leak with a co-worker. Next to the one story building where the leak occurred stood a television tower. In order to move supplies to the roof, the petitioner's co-worker stood on the building while the petitioner lifted the tools and supplies to the co-worker by climbing a few steps up the tower and reaching the tools overhead to hand them to the co-worker, then going back down the tower to get more tools. While performing this work, the petitioner noticed that both of his hands and arms were strained.

The petitioner continued working in the days following his first accident. Then, on April 11, 2011, the petitioner was on a catwalk in the respondent's sewage treatment facility, going to inspect a clarifier. While walking on the catwalk, the petitioner's feet slipped on moisture from rain the night before. The petitioner grabbed onto a handrail to stop himself from falling and felt immediate pain and numbness into his hands and arms.

On April 12, 2011, the petitioner presented at WellGroup Health Partners complaining of shoulder, arm, wrist and hand pain. The petitioner was seen by Dr. Gaurang Zala, given Ibuprofen and referred to follow up with his primary care physician. (PX 5).

The petitioner was seen at WellGroup again on April 26, 2011 with continuing wrist pain. It was noted that the petitioner was wearing wrist braces to help him get through the work day. (PX 5).

On May 6, 2011, the petitioner returned to Dr. Zala who noted the petitioner's pain in the forearms and arms. (PX 5).

On May 13, 2011, the petitioner was seen by Dr. Ram Aribindi of Southland Orthopedics for a consultation on his bilateral shoulder and wrist pain. Dr. Aribindi noted the petitioner's accidents and that he had no pain in his arms prior that time. Dr. Aribindi diagnosed, "bilateral shoulder pain with the right being worse than the left with tendonitis and impingement symptoms with possible rotator cuff pathology. He is with left wrist/hand pain with synovitis/tendonitis of the wrist and some arthritic changes about the hand." Dr. Aribindi recommended the use of a splint for his left wrist and physical therapy for his bilateral shoulders. The petitioner was also placed on modified work duties with no overhead work and no lifting greater than 10 pounds. (PX 3).

On May 24, 2011, the petitioner began physical therapy at ATI Physical Therapy. (PX 6).

On June 13, 2011, the petitioner followed up with Dr. Aribindi. Dr. Aribindi recommended continued physical therapy and a MRI for the right shoulder due to continued shoulder pain. (PX 3).

On June 20, 2011, Dr. Aribindi again saw the petitioner and diagnosed the petitioner with "bilateral hand/wrist pain with some degenerative changes about the right and left wrists and patient with history of right wrist injury with proximal migration of the radius initiated with previous right wrist and elbow surgery. He is with left wrist pain with some underlying degenerative arthritic changes. He is with some swelling about the left index and middle fingers." The petitioner was prescribed a Medrol dose pack and told to continue with therapy for rehab of the left hand. Dr. Aribindi went on to state that, "I have informed him that due to the underlying degenerative changes about the right and left wrist as well as the hands that he may well require some use of anti-inflammatories to help with stiffness, pain, and swelling about the hands. The bilateral wrist and hand arthritis has been aggravated by the recent injury." (PX 3).

On June 28, 2011, the petitioner underwent a right shoulder MRI which revealed mild capsular hypertrophy of the acromioclavicular joint and possible tenosynovitis of the long head of biceps.

Following the MRI, the petitioner saw Dr. Aribindi on July 6, 2011. Dr. Aribindi recommended a repeat Medrol Dosepak and that the petitioner continue range of motion exercises for his wrists and hands. (PX 3).

On July 20, 2011, Dr. Aribindi saw the petitioner and diagnosed improved bilateral wrist and hand pain with underlying degenerative arthritis changes following aggravation from an injury and recommended further therapy. (PX 3).

On November 11, 2011, the petitioner was seen by Dr. Scott Rubenstein at Illinois Bone and Joint Institute, LLC for his bilateral wrist and hand pain. After examining the petitioner, Dr. Rubenstein stated, "Overall, my impression is one of resolving rotator cuff sprain in both of his shoulders and some residuals of probably some ligamentous injuries around his fingers. These can take a notoriously long time to heal up and I have seen them last up to a year in other patients. Right now being 7 months following the injury, I do not think there is anything further to do except wait things out. He is back to work and working without restriction and I see no reason why he cannot continue to do so, and I would just suggest some over the counter anti-inflammatory medications if things flare up and mostly time and patience for his fingers, and I think they will settle down over time. Continue the self exercises he has been doing, and otherwise I think he will have a nice result without needing any further significant intervention at the present time." (PX 1).

The petitioner testified at trial that he did not miss any time from work during his treatment for these injuries. Following his treatment by Dr. Rubenstein, the petitioner did not return for treatment until after the December 13, 2012 accident, which is the subject of case number 12 WC 44551.

During the year of 2012, the petitioner noticed that the pain in his hands and arms was better, but that he was never 100%. He stated that he never got all of his strength back and had lost the ability to work as hard as he had prior to the injuries.

CONCLUSIONS OF LAW

I. On the issue of outstanding medical bills, (J), the arbitrator hereby finds:

The respondent in this case has offered absolutely no defense whatsoever to any aspect of the petitioner's claim. Neither the petitioner's accident nor the causal connection between the petitioner's accident and his condition of ill-being were disputed by the respondent.

The petitioner's medical records clearly reflect that he sustained injuries at work on April 7, 2011 and April 11, 2011, as did the accident reports (PX 14). The petitioner underwent an extensive course of conservative treatment for these injuries. The arbitrator has reviewed the petitioner's treatment and, in the absolute absence of any evidence that these treatments were not reasonable or necessary, finds that the treatments recommended and administered to the petitioner were reasonable and necessary.

The petitioner has presented outstanding medical bills related to his April 7, 2011 and April 11, 2011 accidents as follows: (PX 13)

Provider	Beginning	Ending	Total Charges	WC Paid	WC Adj	Balance
ATI	5/24/2011	6/30/2011	$6,008.77	$2,338.97	$588.91	$3,080.89
Excellent Diagnostic Imaging	6/28/2011	6/28/2011	$3,788.20	$0.00	$0.00	$3,788.20
Franciscan Alliance	4/12/2011	4/26/2011	$1,033.39	$0.00	$0.00	$1,033.39
Health Benefits	5/19/2011	5/19/2011	$472.50	$0.00	$0.00	$472.50
Illinois Bone & Joint	11/11/2011	11/11/2011	$482.00	$193.50	$0.00	$288.50
Southland Orthopaedics	5/13/2011	7/20/2011	$2,231.50	$0.00	$0.00	$2,231.50
Balance			$14,016.36	$2,532.47	$588.91	$10,894.98

The arbitrator hereby orders respondent to pay petitioner $10,894.98 in outstanding medical bills pursuant to Sections 8(a) and 8.2 of the Act. This payment shall be made to the office of petitioner's attorney.

II. On the issue of the nature and extent of the petitioner's injury, (L), the arbitrator hereby finds:

The petitioner in this case sustained an aggravation of underlying degenerative changes in his bilateral wrists, as diagnosed by Dr. Aribindi, as well as bilateral rotator cuff sprains and some ligamentous injuries around his fingers, as diagnosed by Dr. Rubenstein. (PX 3; PX 1). The arbitrator finds that these conditions are causally related to the petitioner's April 7, 2011 and April 11, 2011 work accidents.

The petitioner testified at trial that following the end of his treatment in 2011, he noticed that the pain in his hands and arms was better, but that he was never 100%. He stated that he never got all of his strength back and had lost the ability to work as hard as he had prior to the injuries.

The arbitrator has reviewed all evidence and testimony in this matter and hereby finds that the petitioner sustained a 5% loss of use of both arms due to his April 7, 2011 and April 11, 2011 work accidents.

Therefore, the arbitrator hereby orders that respondent to pay petitioner permanent partial disability benefits of $669.64 per week for 25.3 weeks, as provided in Section 8(e) of the Act. (12.65 weeks for each arm)

III. On the issue of whether penalties and fees should be imposed on respondent, (M), the arbitrator hereby finds:

The arbitrator has reviewed all records and evidence in this matter and finds that the respondent has offered no reasonable basis for withholding medical benefits in this case.

The respondent has offered absolutely no defense to this claim whatsoever. There is no evidence or testimony to dispute any aspect of the petitioner's April 7, 2011 and April 11, 2011 accidents or the injuries that they caused. It appears to the arbitrator that this claim was simply not paid because the respondent didn't get around to it, leaving all of the petitioner's medical bills unpaid and the petitioner exposed to those bills. The respondent's actions in this case have been completely unreasonable. The respondent's denial of this case in the face of the clear facts and medical evidence can only be described as unreasonable, vexatious and solely for the purpose of delay.

In denying compensation, the respondent has not met the burden of demonstrating a reasonable belief that its denial of liability was justified under the circumstances, as required by *Continental Distrib. Co. v. Indus. Comm'n*, 98 Ill.2d 407, 456 N.E.2d 847 (1983), *Bd. of Educ. v. Indus. Comm'n*, 93 Ill.2d 20, 442 N.E.2d 883 (1982) ("*Norwood*" case) and *Bd. of Educ. v. Indus. Comm'n*, 93 Ill.2d 1, 442 N.E.2d 861 (1982) ("*Tully*" case). In *Tully*, the Illinois Supreme Court held that where a delay has occurred in payment of workers' compensation benefits, the employer bears the burden of justifying the delay and the standard he is held to is one of objective reasonableness in his belief. Thus it is not good enough to merely assert honest belief that the employee's claim is invalid or that his award is not supported by the evidence; the employer's belief is "honest" only if the facts that a reasonable person in the employer's position would have would justify it. 42 N.E.2d at 865. The Court added in *Norwood* that the question whether an employer's conduct justifies the imposition of penalties is a factual question for the Commission. The employer's conduct is considered in terms of reasonableness. 442 N.E.2d at 885. Moreover, the Appellate Court has noted that the burden of proof of the reasonableness of its conduct is upon the employer. *Consol. Freightways, Inc. v. Indus. Comm'n*, 136 Ill.App.3d 630, 483 N.E.2d 652, 654 (1985); accord, *Ford Motor Co. v. Indus. Comm'n*, 140 Ill.App.3d, 488 N.E.2d 1296 (1986).

Based on the failure of respondent to present a reasonable basis for not paying for medical treatment, there has been an unreasonable delay of payment. There has certainly been an unreasonable delay in payment of medical bills, without adequate basis for that decision. The arbitrator finds the respondent's behavior to be unreasonable, vexatious and solely for the purpose of delay.

Accordingly, the Arbitrator finds that Respondent shall pay penalties under §19(k) in the amount of $5,447.49, representing fifty percent of the total amount due to date in medical expenses. The arbitrator calculated this amount as follows:

$10,894.98 in outstanding medical / 2 = **$5,447.49 due pursuant to Section 19(k)**

SECTION 16

Pursuant to §16 of the Act, the Arbitrator finds that Respondent shall pay attorneys' fees calculated upon twenty percent of the unpaid medical expenses to date and twenty percent of the §19(k) award. Accordingly, Respondent shall pay the sum of $56,960.55 in attorneys' fees, with the remainder of Petitioner's attorneys' fees, if any, to be paid by Petitioner to his attorneys. This award was calculated by the arbitrator as follows:

$5,447.49 in Section 19(k) + 10,894.98 in outstanding medical = $16,342.47

$16,342.47 x .2 = **$3,268.49 in Section 16 fees**

STATE OF ILLINOIS)
) SS.
COUNTY OF DU PAGE)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Jeffrey L. Barton,

Petitioner,

14IWCC0982

vs.

NO: 11 WC 00612

Village of Addison,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petitions 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, temporary total disability, causal connection, medical expenses, prospective medical expenses, permanent partial disability, and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof. 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 14, 2014 is hereby affirmed and adopted.

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

14IWCC0982

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

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

No bond is required for removal of this cause to the Circuit Court by Respondent. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: NOV 17 2014

David L. Gore

Stephen Mathis

Mario Basurto

DLG/gaf
O: 11/13/14
45

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

14IWCC0982

BARTON, JEFFREY
Employee/Petitioner

Case# **11WC000612**

VILLAGE OF ADDISON
Employer/Respondent

On 1/14/2014, 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:

0159 LAW OFFICE OF FRANCIS J DISCIPIO LTD
1200 HARGER RD
SUITE 500
OAK BROOK, IL 60521

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

STATE OF ILLINOIS)
)SS.
COUNTY OF DUPAGE)

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

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

14IWCC0982

JEFF BARTON,
Employee/Petitioner

v.

VILLAGE OF ADDISON,
Employer/Respondent

Case # 11 WC 612

Consolidated cases: none

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Peter M. O'Malley**, Arbitrator of the Commission, in the city of **Wheaton**, on **11/6/13**. 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. ☒ 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 _____

14IWCC0982

FINDINGS

On the date of accident, **3/31/10**, 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 with respect to his right shoulder ***is*** causally related to the accident, but his current condition of ill-being with respect to his neck, right elbow and right hand ***is not*** causally related to the accident.

In the year preceding the injury, Petitioner earned **$67,131.02**; the average weekly wage was **$1,290.98**.

On the date of accident, Petitioner was **54** years of age, ***married*** with **no** 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 **$25,450.28** for TTD, **$0.00** for TPD, **$0.00** for maintenance, and **$0.00** for other benefits, for a total credit of **$25,450.28**.

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 $860.65 per week for 36-3/7 weeks, commencing 7/19/10 through 3/30/11, as provided in Section 8(b) of the Act.

Respondent shall pay Petitioner the temporary total disability benefits that have accrued from 4/1/10 through 11/6/13, and shall pay the remainder of the award, if any, in weekly payments.

Respondent shall be given a credit of $25,450.28 for temporary total disability benefits that have been paid.

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

In 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

1/6/14
Date

ICArbDec19(b)

JAN 14 2014

STATEMENT OF FACTS:

Petitioner, a 54 year old maintenance worker, worked for the Respondent in its public works department. His job duties included road repair and maintenance, parkway repair, street cleaning, storm inlet cleaning, snowplowing and the like. Petitioner testified that on Friday, March 31, 2010 he was assigned to pulverize dirt to be used in parkway repair and upkeep. This involved the operation of a backhoe and a pulverizer. Petitioner testified that at the end of the day, while exiting the backhoe his hand grabbed a handle which broke off and caused him to fall about 20 inches to the ground, onto his right elbow. Petitioner testified that following the incident he felt instant pain in his right shoulder and neck. On cross examination, Petitioner indicated that he fell and landed on his elbow at the time, but did not know whether there was any impact on the hand or wrist. He also claimed that he struck the side of his head. The incident was unwitnessed.

On direct examination, Petitioner denied having had any pains or problems with his right hand, right shoulder, right elbow or neck prior to the date of the alleged accident. However, in a progress note dated December 15, 2009, or a little more than three (3) months prior to the alleged accident, Dr. Paul Baubly, Petitioner's primary care physician at Center Street Medical, recorded that Mr. Barton presented with complaints of neck pain, among other issues, and diagnosed him with a "neck disorder." (RX6). When questioned about this entry Petitioner indicated that he did not know whether he had been diagnosed with such a condition at that time, although he agreed that he would not have any reason to question the accuracy of said record.

Petitioner testified that following the incident he drove the machine back to the shop, informed his supervisor as to what had happened and filled out an incident report. Neither party submitted the incident report into evidence.

Petitioner continued to work thereafter and first sought treatment at the company clinic on April 8, 2010. Petitioner testified that he was prescribed pain medication and muscle relaxers at that time, and that he subsequently underwent physical therapy. Records from the company clinic were not submitted into evidence by either party. What was submitted was a light duty assignment letter, signed by both Petitioner and Respondent's superintendent, Dan O'Neill, and dated April 8, 2010. (RX1). This letter references a doctor's note (likewise not submitted into evidence) outlining his "restrictions due to the March 31, 2010 injury." (RX1). Petitioner acknowledged receiving and signing this document, noting that he agreed to stay within his restrictions and to contact his supervisor if he had a problem, which he indicated he never did.

Petitioner testified that he next sought treatment at Center Street Medical, his primary care provider. He did not indicate a specific date, nor do the Center Street Medical records submitted into evidence at RX6 contain any reference to any office visits at this facility from the date of the alleged accident through June 7, 2010, and indeed no reference to any work injury until a progress note dated June 10, 2010. Despite the lack of documentation along these lines, it would appear that Petitioner was in fact seen by a medical provider during this time, given that he subsequently underwent an MRI of the right shoulder on May 25, 2010. This diagnostic study was interpreted as revealing a full thickness tear of the anterior supraspinatus tendon as well as moderate degenerative arthritis of the acromioclavicular joint and mild to moderate tendinosis of the arcuate segment of the biceps tendon. (PX5).

In a "progress note" dated June 10, 2010, Dr. Baubly noted that "... pt to see orthopod tomorrow for neck following MRI which showed tear in rotator cuff; H/A's (after falling at work)..." (RX6). Petitioner had seen Dr. Baubly three (3) days earlier, on June 7, 2010, at which time it was noted that Mr. Barton was "due for BMP, lipids, UA." (RX6). No mention of any neck, right shoulder, right elbow or right hand complaints were noted at that time. (RX6).

Petitioner subsequently visited Dr. Eugene Bartucci at Elmhurst Orthopedics on June 11, 2011. At that time Dr. Bartucci recorded that Petitioner sustained a "[r]ight shoulder injury 03/31. Works for the Village of Addison. Was working a backhoe. Grabbed the door and it snapped and it pulled his right arm. Seen by company doctor and then eventually underwent an MRI on 05/25/10. It shows a tear of the rotator cuff, moderate in size, 1.7 x 1.6 cm. He has had left shoulder surgery in the past, biceps tenodesis. Rotator cuff repair, labral repair which appears to be doing okay." (PX4). Dr. Bartucci recommended repair as an outpatient, pending approval. (PX4).

On July 19, 2010, Dr. Bartucci performed surgery consisting of arthroscopy of the right shoulder, arthroscopic subacromial decompression, distal clavicle resection, debridement of biceps tendon and rotator cuff repair (mini) at Elmhurst Memorial Hospital. (PX6). Petitioner testified that following shoulder surgery he kept telling his doctor that he was getting numbness and tingling in his hand. Petitioner subsequently underwent post operative therapy at AthletiCo from August 4, 2010 through February 11, 2011.

In an AthletiCo "therapy initial evaluation" report dated August 4, 2010, it was recorded the "[p]atient reports that on March 31st [2010] he was stepping of [sic] a back hoe while holding onto a handle with his right hand. The handle the patient was holding onto broke and caused him to fall backwards and land onto his elbow which caused him to tear his right rotator cuff… Since the surgery the patient has been off work and been mostly resting his shoulder." (PX4). No mention of any cervical, right elbow or right hand complaints are noted in either this or the subsequent therapy note on August 11, 2010. (PX4). The physician's diagnosis on both occasions was noted as "shoulder surgery." (PX4).

In an AthletiCo "therapy progress note" dated September 1, 2010, it was noted that his shoulder had been feeling better the last couple of weeks and that "[t]he patient also reports some right lateral cervical pain and right biceps pain." (PX4). Once again, the physician's diagnosis at that time was "shoulder surgery." (PX4).

In an AthletiCo "therapy progress note" dated September 22, 2010, it was noted that "[t]he patient[']s chief complaint has to due with lack of active shoulder motion. The patient still has numbness into the left hand, which has not decrease [sic] since the accident…" (PX4). The physician's diagnosis, once again, was noted as "shoulder surgery." (PX4).

In a "progress note" dated September 24, 2010, Dr. Bartucci noted that Petitioner's motion in his shoulder was getting better in therapy but that he still had some achiness. Dr. Bartucci also noted that "[h]e still has some tingling in his hand, the fourth and fifth fingers mainly. If that does not resolve by next time, he should have an EMG. He did complain that he landed on his elbow and pulled his neck at the time of the injury. I think an MRI of the cervical spine would be indicated to evaluate this numbness in his arm." (PX4).

Petitioner subsequently underwent an MRI of the cervical spine at Premiere Health Imaging on September 30, 2010. The MRI was interpreted as revealing degenerative disease in the cervical spine resulting in various degrees of foraminal stenosis, most notably in the form of moderate bilateral foraminal stenosis at C3-4, and a posterior disk osteophyte complex at C6-7 resulting in mild central canal stenosis. (PX5).

In a "telephone conversation" note dated October 4, 2010, Dr. Bartucci recorded that "[c]ervical spine MRI showing foraminal stenosis at C3-4 disc complex, C6-7. He will start therapy for his cervical spine in addition to right shoulder." (PX4).

In an AthletiCo "therapy initial evaluation" report dated October 6, 2010, it was recorded the "[p]atient reports that on March 31st [2010] he was stepping of [sic] a back hoe while holding onto a handle with his right hand. The handle the patient was holding onto broke and caused him to fall backwards and land onto his elbow which

cause [sic] him to tear his right rotator cuff... In addition to shoulder pain the patient had cervical pain since the initial injury... [and] numbness into his right 4th and 5th finger..." (PX4).

In an AthletiCo "therapy progress note[s]" dated October 13, 2010, October 27, 2010 and November 22, 2010 Petitioner was described as being post status cervical radiculopathy and rotator cuff tear after hurting his shoulder and cervical spine at work on March 31, 2010. (PX4). The physician's diagnosis noted throughout this period was cervical radiculopathy and rotator cuff tear.

In a "progress note" dated October 15, 2010 Dr. Bartucci noted that Petitioner's shoulder was still stiff and sore and that "[h]e is also having numbness in his arm which is presumably secondary to a C6-7 disc herniation with right sided compression and extrusion." (PX5). Petitioner was administered a subacromial and AC joint injection on that date. (PX5). In addition, Dr. Bartucci recommended continued therapy and noted that "[h]e would only be able to go for sitting 1 handed work." (PX5).

In a "progress note" dated October 29, 2010, Dr. Bartucci noted that Petitioner's right shoulder was improving and that the injections seemed to help. (PX4). Dr. Bartucci indicated that Petitioner was still weak and lacked rotation and that "[h]e still has pain in his neck and numbness in his arm." (PX4). Dr. Bartucci recommended that Petitioner continue with rehab and that "[i]f the right hand continues to be numb, I am recommending an EMG to evaluate what the cause is, if it is indeed his cervical problem." (PX4). Dr. Bartucci's impression was cervical radiculopathy. (PX4).

Petitioner underwent an EMG/nerve conduction study on his right hand on November 9, 2010 at Marianjoy Medical Group which revealed severe right median nerve neuropathy at the right wrist (carpal tunnel syndrome) and concurrent right ulnar neuropathy at the elbow "most likely traumatic from patient's fall." (PX4).

In a "progress note" dated November 9, 2010, Dr. Bartucci indicated that Petitioner "has severe carpal tunnel on the right and ulnar neuropathy of the elbow, cubital tunnel syndrome. He landed on his elbow when he fell at work, injuring his shoulder. That appears to be the cause of the cubital tunnel syndrome and possibly the carpal tunnel. That may require surgical procedure. His cervical spine is still bothering him, painful. Therapy does not seem to be helping that much. His shoulder range of motion on the right ... is improving. Range is good. Strength slowly improving. I am encouraged by that. He has multiple aches and pains ... Off work at this time." (PX4).

In a "progress note" dated November 23, 2010, Dr. Bartucci noted that Petitioner had been "doing pretty well until yesterday when he noticed increased weakness and discomfort in the shoulder. He has good movement but is quite weak. Therapy indicates he is progressing. I am recommending he get a second opinion for his cervical. He will be referred back to Dr. Koutsky at this time." (PX4).

In a consultation report dated December 3, 2010, Dr. Kevin M. Koutsky recorded that Petitioner presented with neck pain and bilateral upper extremity pain, more down the right arm than the left arm, as well as some numbness and tingling into his middle and ring finger on the right when compared to the left. (PX4). Dr. Koutsky noted that "[h]is symptoms began on March 31, 2010, after a work-related injury. He was working for the Village of Addison as a maintenance worker. He was getting out of a backhoe, and the handle snapped off. He landed on his right elbow, pushing his arm into his shoulder and into his neck. He did also have a shoulder injury at that time, but he did notice numbness and tingling down the right arm into his fingers..." (PX4). Following his examination, and review of the cervical MRI, Dr. Koutsky opined that Petitioner suffered from a C6-7 disc herniation with right upper extremity radiculitis, status post shoulder surgery. (PX4). Dr. Koutsky recommended that Petitioner continue with physical therapy, including cervical range of motion, strengthening

and stabilization, as well as a Pain Clinic evaluation for cervical epidural steroid injection. (PX4). Finally, Dr. Koutsky noted that "[u]ltimately if his symptoms do not improve despite conservative treatment, we will discuss surgical treatment options for his herniated disk." (PX4).

In an AthletiCo "therapy progress note" dated December 13, 2010, the therapist noted that the "[p]atient reports that he initially hurt his shoulder and cervical spine at work on March 31, 2010" and that "...he still has constant cervical pain." (PX4).

In a "progress note" dated December 14, 2010, Dr. Bartucci noted that some of Petitioner's "functions are quite good, movement is good. Strength is not bad but he gets 1 area when he is lifting that catches and is very painful anterior. It could be suture impingement or the edge of the tear, but it does seem like that particular problem is coming from his shoulder." (PX4).

At the request of Respondent, Petitioner visited Dr. Lawrence D. Lieber on December 20, 2010 for purposes of a §12 evaluation. In a report dated December 21, 2010, Dr. Lieber opined that "[t]he petitioner's right rotator cuff was in direct relationship to the March 31, 2010 work injury. However, the cervical symptoms and right elbow complaints are not related or caused by that injury. No further treatment is necessary in association with the March 31, 2010 injury to the neck and right elbow area." (RX3). Dr. Lieber believed, however, that Petitioner evidenced poor progression of his right shoulder and could require another four weeks of physical therapy and possible cortisone injections, with no further treatment necessary thereafter. (RX3). Dr. Lieber went on to opine that Petitioner would be able to return to his employment and will reach maximum medical improvement within the ensuing four to six weeks. (RX3).

In a "progress note" dated January 6, 2011, Dr. Bartucci noted that Petitioner was using his electrical stimulation unit an average of 3 hours and 16 minutes a day and reported a 33% decrease in his pain level. (PX4).

In an AthletiCo "therapy progress note" dated January 7, 2011, the therapist had noted that "[o]ur limiting factor at this point in therapy has been the numbness and tingling that Jeff experiences in his right hand which he describes as getting much worse in the past few weeks..." (PX4).

In a letter dated January 17, 2011, Respondent's §12 examining physician, Dr. Lieber, noted that upon review of a job description provided to him for a maintenance worker 2, as well as a review of his previous report, that "it appears that Mr. Barton is able to return to full employment, with no restrictions, in association with his work injury of March 31, 2010. The petitioner would be able to return to those job duties after the recommended treatment protocol as suggested in my evaluation, that of a cortisone injection and physical therapy for another four weeks. There is no objective evidence that would require this individual from further restrictions upon completion of the recommended treatment protocol." (RX4).

In an AthletiCo "therapy progress note" dated February 7, 2011, the therapist noted that Petitioner was "now with full shoulder joint mobility, appropriate cuff and scapular strength, but is still lacking pain-free strength with against gravity activities secondary to faulty arthro-kinematics. I do feel as though this patient will continue to improve upon these complaints as he gets stronger ... His numbness complaints to the ulnar nerve distribution has limited are [sic] progress somewhat in therapy, and he has not responded well [to] cervical injections to date. It does appear that their [sic] is an elbow component to this neuropathy ..." (PX4).

In a "progress note" dated February 8, 2011, Dr. Bartucci indicated that Petitioner still had grinding and significant weakness in his right shoulder, but that he did not think that Mr. Barton was ready for surgery.

(PX4). Dr. Bartucci went on to state that Petitioner "also has carpal/cubital tunnel syndrome of the right hand from the fall. The cubital tunnel is severe. He has interosseous wasting in his hand. I told him that should be addressed fairly soon." (PX4).

In a "progress note" dated March 4, 2011, Dr. Bartucci noted that Petitioner still had pain and weakness in his right shoulder and was "not quite ready for work." (PX4). Dr. Bartucci also indicated that Petitioner "has right hand severe muscle wasting and cubital/carpal tunnel compression syndrome" and "definitely needs to have the surgery on that as soon as possible." (PX4). Dr. Bartucci stated that in the meantime Petitioner was authorized off work. Finally, Dr. Bartucci indicated that "[t]he injury on his shoulder was in March of 2010. He fell directly on his elbow, which pushed his shoulder and in all likelihood damaged the nerve in his elbow." (PX4).

On March 21, 2011, Petitioner underwent surgery at the hands of Dr. Bartucci consisting of cubital tunnel release and carpal tunnel release of the right arm. (PX3). Under "indications," it was noted that Petitioner presented with severe cubital tunnel and moderate carpal tunnel syndrome and that "[t]his is a probable work-related injury." (PX3).

In a "progress note" dated March 23, 2011, Dr. Bartucci noted that Petitioner's hand was doing well, although he was in some pain, and that "[t]he nerve was too tight and under too much pressure to transpose to the ulnar nerve." (PX4). Petitioner was to work on light exercise and return in ten days for suture removal. (PX4).

In a letter dated March 30, 2011, Respondent's §12 examining physician, Dr. Lieber, noted that there was no change from his original report and that Petitioner, having completed therapy, was able to return to employment with no restrictions. (RX5). Dr Lieber also indicated that there were no further treatment recommendations with respect to the work injury and that "Mr. Barton is able to return to normal job duties in Public Works for the Village of Addison based upon review of all records." (RX5). Finally, Dr. Lieber opined that Petitioner had reached "maximum medical improvement in association with his work injury of March 31, 2010 and requires no further treatment at this time or in the future." (RX5).

In a "progress note" dated May 24, 2011, Dr. Bartucci noted that the right shoulder had improved and "will be returned to work 5/25/2011 full duty." (PX4). Petitioner testified that he returned to full duty work on May 25, 2011 and that he has continued to work in that capacity up through the date of arbitration.

In a "progress note" dated June 15, 2011, Dr. Bartucci indicated that Petitioner's overall condition was improving and that "[h]is main problem is grip strength, first dorsal compartment wasting, pinch and opposition. He is getting better but it is very slow. I am going to discharge him for now and he will follow up as needed." (PX4).

In a "progress note" dated September 16, 2011, Dr. Bartucci noted that Petitioner "still has significant weakness in his arm, mostly in the ulnar distribution of his hand. His opposition strength is improving. Shoulder has gotten better. He also has issues with cervical radiculopathy. I told him right now there is nothing more that can be done. They will wait on it and see how it is in a few months." (PX4).

Petitioner returned to Dr. Koutsky on October 10, 2011 at which time he noted that the injections had provided some temporary relief but that the symptoms had recurred. (PX8). Dr. Koutsky stated that Petitioner had been working through his pain and was "here today to discuss more definitive options." (PX8). Along these lines, Dr. Koutsky opined that since Petitioner had "failed all conservative management including medications, therapy, and injections", and given that "[h]is MRI scan does show evidence of a C6-7 herniation after a work related

injury ... I do think he would be a reasonable candidate for anterior cervical decompression and fusion with instrumentation and bone graft." (PX8).

In a "progress note" dated June 27, 2012, Dr. Koutsky noted that Petitioner "continues to have symptoms of cervical radiculopathy, due to a work related C6-7 disk herniation. He has failed all conservative management. He would be a reasonable candidate for anterior cervical decompression and fusion with instrumentation and bone graft." (PX4). Dr. Koutsky had made a similar recommendation for surgery in a "progress note" dated October 10, 2011. (PX4). Dr. Koutsky recommended that Petitioner see Dr. Geoffrey Dixon for neurosurgical evaluation prior to surgery, and that he continue working and taking his medicine for his discomfort in the interim. (PX4).

Petitioner returned to Dr. Koutsky on December 19, 2012 and March 13, 2013 at which time it was noted that Mr. Barton was still suffering from a "work related aggravation of his cervical spondylosis and stenosis" and they were still awaiting authorization for a neurosurgical consultation with Dr. Dixon as well as authorization for anterior cervical decompression and fusion with instrumentation. (PX8).

In a "progress note" dated June 5, 2013, Dr. Koutsky noted that Petitioner was still having a lot of problems in the neck and upper extremity, and that they had been awaiting authorization for a neurological evaluation with Dr. Dixon. (PX8). Dr. Koutsky indicated that Petitioner had been working and has been taking his medications on an as-needed basis. (PX8). In addition, Dr. Koutsky stated that Petitioner "does have a work-related aggravation of his stenosis." (PX8). Finally, Dr. Koutsky recommended a new MRI of the cervical spine, given that the last one was taken a while ago. (PX8).

An MRI of the cervical spine performed on June 11, 2013 was interpreted as evidencing mild C6-7 DJD with mild posterior bulging disc/osteophyte complex. (PX8). This report also noted no evidence of focal disc herniation or significant spinal stenosis. (PX8).

In a "progress note" dated July 17, 2013, Dr. Koutsky indicated that Petitioner had seen Dr. Dixon who concurred with the assessment for surgery. (PX8). Dr. Koutsky also noted that Petitioner's symptoms were still disabling and interfered with his function. (PX8). Dr. Koutsky indicated that they were awaiting authorization for decompression and stabilization with instrumentation. (PX8). Dr. Koutsky reiterated the fact that they were still awaiting authorization for the aforementioned surgery in a "progress note" dated September 6, 2013. (PX8).

Petitioner testified that he still currently experiences pain in his neck and numbness and tingling down his arm on the right side. He also indicated that he would like to have the surgery recommended by Dr. Koutsky.

WITH RESPECT TO ISSUE (C), DID AN ACCIDENT OCCUR THAT AROSE OUT OF AND IN THE COURSE OF THE PETITIONER'S EMPLOYMENT BY THE RESPONDENT, THE ARBITRATOR FINDS AS FOLLOWS:

Petitioner testified that on March 31, 2010 he was running a backhoe tracker, loosening dirt to load into the pulverizer. He indicated that he was exiting the back hoe towards the end of the day when the handle on the door snapped off and he fell to the ground, landing on the right side of his elbow and forcing his whole body to slam into the ground. He noted that one foot was coming off the step when he fell, and that the step was about 20" off the ground. On cross examination, Petitioner indicated that he fell and landed on his elbow at the time, but did not know whether there was any impact on the hand or wrist. He also claimed that he struck the side of his head. Petitioner testified that he felt immediate pain in his right shoulder and neck following the incident. He noted that he shrugged it off at first, shut down the machine and drove it back to the shop. Then he told his

supervisor and filled out an incident report. Neither party submitted this report into evidence, nor was the supervisor called to testify.

Petitioner indicated that he tried to go back to work and eventually asked to go to convenient care in April of 2010. Records from the company clinic for this visit were not submitted into evidence by either party. What was submitted was a light duty assignment letter, signed by both Petitioner and Respondent's superintendent, Dan O'Neill, and dated April 8, 2010. (RX1). This letter references a doctor's note on that date (likewise not submitted into evidence) outlining his "restrictions due to the March 31, 2010 injury." (RX1).

Petitioner testified that he next sought treatment at Center Street Medical, his primary care provider. Petitioner did not testify to a specific date, nor do the Center Street Medical records submitted into evidence contain any reference to any office visits at this facility from March 1, 2010 through June 7, 2010. (RX6). Indeed, no reference to any work injury can be found in these records until a "progress note" dated June 10, 2010, at which time Dr. Baubly noted that "... pt to see orthopod tomorrow for neck following MRI which showed tear in rotator cuff; H/A's (*after falling at work*)..." (RX6). (Emphasis added). Despite the lack of documentation along these lines, it would appear that Petitioner was in fact seen by a medical provider during this time, given the aforementioned MRI of the right shoulder, which took place on May 25, 2010.

In any event, the record shows that Petitioner subsequently visited Dr. Bartucci on June 11, 2010 at which time he recorded that the patient had sustained a "[r]ight shoulder injury 03/31. Works for the Village of Addison. *Was working a backhoe. Grabbed the door and it snapped and it pulled his right arm*. (Emphasis added).

In an AthletiCo "therapy initial evaluation" report dated October 6, 2010, it was recorded that the "[p]atient reports that on March 31st [2010] he was *stepping of [sic] a back hoe while holding onto a handle with his right hand. The handle the patient was holding onto broke and caused him to fall backwards and land onto his elbow*..." (Emphasis added).

Dr. Bartucci eventually referred Petitioner to Dr. Koutsky. In a consultation report dated December 3, 2010, Dr. Koutsky recorded that Petitioner's "... symptoms began on March 31, 2010, after a work-related injury. He was working for the Village of Addison as a maintenance worker. *He was getting out of a backhoe, and the handle snapped off. He landed on his right elbow, pushing his arm into his shoulder and into his neck*..." (PX4). (Emphasis added).

Based on the above, and the record taken as a whole, the Arbitrator finds that Petitioner sustained accidental injuries arising out of and in the course of his employment on March 31, 2010. While the aforementioned histories vary somewhat as to the exact mechanism of injury, referring to Petitioner either landing/falling on his right elbow or else pulling/pushing his right arm, the preponderance of the credible evidence supports Petitioner's claim that the incident in fact occurred on the date alleged. The real question is whether his current condition of ill-being with respect to his cervical spine, right elbow and right hand/wrist, in addition to his undisputed right shoulder injury, are causally related to the accident in question.

WITH RESPECT TO ISSUE (F), IS THE PETITIONER'S PRESENT CONDITION OF ILL-BEING CAUSALLY RELATED TO THE INJURY, THE ARBITRATOR FINDS AS FOLLOWS:

There would appear to be no dispute that Petitioner's condition of ill-being with respect to his right shoulder is causally related to the March 31, 2010 accident, particularly in light of the fact that Respondent's §12 examining physician, Dr. Lieber, stated as much. (RX3). The question is whether Petitioner's conditions of ill-being with respect to his right elbow, right hand/wrist and cervical spine are also related to the accident.

Petitioner's claim is based on the theory that his cervical, cubital tunnel and carpal tunnel conditions all flowed out of a single, identifiable traumatic event – namely, the incident on March 31, 2010 when the handle on the door of his backhoe broke and he fell 20" to the ground, landing on his elbow. That being the case, it does not appear that Petitioner is claiming that the aforementioned conditions were the consequence of repetitive trauma occasioned by his work for Respondent. In fact, Petitioner presented little if any evidence to support such a theory of recovery, other than his general testimony to the effect that his job involved, among other things, sidewalk grinding. Indeed, Petitioner provided no evidence, testimonial or otherwise, as to the frequency or duration of any specific task or tasks that may have contributed to any of these conditions. Furthermore, Petitioner submitted no medical opinions that would support a claim that these conditions were the result of repetitive trauma. Therefore, the analysis must focus exclusively on Petitioner's claim that his cervical, cubital tunnel and carpal tunnel conditions were the result of the traumatic event that occurred on March 31, 2010.

Along these lines, the evidence shows that Petitioner had complaints relative to his neck a little more than three (3) months prior to March 31, 2010, as reflected in the office note of Dr. Baubly dated December 15, 2009. At that time, Dr. Baubly diagnosed Petitioner with a "neck disorder", among other things. (RX6). There is no indication that any treatment was recommended by Dr. Baubly for this condition at that time, or that Petitioner was given any restrictions due to his complaints. (RX6). Indeed, the reason for the visit appears to have had more to do with a dry cough Petitioner had developed a month earlier, as well as to follow up with respect to his hypertension and GERD. (RX6).

In any event, Petitioner continued to work full duty up to the date of the accident on March 31, 2010. On that date, Petitioner claims that he was exiting the backhoe when the handle on the door broke, causing him to fall from a step approximately 20" off the ground, and landing on his elbow. Petitioner could not recall whether he impacted his right hand or wrist at that time, but did claim that he struck the side of his head. Petitioner also claimed that he felt instant pain in his right shoulder and neck. He returned to the shop, reported the incident to the superintendent and filled out an incident report. No incident report was submitted into evidence, and the superintendent was not called to testify.

It appears that Petitioner continued to work thereafter until seeking treatment at the company clinic on or about April 8, 2010. Unfortunately, the company clinic records were not submitted into evidence. Likewise, the records from Petitioner's primary care provider, Center Street Medical, do not appear to contain any references to, much less office notes for, any visits made to the facility between March 1, 2010 and June 7, 2010 – this despite the fact that Petitioner obviously had to have received a referral from some provider for the MRI of his right shoulder he underwent on May 25, 2010. Thus, even though the evidence strongly suggests that Petitioner sought treatment during this time, there is no documentary evidence in the form of office notes and the like that can either substantiate or disprove Petitioner's claim that he complained of neck pain as well as right shoulder pain immediately following the accident.

Instead, what we have is a "progress note" dated June 10, 2010 wherein primary care physician Dr. Baubly notes, somewhat cryptically, that "... pt to see orthopod tomorrow for neck following MRI which showed tear in rotator cuff; H/A's (*after falling at work*)..." (RX6). (Emphasis added). Petitioner had seen Dr. Baubly three (3) days earlier, on June 7, 2010, at which time it was noted that Mr. Barton was "due for BMP, lipids, UA." (RX6). No mention of any neck, right shoulder, elbow or hand complaints were noted at that time. (RX6).

The next day, June 11, 2010, Petitioner is seen by Dr. Bartucci. On that date, Dr. Bartucci recorded that Petitioner sustained a "[r]ight shoulder injury 03/31. Works for the Village of Addison. Was working a backhoe. Grabbed the door and it snapped and it pulled his right arm. Seen by company doctor and then eventually underwent an MRI on 05/25/10. It shows a tear of the rotator cuff, moderate in size, 1.7 x 1.6 cm.

He has had left shoulder surgery in the past, biceps tenodesis. Rotator cuff repair, labral repair which appears to be doing okay." (PX4). Dr. Bartucci recommended repair as an outpatient, pending approval. (PX4).

On July 19, 2010, Dr. Bartucci performed surgery consisting of arthroscopy of the right shoulder, arthroscopic subacromial decompression, distal clavicle resection, debridement of biceps tendon and rotator cuff repair (mini) at Elmhurst Memorial Hospital. (PX6). Petitioner testified that following shoulder surgery he kept telling his doctor that he was getting numbness and tingling in his hand.

Petitioner subsequently underwent post operative therapy at AthletiCo from August 4, 2010 through February 11, 2011.

In an AthletiCo "therapy initial evaluation" report dated August 4, 2010, it was recorded the "[p]atient reports that on March 31st [2010] he was stepping of [sic] a back hoe while holding onto a handle with his right hand. The handle the patient was holding onto broke and caused him to fall backwards and land onto his elbow which caused him to tear his right rotator cuff... Since the surgery the patient has been off work and been mostly resting his shoulder." (PX4). No mention of any cervical, right elbow or right hand complaints are noted in either this or the subsequent therapy note on August 11, 2010. (PX4). The physician's diagnosis on both occasions was noted as "shoulder surgery." (PX4).

Indeed, it was not until September 1, 2010, or five (5) months following the accident, that the records clearly reference specific complaints relative to the cervical spine – namely, that "[t]he patient also reports some right lateral cervical pain and right biceps pain." (PX4). Three (3) weeks later, on September 22, 2010, AthletiCo records also finally reference "... numbness into the left hand, which has not decrease [sic] since the accident..." (PX4). Two (2) days later, on September 24, 2010, Dr. Bartucci takes up the cause, noting that "[h]e still has some tingling in his hand, the fourth and fifth fingers mainly. If that does not resolve by next time, he should have an EMG. He did complain that he landed on his elbow and pulled his neck at the time of the injury. I think an MRI of the cervical spine would be indicated to evaluate this numbness in his arm." (PX4).

Petitioner subsequently underwent an MRI of the cervical spine at Premiere Health Imaging on September 30, 2010. The MRI was interpreted as revealing degenerative disease in the cervical spine resulting in various degrees of foraminal stenosis, most notably in the form of moderate bilateral foraminal stenosis at C3-4, and a posterior disk osteophyte complex at C6-7 resulting in mild central canal stenosis. (PX5). No mention of any herniated or protruded disc is made in either this MRI or the one subsequently performed on June 11, 2013. (PX8). Indeed, that most recent MRI of the cervical spine was interpreted as evidencing only mild C6-7 DJD with mild posterior bulging disc/osteophyte complex with *no evidence of focal disc herniation or significant spinal stenosis*. (PX8). (Emphasis added). Dr. Bartucci, in a note dated October 4, 2010, originally described the results as evidencing "foraminal stenosis at C3-4 disc complex, C6-7." (PX4). However, since that time, both Dr. Bartucci and Dr. Koutsky have repeatedly referenced the existence of a C6-7 disc herniation as the basis for the recommended anterior cervical decompression and fusion with instrumentation and bone graft. (PX4).

In any event, it is at this point that the records begin to focus on complaints beyond the right shoulder. To wit, in an AthletiCo "therapy initial evaluation" report dated October 6, 2010, it was recorded the "[p]atient reports that on March 31st [2010] he was stepping of [sic] a back hoe while holding onto a handle with his right hand. The handle the patient was holding onto broke and caused him to fall backwards and land onto his elbow which cause [sic] him to tear his right rotator cuff... *In addition to shoulder pain the patient had cervical pain since the initial injury... [and] numbness into his right 4th and 5th finger*..." (PX4). (Emphasis added).

In an AthletiCo "therapy progress note[s]" dated October 13, 2010, October 27, 2010 and November 22, 2010 Petitioner was described as being post status cervical radiculopathy and rotator cuff tear after hurting his shoulder and cervical spine at work on March 31, 2010. (PX4). The physician's diagnosis noted throughout this period was cervical radiculopathy and rotator cuff tear.

In a "progress note" dated October 15, 2010 Dr. Bartucci noted that Petitioner's shoulder was still stiff and sore and that "[h]e is also having numbness in his arm which is presumably secondary to a C6-7 disc herniation with right sided compression and extrusion." (PX5).

In a "progress note" dated October 29, 2010, Dr. Bartucci noted that Petitioner's right shoulder was improving, but that "[h]e still has pain in his neck and numbness in his arm." (PX4). Dr. Bartucci recommended that Petitioner continue with rehab and that "[i]f the right hand continues to be numb, I am recommending an EMG to evaluate what the cause is, if it is indeed his cervical problem." (PX4). Dr. Bartucci's impression was cervical radiculopathy. (PX4).

Petitioner underwent an EMG/nerve conduction study on his right hand on November 9, 2010 at Marianjoy Medical Group which revealed severe right median nerve neuropathy at the right wrist (carpal tunnel syndrome) and concurrent right ulnar neuropathy at the elbow "*most likely traumatic from patient's fall*." (PX4). (Emphasis added).

In a "progress note" dated November 9, 2010, Dr. Bartucci indicated that Petitioner "has severe carpal tunnel on the right and ulnar neuropathy of the elbow, cubital tunnel syndrome. *He landed on his elbow when he fell at work, injuring his shoulder. That appears to be the cause of the cubital tunnel syndrome and possibly the carpal tunnel*..." (PX4). (Emphasis added).

Petitioner was subsequently referred to Dr. Koutsky. In a consultation report dated December 3, 2010, Dr. Koutsky noted that Petitioner's "symptoms began on March 31, 2010, after a work-related injury. He was working for the Village of Addison as a maintenance worker. He was getting out of a backhoe, and the handle snapped off. *He landed on his right elbow, pushing his arm into his shoulder and into his neck. He did also have a shoulder injury at that time, but he did notice numbness and tingling down the right arm into his fingers*..." (PX4). (Emphasis added).

In an AthletiCo "therapy progress note" dated December 13, 2010, the therapist noted that the "[p]atient reports that *he initially hurt his shoulder and cervical spine at work on March 31, 2010*" and that "...he still has constant cervical pain." (PX4). (Emphasis added).

At the request of Respondent, Petitioner visited Dr. Lieber on December 20, 2010 for purposes of a §12 evaluation. In a report dated December 21, 2010, Dr. Lieber opined that "[t]he petitioner's right rotator cuff was in direct relationship to the March 31, 2010 work injury. However, *the cervical symptoms and right elbow complaints are not related or caused by that injury*..." (RX3). (Emphasis added). Dr. Lieber noted that "the petitioner showed significant degenerative cervical disc disease and abnormality within the elbow, right upper extremity, that is pre-existing and shows no objective evidence of any acute abnormality that can be related to the March 31, 2010 event." (RX3).

In a "progress note" dated February 8, 2011, Dr. Bartucci indicated that in addition to grinding and significant weakness in his right shoulder, Petitioner "*also has carpal/cubital tunnel syndrome of the right hand from the fall*. The cubital tunnel is severe. He has interosseous wasting in his hand. I told him that should be addressed fairly soon." (PX4). (Emphasis added).

In a "progress note" dated March 4, 2011, Dr. Bartucci indicated that "[t]he injury on his shoulder was in March of 2010. *He fell directly on his elbow, which pushed his shoulder and in all likelihood damaged the nerve in his elbow*." (PX4). (Emphasis added).

On March 21, 2011, Petitioner underwent surgery at the hands of Dr. Bartucci consisting of cubital tunnel release and carpal tunnel release of the right arm. (PX3). Under "indications," it was noted that Petitioner presented with severe cubital tunnel and moderate carpal tunnel syndrome and that "*[t]his is a probable work-related injury*." (PX3). (Emphasis added).

In a note dated December 19, 2012 and March 13, 2013, Dr. Koutsky indicated Mr. Barton was still suffering from a "*work related aggravation of his cervical spondylosis and stenosis* ..." (PX8). (Emphasis added). Dr. Koutsky reiterated this opinion in a "progress note" dated June 5, 2013. (PX8).

In light of the above, it appears that both Dr. Bartucci and Dr. Koutsky believe that Petitioner's cervical, cubital tunnel and carpal tunnel conditions were either caused or aggravated by the incident on March 31, 2010. However, these opinions would appear to be based almost entirely on the assumption that Petitioner had complaints relative his neck, right elbow and right hand/wrist, in addition to his right shoulder, immediately following the incident in question. Unfortunately, Petitioner presented little more than his own self-serving testimony along these lines, given the inexplicable absence of any contemporaneous histories. Along these lines, the Arbitrator finds it troubling that no initial treating records, either from the company clinic on or about April 8, 2010, or any office notes from Dr. Baubly prior to June 7, 2010, were submitted into evidence. In addition, it appears that the initial physical therapy records were likewise not submitted for consideration.

What we do have, in term of documentary evidence, are medical records that show that Petitioner's treatment initially was to his right shoulder, and that it wasn't until months later that complaints relative to his neck, and then his elbow and hand, began to appear in the record. Furthermore, the Arbitrator questions the significance of the cervical MRI studies, and is more apt to agree with Dr. Lieber's impression that the findings were degenerative and pre-existing in nature. Likewise, given the lack of documentary support for Petitioner's claim that he experienced instant pain in his neck as well as his shoulder at the time of the incident, the Arbitrator finds the opinion of Dr. Lieber -- to the effect that the accident neither aggravated nor caused the cervical symptoms, as well as the right elbow complaints -- to be more persuasive than the opinions offered by Drs. Bartucci and Koutsky. The Arbitrator also questions how, from a practical standpoint, Petitioner's carpal tunnel syndrome could have physiologically been caused by the incident given that there appears to have been no direct trauma to the wrist.

Accordingly, based on the above, and the record taken as a whole, the Arbitrator finds the condition of the right shoulder is causally related to the accident, but the conditions in the cervical spine, right elbow, and right wrist are not related to the accident.

WITH RESPECT TO ISSUE (J), WERE THE MEDICAL SERVICES THAT WERE PROVIDED TO PETITIONER REASONABLE AND NECESSARY AND HAS RESPONDENT PAID ALL APPROPRIATE CHARGES FOR ALL REASONABLE AND NECESSARY MEDICAL SERVICES, THE ARBITRATOR FINDS AS FOLLOWS:

The parties stipulated on the record that the Respondent paid all appropriate charges for all reasonable and necessary medical services to the right shoulder. Based on the Arbitrator's finding that any other conditions of ill-being are not related to the accident, the petitioner's claim for out-of-pocket medical expenses associated with treatment for his neck, right elbow and right hand/wrist is hereby denied.

WITH RESPECT TO ISSUE (K), IS PETITIONER ENTITLED TO ANY PROSPECTIVE MEDICAL CARE, THE ARBITRATOR FINDS AS FOLLOWS:

Petitioner is seeking prospective medical care in the form of ongoing care for his cervical spine, right elbow and right hand/wrist, including surgery recommended by Dr. Koutsky consisting of anterior cervical decompression and fusion with instrumentation. (PX8).

Based on the above, and the record taken as a whole, and in light of the Arbitrator's determination as to causation (issue "C", supra), the Arbitrator finds that Petitioner failed to prove his entitlement to prospective medical care and treatment with respect to his cervical spine, right elbow and/or right hand/wrist. Accordingly, Petitioner's claim for same, including cervical surgery, is hereby denied.

WITH RESPECT TO ISSUE (L), WHAT AMOUNT OF COMPENSATION IS DUE FOR TEMPORARY TOTAL DISABILITY, THE ARBITRATOR FINDS AS FOLLOWS:

The evidence shows that Petitioner continued to work for Respondent following the accident until his shoulder surgery on July 19, 2010. Petitioner was restricted from work by Dr. Bartucci thereafter.

In a report dated December 20, 2010, Dr. Lieber, Respondent's §12 examining physician, opined that Petitioner would be able to return to full duty employment with respect to the right shoulder after four additional weeks of aggressive physical therapy, after which he will have reached MMI. (RX3). Thereafter, in a letter dated January 17, 2011, Dr. Lieber noted that upon review of a job description provided to him for a maintenance worker 2, as well as a review of his previous report, that "it appears that Mr. Barton is able to return to full employment, with no restrictions, in association with his work injury of March 31, 2010. The petitioner would be able to return to those job duties after the recommended treatment protocol as suggested in my evaluation, that of a cortisone injection and physical therapy for another four weeks. There is no objective evidence that would require this individual from further restrictions upon completion of the recommended treatment protocol." (RX4).

The record shows that Petitioner continued in physical therapy at AthletiCo, receiving treatment with respect to his right shoulder, through February 11, 2011, at which time he given instructions as to home exercises and discharged from the program. (PX7). In an AthletiCo "therapy progress note" dated February 7, 2011, the therapist noted that Petitioner was "now with full shoulder joint mobility, appropriate cuff and scapular strength, but is still lacking pain-free strength with against gravity activities secondary to faulty arthro-kinematics. I do feel as though this patient will continue to improve upon these complaints as he gets stronger..." (PX4).

Thereafter, Petitioner continued to treat with Dr. Bartucci. In a "progress note" dated March 4, 2011, Dr. Bartucci noted that Petitioner still had pain and weakness in his right shoulder and was "not quite ready for work." (PX4).

In a letter dated March 30, 2011, Respondent's §12 examining physician, Dr. Lieber, noted that there was no change from his original report and that Petitioner, having completed therapy, was able to return to employment with no restrictions. (RX5). Dr Lieber also indicated that there were no further treatment recommendations with respect to the work injury and that "Mr. Barton is able to return to normal job duties in Public Works for the Village of Addison based upon review of all records." (RX5). Finally, Dr. Lieber opined that Petitioner had reached "maximum medical improvement in association with his work injury of March 31, 2010 and requires no further treatment at this time or in the future." (RX5).

Based on the above, and the record taken as a whole, and in light of the Arbitrator's determination with respect to causation (issue "C", supra), the Arbitrator finds that Petitioner was temporarily totally disabled from July 19, 2010, the date of the right shoulder surgery, through March 30, 2011, the date of Dr. Lieber's finding of MMI with respect to the right shoulder, for a period of 36-3/7 weeks.

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

Petar Vincetic,

Petitioner,

14IWCC0983

vs.

NO: 12 WC 33211

3150 Condominium Association,

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 May 21, 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.

14IWCC0983

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

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

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $26,000.00. 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: NOV 17 2014

David L. Gore

Stephen Mathis

Mario Basurto

DLG/gaf
O: 11/6/14
45

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

14IWCC0983

VINCETIC, PETAR
Employee/Petitioner

Case# 12WC033211

3150 CONDOMINIUM ASSOCIATION
Employer/Respondent

On 5/21/2014, 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:

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CHICAGO, IL 60603

2023 LAW OFFICES OF LORETTA M GRIFFIN
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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)

14IWCC0983

Petar Vincetic
Employee/Petitioner

Case # **12 WC 33211**

v.

Consolidated cases: N/A

3150 Condominium Association
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 **Brian Cronin**, Arbitrator of the Commission, in the city of **Chicago**, on **September 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 present condition of ill-being causally related to the injury?
G. ☐ What were Petitioner's earnings?
H. ☐ What was Petitioner's age at the time of the accident?
I. ☐ What was Petitioner's marital status at the time of the accident?
J. ☒ Were the 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, **6/2/2011**, 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 **$37,835.46**; the average weekly wage was **$727.61**.

On the date of accident, Petitioner was **55** years of age, ***single*** with **3** dependent children.

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

Respondent shall be given a credit of **$33,054.06** for TTD, **$0.00** for TPD, **$0.00** for maintenance, and **$0.00** for other benefits, for a total credit of **$33,054.06**.

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 in the amount of **$485.07**/week for **108-4/7**weeks, for the period of **6/3/2011 through 9/23/2012 (68-3/7 week)**, **10/22/2012 through 1/20/2013 (13 weeks)** and **3/5/2013 through 9/10/2013 (27-1/7 weeks)**, which is the period of temporary total disability for which compensation is due.

- Respondent shall pay the further sum of **$1,443.00** for necessary medical services as provided in Section 8(a) of the Act. This includes payment of the medical bills of Hinsdale Orthopaedic ($1247.00) and Pain Specialists of Greater Chicago ($196.00). The medical bills are awarded subject to payment pursuant to Section 8(a) and subject to Section 8.2 of the Act. The payment shall be sent directly to Petitioner's attorney in accordance with Section 7080.20 of the Rules Before the Illinois Workers' Compensation Commission.

- Respondent shall authorize and provide payment for the medical treatment, including the injections, as recommended by Petitioner's treating physician, Dr. Michael Zindrick. The authorization shall be in writing and forwarded to Petitioner's attorney.

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.

Brian T Cronin

Signature of Arbitrator

May 20, 2014

Date

ICArbDec19(b)

MAY 21 2014

Petar Vincetic

14IWCC0983

v. Case #: 12 WC 33211

3150 Condominium Association

ATTACHMENT TO ARBITRATOR'S DECISION

I. STATEMENT OF FACTS

A. Work History

Petitioner testified that he was employed by Respondent as a janitor. As of June 2, 2011, he had been employed by Respondent for approximately 21 years.

Petitioner testified regarding his job duties for Respondent as a janitor. Petitioner testified that his shift began at 5:30 am. At the beginning of his shift, Petitioner would ask the desk worker whether there were any emergencies that had occurred overnight. Then Petitioner would begin his normal work day. He would mop the floors in the lobby, desk area, kitchen, bathroom and back hallway. He would then vacuum the rugs and runners in the hallways and front lobby. Next, Petitioner would clean the furniture, benches and desks in the front, kitchen and bathroom. Petitioner would also inspect the building for debris or trash. In the summer, Petitioner would clean and repair the swimming pool. He would also pull the trash from all the tiers in the building. Pulling the trash took about three (3) hours to complete. Petitioner performed work inside and outside. Petitioner testified that the building was 36 stories high.

Petitioner testified that he performed lifting and carrying as part of his job duties as a janitor for Respondent. Petitioner testified that sometimes he lifted a person who had fallen

from a toilet. Petitioner also performed bending, squatting, kneeling and pushing/pulling activities. He pushed and pulled garbage containers from the basement floor to the loading dock. The loading dock was about 300 feet away from the basement floor and up a ramp. The containers could weigh up to 100 pounds or more. He would pull the containers to the loading dock at least twice a week. Petitioner also climbed ladders and stairs. He worked with power tools, floor scrubbers and vacuums. Petitioner also used hand tools. As part of his job, Petitioner stood, walked and performed twisting activities.

Petitioner's shift was eight (8) hours per day. He had two (2) fifteen (15) minute breaks and a lunch break throughout the day. During the rest of the day, he was "not really allowed" to sit down.

B. Prior Medical Treatment

Prior to June 2, 2011, Petitioner had not sustained any accidents involving his back. Further, prior to June 2, 1011, Petitioner had not received any medical treatment for his low back. Petitioner testified that prior to work on June 2, 2011, his back was "fine."

C. Work-Related Accident of June 2, 2011

Petitioner testified that on June 2, 2011, he was working for Respondent. He was cleaning the pool with Bill Nichols. They were scrubbing the bottom of the pool. Petitioner was on his knees using the scrubbing pad. When his scrubbing pad dried out, he stood up and walked two feet to the bucket to soak the pad in the bucket of solution. As he was walking back, he slipped and fell on a slippery spot. He legs went out from under him and he fell onto his back. Because of the angle of the pool, he slid to the deeper side of the pool on his left side. Mr. Nichols advised Petitioner not to move. Petitioner stayed in the position that he landed in for about

fifteen (15) minutes. Following the accident of June 2, 2011, Petitioner felt pain in his lower back.

D. Medical Treatment

Following, the work-related accident of June 2, 2011, Petitioner sought medical care. Petitioner was initially examined at the emergency room at St. Joseph's Hospital on June 2, 2011. (PX 1). The physician in the emergency room prescribed Vicodin and advised Petitioner to follow up in two (2) weeks. (PX 1).

Petitioner was examined by Dr. Eric Chassin on June 10, 2011. (PX 2). Dr. Chassin recommended that Petitioner undergo an MRI study of his back and left hip. (PX 2). Petitioner underwent the recommended MRI studies on June 10, 2011, at Salt Creek Medical Imaging. (PX 3). The MRI study of the back showed spondylosis, multilevel disc protrusions with associated spinal stenosis most marked at L2-L3 and L3-L4, neural forminal stenosis, L4-L5 disc protrusion, a slight upward extrusion severely stenosing the left neural foramen and a left L4 root displacement superiorly and compressed. (PX 3).

Dr. Chassin reviewed the MRI studies on June 13, 2011. (PX 2). Dr. Chassin set forth a diagnosis of low back and left leg pain, left L4 radiculopthy and left hip degenerative disc disease. (PX 2). Dr. Chassin referred Petitioner to Dr. Ira Goodman for pain management and opined that Petitioner was unable to work. (PX 2).

Petitioner was examined by Dr. Goodman on July 18, 2011. (PX 4). Dr. Goodman set forth a diagnosis of facet joint syndrome, lumbar radiculopathy and discogenic back pain. (PX 4). He recommended that Petitioner undergo a left lumbar transforminal epidural steroid injection at L3-L4 and L4-L5. (PX 4). Petitioner was to remain off work. (PX 4). Dr. Goodman administered

the recommended injections on August 4, 2011, August 22, 2011 and September 8, 2011. (PX 4).

On November 17, 2011, Dr. Goodman recommended that Petitioner undergo diagnostic facet joint injections since the primary pain was in the facet joints. (PX 4). Petitioner underwent bilateral lumbar facet joint injections at L3-L4, L4-L5 and L5-S1. (PX 4). The facet joints generated significant pain. (PX 4).

On December 12, 2012, Dr. Goodman examined Petitioner. (PX 4). He offered a diagnosis of discogenic back pain with radiculopathy and facet syndrome. (PX 4). Dr. Goodman referred Petitioner to Dr. Zindrick or Dr. Lorenz for surgical intervention. (PX 4).

Petitioner was examined by Dr. Zindrick on January 5, 2012. (PX 5). Dr. Zindrick diagnosed Petitioner with multilevel degenerative disc disease with spinal stenosis most prominent at L2-L3 and L3-L4 caused by a work-related injury. (PX 5). Dr. Zindrick opined that the symptoms stem from a work-related accident. (PX 5). He recommended a repeat MRI study. (PX 5).

At the request of his employer, Petitioner was examined by Dr. Edward Goldberg on January 25, 2012 pursuant to Section 12. (PX 6). Dr. Goldberg diagnosed Petitioner with an aggravation of lumbar spinal stenosis from L2-L3 through L4-5 and an aggravation of an asymptomatic herniation, or a new herniation, at L3-L4. (PX 6). Dr. Goldberg found that Petitioner's symptoms were related to the work-related accident. (PX 6). Dr. Goldberg recommended that Petitioner undergo surgery for his low back condition. (PX 6). Dr. Goldberg recommended that Petitioner undergo laminectomies at L2 through L4 and a diskectomy at L3-L4. (PX 6). He would also explore the foramen on the left at L4-L5, and if there is a herniation, remove that as well. (PX 6). He recommended that Petitioner could return to sedentary work. (PX 6).

Petitioner chose to receive medical treatment from Dr. Goldberg and to allowed Dr. Goldberg to perform the recommended surgery. Petitioner testified that Dr. Goldberg seemed like a good doctor.

Petitioner underwent the recommended surgery performed by Dr. Goldberg on February 16, 2012. (PX 8). Dr. Goldberg performed a laminectomy at L2 with bilateral partial facetectomies, laminectomy at L3 with bilateral partial facetectomies at L3-L4 and laminectomy at L4 with bilateral partial facetectomies at L4-L5. (PX 8). The post-operative diagnosis was lumbar spinal stenosis at L2-L3, L3-L4 and L4-L5. (PX 8).

Petitioner remained under the post-operative care of Dr. Goldberg. (PX 7). Post-operative care included physical therapy, work conditioning and functional capacity evaluations. (PX 7). Petitioner participated in physical therapy and work conditioning at ATI Physical Therapy from March 12, 2012 through June 26, 2012. (PX 10).

Petitioner underwent an FCE on May 14, 2012. (PX 9). The FCE was valid and indicated that Petitioner was capable of working at a light physical demand level. (PX 9). Following the FCE, Petitioner continued to participate in work conditioning. (PX 7). On May 30, 2012, Dr. Goldberg documented that Petitioner continued to have dull low back pain. (PX 7). Petitioner underwent a second FCE on June 28, 2012. (PX 9). The FCE set forth that Petitioner could work at a light to medium physical demand level with occasional lifting of 37 pounds from floor to chair, 52 pounds from desk to chair, 37 pounds above the shoulder and carry 47 pounds. (PX 9). He could stand for one (1) to two (2) hours with 16 minute durations and walk for four (4) to five (5) hours, with occasional, moderate distances. (PX 9).

On July 9, 2012, Dr. Goldberg noted that Petitioner's pain increased in work conditioning. (PX 7). He also wrote that Petitioner continued to take Norco. (PX 7). Dr. Goldberg recommended that Petitioner return to work within the permanent restrictions of the FCE. (PX 7). He recommended that Petitioner take over-the-counter, anti-inflammatory medication. (PX 7).

Petitioner returned to Dr. Goldberg on August 10, 2012. (PX 7). Dr. Goldberg documented that Petitioner had pain with standing, walking or sitting for more than fifteen (15) minutes. (PX 7). Dr. Goldberg recommended that Petitioner undergo an MRI study of the back. (PX 7).

Petitioner underwent the recommended MRI study on August 16, 2012 at Naperville Imaging Center. (PX 11). The MRI study revealed that Petitioner had post-surgical changes of L2 to L4 laminectomies, mild multilevel lumbar spondylosis and facet arthrosis, right posterior annular tear at L1-L2, mild diffuse disc bulge with a superimposed small central/right paracentral disc extrusion at L2-L3, mild diffuse disc bulge and post-operative granulation tissue at L3-L4, mild diffuse disc bulge with a superimposed broad-based left foraminal/extraforaminal disc protrusion and annular tear at L4-L5, the L4-L5 disc protrusion contacts the ventral aspect of the exiting left L4 nerve root, minimal disc bulge at L5-S1, no significant lumbar spinal canal stenosis, mild lumbar levoscoliosis and retrolisthesis of L3 and L4, multilevel thoracolumbar vertebral body endplate Schmorl's nodes. (PX 11).

Petitioner was examined by Dr. Goldberg on August 31, 2012. (PX 7). Dr. Goldberg documented that Petitioner was experiencing worsening axial low back pain and that work conditioning was exacerbating his pain. (PX 7). Dr. Goldberg set forth a diagnosis of axial back

pain status/post L2 through L5 decompression. (PX 7). Dr. Goldberg recommended that Petitioner undergo an FCE. (PX 7).

Petitioner underwent the FCE study at ATI Physical Therapy on September 13, 2012. (PX 9). The evaluator found Petitioner's FCE results to be invalid. (PX 9).

Dr. Goldberg examined Petitioner on September 14, 2012. (PX 7, RX 1). He noted that the MRI study did show degenerative changes. (PX 7, RX 1). Dr. Goldberg mentioned in his report that the FCE was invalid. He set forth that Petitioner could return to work with the permanent restrictions previously indicated. (PX 7, RX 1). Specifically, Dr. Goldberg opined that Petitioner could return to light to medium level work with maximum occasional lifting of 36 pounds from floor to chair, frequent lifting of 28 pounds from floor to chair, occasional lifting of 52 pounds at waist level, 28 pounds frequently, occasional overhead lifting of 36 pounds and frequent lifting of 25 pounds and permission to change positions from sitting to standing to walking every 30 minutes. (PX 7, RX 1).

Petitioner returned to work for Respondent on September 24, 2012. Petitioner testified that the work was not within the restrictions of Dr. Goldberg. Further, Petitioner testified that when he returned to work for Respondent, he experienced increased back pain. Because of the increased back pain, Petitioner chose to return to a physician. He requested that the insurance company authorize payment for him to have a second opinion. The insurance company did not authorize a second opinion. Further, Petitioner was informed by Mila Kogan, a nurse case manager hired by the insurance company, that no further medical treatment by Dr. Goldberg would be authorized. She told Petitioner that Dr. Goldberg was finished providing treatment to him and that his case was closed. Petitioner's unrebutted testimony was that Ms. Kogan

specifically advised Petitioner that Dr. Goldberg would not see him again and that he could not receive a second opinion. Petitioner testified that Ms. Kogan attended his medical appointments and was responsible for obtaining approval for medical treatment.

Petitioner testified that since workers' compensation would not approve a second opinion or another appointment with Dr. Goldberg, he decided to return to Dr. Zindrick. Petitioner was examined by Dr. Zindrick on October 22, 2012. (PX 5). Dr. Zindrick documented that Petitioner noted increased pain in physical therapy and work conditioning. (PX 5). Petitioner noted that his pain increased significantly in work conditioning. (PX 5). Petitioner returned to work with restrictions and continued to have ongoing pain. (PX 5). The pain was mostly in his back with some numbness down his leg. (PX 5). The numbness decreased after the surgery, but returned during work conditioning. (PX 5). Petitioner had increased pain with standing, lifting, walking with weight and bending. (PX 5). Dr. Zindrick took x-rays, which showed multilevel degenerative changes. (PX 5). He also reviewed the MRI, which showed laminectomy defects at L2-L3 and L3-L4 with disc bulging. (PX 5). Dr. Zindrick set forth that Petitioner was status/post laminectomy with ongoing low back pain and radiculopathy. (PX 5). Dr. Zindrick released Petitioner to return to work with the restrictions of no lifting over twenty (20) pounds, no bending, kneeling, squatting or overhead reaching or repetitive overhead use of his arms. (PX 5). Respondent did not accommodate the work restrictions of Dr. Zindrick.

Dr. Zindrick examined Petitioner on December 12, 2012. (PX 5). Dr. Zindrick documented that Petitioner continued to experience ongoing back pain, numbness and tingling. (PX 5). Dr. Zindrick opined that Petitioner could return to work with a twenty (20) pound lifting restriction. (PX 5). The handwritten work status note set forth the work restrictions of no lifting over

twenty (20) pounds. (PX 5). However, the typewritten work restrictions, also dated and electronically signed on December 12, 2012, set forth the work restrictions of no lifting greater than twenty (20) pounds, sitting, standing and walking as comfort allows, no bending, squatting or kneeling, no reaching or lifting or repetitive overhead use of the upper extremity, no overhead activities and limited pushing/pulling. (PX 5).

On cross-examination, Respondent's attorney asked Petitioner whether he asked Dr. Zindrick to change his work restrictions after December 12, 2012. Petitioner testified that he called Dr. Zindrick's office to obtain a copy of a completed work status note. Petitioner testified that one time Joan Brachmann advised him that he could return to work within his old restrictions. Petitioner advised Ms. Brachmann that he had new work restrictions, which Ms. Brachmann had not received. Petitioner testified that he called the doctor's office and spoke with the doctor's assistant and requested that they forward the work status note to his employer. Petitioner's understanding was that the disability form had not been filled out. He requested that the form be filled out. Petitioner testified that he did not request that the doctor's office revise the work restrictions. Respondent's witnesses, including Ms. Brachmann, did not provide any testimony relative to this issue.

Petitioner was examined by Dr. Zindrick on January 28, 2013. (PX 5). Dr. Zindrick noted that Petitioner had returned to work. (PX 5). Petitioner's symptoms increased with working. (PX 5). Petitioner presented with complaints of back pain, muscle cramps, stiffness and trouble walking. (PX 5). Petitioner testified that lying down helped the symptoms. (PX 5). Dr. Zindrick set forth a diagnosis of low back pain status/post laminectomy with underlying degenerative disc disease. (PX 5). Dr. Zindrick opined that Petitioner should continue to work and use

Relafen. (PX 5). Dr. Zindrick recommended that Petitioner continue on his current work restrictions. (PX 5).

On February 25, 2013, Petitioner was again examined by Dr. Zindrick. (PX 5). Petitioner noted increased pain since he had finished work. (PX 5). Dr. Zindrick recommended that Petitioner should continue on his current work restrictions. (PX 5).

Dr. Zindrick examined Petitioner on March 5, 2013. (PX 5). Dr. Zindrick noted that Petitioner's back was worse. (PX 5). Petitioner had increased back pain at work with no new accident. (PX 5). Petitioner's back condition affected his basic jobs at work and his ability to sleep. (PX 5). Petitioner's condition was worse with bending, lifting, twisting and prolonged standing. (PX 5). Petitioner had restricted and painful range of motion in his back and spasm with flexion. (PX 5). The x-rays showed motion at L3-L4 with motion on flexion and extension with multilevel anterior spurring and degenerative changes. (PX 5). Dr. Zindrick set forth a diagnosis of ongoing and increasing back pain with radiculopathy with underlying degenerative disc disease, disc bulging and L3-L4 spondylolisthesis postlaminectomy. (PX 5). Dr. Zindrick opined that Petitioner was unable to return to work. (PX 5).

On April 5, 2013, Dr. Zindrick documented that Petitioner had continuing pain that was worse with walking, bending and sitting. (PX 5). Petitioner tried to return to work without success. (PX 5). Dr. Zindrick recommended that Petitioner remain off work. (PX 5). He also recommended that Petitioner undergo facet joint injections. (PX 5).

Petitioner was examined by Dr. Goodman on April 11, 2013. (PX 4). Dr. Goodman documented that Petitioner had limited range of motion in the back, with pain on motion. (PX 4). Dr. Goodman set forth that Petitioner had post-laminectomy syndrome with greatest

problem in the lower lumbar facet joints, which were likely exacerbated during post-operative physical therapy and/or work hardening, significant disc disease at L2-L3, L3-L4 and L4-L5 with lesser disease at L1-2 and L5-S1, as well as granulation tissue from the recent surgery. (PX 4). Dr. Goodman recommended that Petitioner undergo bilateral lumbar facet joint injections at L3-L4, L4-L5 and L5-S1. (PX 4).

Petitioner was last examined by Dr. Zindrick on August 27, 2013. (PX 5). Dr. Zindrick set forth that Petitioner's symptoms have not improved. (PX 5). Dr. Zindrick wrote that Petitioner was post-laminectomy low back pain with multilevel degenerative disc disease. (PX 5). Dr. Zindrick opined that Petitioner is unable to work. (PX 5). He documented that Petitioner "is trying to work in a reduced rate unsuccessfully." (PX 5). Dr. Zindrick recommended that Petitioner undergo injections. (PX 5).

Petitioner testified that he has not undergone the facet joint injections recommended by Dr. Zindrick and Dr. Goodman since they have not been approved by the insurance company. He testified that he would like to undergo the recommended medical treatment.

E. Medical Opinions of Dr. Michael Zindrick

The narrative report of Dr. Zindrick, dated July 11, 2013, was admitted into evidence. (PX 12). The care and treatment of Petitioner was documented in the report. (PX 12). Dr. Zindrick opined that Petitioner's current diagnosis was post-laminectomy syndrome with ongoing chronic low back pain secondary to a work-related accident of June 2, 2011. (PX 12). Dr. Zindrick noted that Petitioner had asymptomatic pre-existing degenerative disc disease. (PX 12). Dr. Zindrick wrote that Petitioner's work-related accident resulted in the ongoing symptoms and an aggravation of the pre-existing disc injury, which required surgical

intervention. (PX 12). Dr. Zindrick noted that following the surgery, Petitioner continued to have ongoing chronic back pain. (PX 12). He opined that Petitioner had not yet reached maximum medical improvement as it relates to his back condition. (PX 12). Dr. Zindrick recommended that Petitioner undergo lumbar facet joint injections and possible facet rhizotomies depending on the response to the injections. (PX 12).

Further, Dr. Zindrick set forth that Petitioner is currently incapable of gainful employment. (PX 12). He noted that Petitioner attempted to return to work with quite limited restrictions and was unable to perform work within those restrictions. (PX 12). Petitioner's return to work was unsuccessful. (PX 12).

Dr. Zindrick also reviewed the Section 12 report of Dr. Zelby. (PX 12). He agreed with Dr. Zelby that Petitioner sustained a work-related accident that resulted in the need for surgery; however, he did not agree that Petitioner has a normal back and is capable of returning to full and unrestricted work. (PX 12). Dr. Zindrick noted that Petitioner has attempted to return to work and would work an eight (8) hour day even with significant restrictions. (PX 12). Dr. Zindrick also disagreed with Dr. Zelby with regard to medical causation. (PX 12). He noted that Petitioner has classic post-laminectomy symptoms and ongoing back pain. (PX 12).

The Arbitrator notes that this narrative report was prepared at the request of Petitioner's Counsel. The report is not contemporaneous with the time of treatment. In his report Dr. Zindrick disagreed with the conclusions of the Section 12 physician, Dr. Zelby, but made no comment about the conclusions reached by Dr. Goldberg. Additionally, in this July 11, 2013 narrative report, Dr. Zindrick made no mention of the invalid FCE or the evaluator's conclusion that Petitioner was manipulating the findings.

F. Medical Opinions of Dr. Andrew Zelby, Respondent's Section 12 Physician

At the request of Respondent, Petitioner was examined by Dr. Zelby on May 10, 2013. (RX 5). Dr. Zelby wrote, *inter alia*, the following: "Mr. Vincetic feels that his symptoms are exacerbated with anything he tries to do, and said that he cannot even brush his teeth without severe pain." Upon examination, Dr. Zelby found, *inter alia*, the following: "Inconsistent behavioral responses are positive for non-anatomic sensory changes." Dr. Zelby diagnosed Petitioner with lumbosacral spondylosis, herniated lumbar disc and history of lumbar laminectomy. (RX 5). He opined that the work-related accident caused an aggravation of a pre-existing condition and a new herniation at L4-L5, which required surgery. (RX 5). Dr. Zelby further opined that the medical treatment he received was reasonable and necessary through September 2012, but that the medical treatment he received after his return to work was not related to the accident. (RX 5). Dr. Zelby stated that based on his demonstrative abilities, Petitioner could return to work without any restrictions since his performance in work conditioning was inconsistent with the results of the FCE. (RX 5). Dr. Zelby asserted that the surgery made Petitioner's lumbar condition better than it was prior to the accident of June 2, 2011. (RX 5). Dr. Zelby stated that Petitioner reached maximum medical improvement in September 2012 and is qualified to perform his full job duties. (RX 5). There is no evidence that Dr. Zelby reviewed any medical records for dates of service prior to June 2, 2011.

G. Work Conditioning and Functional Capacity Evaluations ("FCEs")

Petitioner testified that following his back surgery on February 16, 2011, and during physical therapy and work conditioning, his back pain became worse. Petitioner especially noticed pain in his back during work conditioning. Petitioner testified regarding the work conditioning

program. Petitioner testified that during work conditioning, he worked on lifting by way of several different exercises. The lifting exercises involved a machine, manual lifting and walking with weights. Petitioner testified that during work conditioning, he did not perform any twisting activities. Further, Petitioner testified that during work conditioning, he was taking Norco. Petitioner's physical therapist, Maurice, recommended that he take pain medication during work conditioning. During work conditioning, Petitioner was given between four (4) or five (5) breaks. Petitioner testified that work conditioning lasted approximately five (5) hours per day.

Petitioner underwent three Functional Capacity Evaluations ("FCEs"): May 14, 2012, June 28, 2012 and September 13, 2012. Following the May 14, 2012 FCE, the evaluator found the results to be VALID and released Petitioner to a LIGHT physical demand level. (PX 9) Following the June 28, 2012 FCE, the evaluator found the results to be VALID and released Petitioner to a LIGHT-to-MEDIUM physical demand level. (PX 9) Following the September 13, 2012 FCE, the evaluator found the results to be INVALID and opined that the levels identified by Petitioner represent less than their true safe capability level. (PX 9, RX 1)

The evaluator for the September 13, 2012, Jon Bealy, ATC, CWcHP, further opined:

> "This is identified to be an invalid representation of the present physical capabilities of PETAR VINCETIC based upon consistencies and inconsistencies when interfacing grip dynamometer graphing, heart rate variations, weights achieved, and selectivity of pain reports and pain behaviors. **The results represent a manipulated effort by the client.**" (PX 9, RX 1)

Petitioner testified that the lifting he performed during the FCE was different than the lifting he performed in the work conditioning program. The FCE tested lifting by placing weights in a box, starting with one pound and increasing the weight. Petitioner would pick up the box, lift it

up, turn and place the box on a shelf. The lifting was more difficult in the FCE. During the FCE, Petitioner did not take pain medication because he drove himself to the appointment and he could not take Hydrocodone and drive his car. Petitioner was given one fifteen (15) minute break during the FCE. The FCE lasted approximately four (4) hours. The FCE also tested Petitioner's physical ability to sit, stand, walk, bend, stoop, kneel, and other physical activities. Petitioner testified that he experienced back pain during the FCE. (PX 9).

H. Return to Work

1. Dr. Goldberg's Release

In a letter addressed to Ms. Mila Kogan and dated September 14, 2012, Dr. Goldberg wrote the following:

> "Mr. Vincetic was seen in the office today. He continues to complain of low back pain without radicular symptoms. He completed a new functional capacity evaluation dated 9/13/2012. It was performed at ATI, the same facility but different location. It indicates it was invalid. In view of this, I feel he should return to work with permanent restrictions per the original functional capacity evaluation. This allows him to occasionally lift 36 pounds from floor to waist and frequently 28 pounds. He can occasionally lift 52 pounds at waist level and 28 pounds frequently. He can overhead lift 36 pounds occasionally and 25 pounds frequently. He should be allowed to change positions from sitting to standing every 30 minutes.
>
> Additionally, he did have the MRI done postoperatively which shows degenerative change. There is no evidence of nerve compression.
>
> The patient is at maximum medical improvement. I did write a prescription for Mobic 15 mg p.o. daily p.c. p.r.n. pain. If he requires the Mobic for residual back pain, it would be reasonable for him to see his internist. Questions were answered. No followup is scheduled. The patient is at maximum medical improvement."

2. Petitioner's Testimony

Petitioner returned to modified duty with Respondent on September 24, 2012. Petitioner testified that when he returned to work for Respondent, the pain in his back became worse. Petitioner testified that he tried to keep up with the pain, but the pain become worse each day.

The modified job description, which was provided to Petitioner by Respondent, was admitted into evidence. (PX 13). The job description was provided to Petitioner by the chief engineer, Muharem Ivackovic. Petitioner testified that he performed all of the jobs duties listed in the job description. He had difficulty removing the garbage from the floors, tiers and chutes. The job required bending, lifting and pulling. It could take over three (3) hours of time to remove the garbage. Petitioner testified that while he was performing the job duties, he was not able to take breaks. He was not provided with any work which would allow him to sit down and some of the tasks assigned to him lasted longer than thirty (30) minutes. For example, removing the garbage from all tiers, cleaning the mechanical room basement, mopping the stairways and helping with work orders took longer than thirty (30) minutes. While he was performing the job duties, Petitioner noticed an increase in pain in his back. Petitioner took Mobic for his back while working. Petitioner's testimony in this regard was unrebutted.

Because of the pain in his back, Petitioner returned to Dr. Zindrick for an evaluation. Dr. Zindrick provided Petitioner with updated work restrictions. Petitioner testified that the modified job in which he was working was not within the restrictions of Dr. Zindrick and that Respondent did not accommodate the work restrictions of Dr. Zindrick. Petitioner testified that cleaning the revolving door, furniture, bathroom and toilet, floors and benches all required bending. Petitioner also testified that the jobs required squatting and overhead work.

Petitioner testified that overhead work included changing the light bulbs and cleaning the chandeliers and mirrors.

Petitioner testified that he did not work for Respondent for the period of October 22, 2012 through January 20, 2013. Petitioner did not receive any benefits during this period of time. He remained under the work restrictions and medical care of Dr. Zindrick between October 22, 2012 and January 20, 2013.

Respondent offered Petitioner a new modified-duty job in January 2013. The modified-duty job description was admitted into evidence. (PX 14). Petitioner returned to work for Respondent on January 21, 2013. Petitioner testified that when he returned to work with the restrictions of Dr. Zindrick, the pain in his back increased. Petitioner did testify that the job was within the work restrictions of Dr. Zindrick. However, some tasks he performed were not within the restrictions. Petitioner testified that changing a light bulb would require overhead work and he may have to use a ladder. Petitioner testified that did not always change light bulbs and the light bulbs were not always burned out; however, sometimes he could change five (5) in one day. Petitioner testified that the engineers in the building would also change the light bulbs. Petitioner testified that he did not have to change the light bulbs or climb a ladder on his second return to work. Petitioner further testified that he was required to perform some bending, and kneeling in performing his job. He had to remove the gas tank from the barbecue. In order to perform that task, he had to bend.

Petitioner testified that he could shred paper in the office; however, shredding paper actually caused him pain in his back. With regard to paper shredding, Petitioner would sit in a chair with the shredder in front of him. The papers were placed on the floor next to him.

Petitioner would twist and bend to pick up the paper and then feed it into the machine. When the machine was full, Petitioner would take off the top, empty the shredder into a garbage bag and start again. The job required bending and twisting. Petitioner testified that he was only provided with between one (1) to two (2) hours of office work per day. Petitioner's testimony on this point was unrebutted.

Petitioner testified that Joan Brachmann, Mike Ivackovic and Bill Nichols advised him that he could take breaks during the work day and change the activities. Petitioner's testimony was consistent with the testimony of Ms. Brachmann and Mr. Ivackovic. However, it was Petitioner's unrebutted testimony that on one occasion when Petitioner was resting in the break room, Ms. Brachmann advised him that he should be shredding paper instead of sitting down. Petitioner also testified that Mr. Nichols was in the room during this conversation. Petitioner's testimony with regard to this incident was unrebutted.

Petitioner testified that no one told him how to perform the job duties assigned to him. Petitioner testified that he "should not" stop performing duties in the middle of his work because he could not leave his equipment in the area where people walked. Petitioner used the example of mopping to illustrate this point; however, he testified that he did not perform mopping when he returned to work in January 2013. Petitioner testified that he performed his job duties separately and away from Mr. Nichols and Mr. Ivackovic. He worked alone. Petitioner testified that he had been told, prior to the work-related accident, that it was not appropriate to stop work in the middle of a task because it was a safety hazard. Petitioner testified that he had to keep in mind the safety of the building's residents.

Petitioner testified that he did not perform any work for Respondent after March 5, 2013. He has not received any benefits since March 5, 2013.

3. Testimony of Joan Brachmann

Respondent presented the testimony of Joan Brachmann. Ms. Brachmann is the property manager at 3150 Condominium. She works for Lieberman Management Services. Her job duties include staffing, maintenance of the building, setting up projects, working on the Board, preparing management reports, hiring, disciplining employees and fielding homeowners' complaints.

Ms. Brachmann only testified regarding Petitioner's return to work for the period of January 2013 through March 2013. Ms. Brachmann testified that she received an off work note from Dr. Zindrick indicating that Petitioner had a twenty (20) pound lifting restrictions, which Respondent could accommodate. Petitioner advised her that the twenty (20) pound work restriction was not correct.

Ms. Brachmann testified that Petitioner was instructed not to exceed his restrictions. She testified that Petitioner was instructed to take extra breaks if needed. Petitioner was to ask Mr. Nichols or Mr. Ivackovic for help if he was unable to perform a task.

Petitioner was assigned the tasks of checking light bulbs and propane tanks, not changing light bulbs and propane tanks. Petitioner did not perform any mopping during the second return to work period. The list of assignments was prepared by Ms. Brachmann and Mr. Ivackovic.

Ms. Brachmann has not worked in maintenance. She has performed mopping around the condominium. Ms. Brachmann testified that she did not personally oversee Petitioner's work;

rather, Petitioner performed his work independently. Petitioner received his work assignment from Mr. Nichols or Mr. Ivackovic in the morning. Ms. Brachmann did not tell Petitioner how to perform his job duties. Mr. Nichols or Mr. Ivackovic also worked independently throughout the building. She testified that every janitor has a list of jobs to perform and they perform them on their own throughout the day.

Two correspondences from Ms. Brachmann to Petitioner were admitted into evidence. No testimony was presented in connection with these letters and no context was provided with regard to these letters. The first correspondence was dated November 6, 2012. (RX 3). The letter documented that Petitioner was released to return to work with permanent restrictions on September 14, 2012. (RX 3). Petitioner worked for one week and called in sick on October 3, 2012. (RX 3). The letter further documented that Respondent could not accommodate the new restrictions. (RX 3). It further indicated that "the workers' compensation claim was closed with the permanent restrictions given to you. This is no longer an insurance issue." (RX3).

The second correspondence was dated December 21, 2012. (RX 4). The letter documented that Petitioner could return to work with the restrictions of no lifting more than twenty (20) pounds. (RX 4). It indicated that Petitioner made a call and that Respondent received a new work status note documenting the new work restrictions from October 22, 2012. (RX 4). Respondent was not able to accommodate those work restrictions. (RX 4).

4. Testimony of Muharem Ivackovic

Respondent also presented the testimony of Muharem (Mike) Ivackovic, the building engineer at 3150 Condominiums. Mr. Ivackovic testified that Petitioner could take breaks as

needed, change his positions and only perform tasks which he was physically able to perform. He testified that he did not know whether Petitioner changed light bulbs.

Mr. Ivackovic testified that Petitioner was required to check the propane tanks. He testified the tanks can be checked or shaken by hand. The tanks have a device on the side of the tank to indicate whether or not the tank is full. A full tank weighs between 25 and thirty (30) pounds and an empty tank weighs between six (6) and ten (10) pounds. He testified that the gauge for the propane grill was on the side of the grill.

Mr. Ivackovic testified that Petitioner was a good employee. He testified that he did not observe Petitioner performing his job duties when he returned to work in January 2013. He testified that the building is busy and there is not time to observe someone working. He was assigned other job duties than Petitioner. He did not tell Petitioner how to perform the assigned jobs. Mr. Ivackovic testified that no one told Petitioner when to perform each task. Petitioner was given a list and told to perform the duties on the list.

5. Testimony of William Nichols

Respondent presented the testimony of William Nichols, the assistant building engineer. Mr. Nichols monitored the boiler, cleaned and performed work in tenant's apartments. Mr. Nichols testified that he did not know whether Petitioner changed any light bulbs or the propane gas tanks when he returned to work in January 2013.

Mr. Nichols did not direct Petitioner in how to perform his job duties for Respondent. He performed work away from Petitioner during the day.

I. Medical Bills

The medical bills from Hinsdale Orthopedics and Pain Specialists of Greater Chicago were submitted into evidence. The medical bill from Hinsdale Orthopedics reflected an outstanding balance of $1,247.00. (PX 15). The medical bill from Pain Specialists of Greater Chicago reflected an outstanding balance of $196.00. (PX 16). Respondent only objected to liability for the medical bills.

J. Current Subjective Complaints

Petitioner testified that since June 2, 2011, he has not sustained any new accidents involving his back. Petitioner testified that he experiences pain in his back and that the only comfortable position for him is lying down. Petitioner testified that the pain is in his lower back and legs. He testified that any prolonged walking or sitting causes pain in his back. Petitioner testified that he used to be active. Currently, he wakes up two (2) to three (3) times per night. Petitioner testified that he is taking Tramadol for the pain. He takes three (3) Tramadol daily.

II. CONCLUSIONS OF LAW

In support of his decision with regard to issue (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:

The Arbitrator concludes that Petitioner's current condition of ill-being in connection with his back, including the post-laminectomy symptoms with ongoing back pain and aggravation of the multilevel degenerative disc disease, is causally connected to the work-related accident of June 2, 2011. The Arbitrator finds that based on the medical records, Petitioner underwent surgery to L2-L3, L3-L4 and L4-L5 and had ongoing and consistent back pain following the

surgery. The Arbitrator relies on Petitioner's testimony and the medical records and opinions of Dr. Zindrick and Dr. Goodman. The Arbitrator accords little weigh to the medical opinions of Dr. Zelby, Respondent's Section 12 physician.

To recover under the Act, an employee must show that there is a causal connection between the claimant's employment and the injury. In *Sisbro, Inc. v. Industrial Commission*, 207 Ill.2d 193, 797 N.E.2d 665 (2003), the Illinois Supreme Court held that "even though an employee has a preexisting condition which may make him more vulnerable to injury, recovery for an accidental injury will not be denied as long as it can be shown that the employment was also a causative factor." *Id.* The accident "need not be the sole causative factor, nor even the primary causative factor, as long as it was *a* causative factor in the resulting condition of ill-being." *Id.* (emphasis in original).

A. Medical Opinions of Dr. Zindrick and Dr. Goodman

Petitioner established medical causation in connection with his low back condition through the medical records and opinions of Dr. Zindrick and Dr. Goodman. The Arbitrator also notes that the medical records of Dr. Goldberg and ATI physical therapy document that Petitioner's back pain increased during work conditioning.

Dr. Goodman set forth that Petitioner's diagnosis was post-laminectomy syndrome with the greatest problem in the lower lumbar facet joints. Dr. Goodman opined that the facet joints were likely exacerbated during post-operative physical therapy and/or work hardening. Dr. Goodman's opinions are consistent with Petitioner's testimony that the pain in his back increased during work conditioning.

Further, Dr. Zindrick opined that Petitioner's diagnosis was post-laminectomy symptoms with ongoing chronic low back pain secondary to a work-related accident of June 2, 2011. Dr. Zindrick set forth that Petitioner's work-related accident resulted in the ongoing symptoms and an aggravation of the pre-existing disc injury which required surgical intervention. Dr. Zindrick noted that following the surgery, Petitioner continued to have ongoing chronic back pain. Dr. Zindrick opined that Petitioner's symptoms were consistent with classic post-laminectomy syndrome.

The Arbitrator notes that Dr. Zelby, Respondent's Section 12 physician, does not dispute that Petitioner's underlying degenerative disc disease was aggravated as a result of the work-related accident of June 2, 2011. Dr. Zelby opined that the need for surgery was causally related to the work-related accident of June 2, 2011.

B. Chain of Events Analysis

The Arbitrator further concludes that Petitioner has established causation as it relates to Petitioner's low back, i.e., the post-laminectomy symtoms with ongoing back pain and aggravation of the multilevel degenerative disc disease, through the "chain of events" analysis. Proof of prior good health and change immediately following and continuing after an injury may establish that the impaired condition was due to injury. *Ill. Power Co. v. Indus. Comm'n*, 176 Ill.App.3d 317, 530 N.E.2d 617 (4th Dist. 1988).

In *Kawa v. Illinois Workers' Compensation Commission*, 372 N.E.2d 123, 991 N.E.2d 430 (1st Dist. 2013), the Appellate Court reaffirmed the chain of events analysis. The court found that the claimant established a "causal nexus between the accident and his condition of ill-being"

based on the evidence that the claimant's condition had begun no sooner than the work-related accident and continued with no intervening cause that broke the chain of events. *Id.*

In the instant case, Petitioner testified that prior to June 2, 2011, he had not sustained any accidents or injuries to his back. Further, Petitioner testified that prior to work on June 2, 2011, his back felt fine. Petitioner's testimony on this point was unrebutted.

Immediately following the work-related accident of June 2, 2011, Petitioner began a course of medical care for his low back that continues to the present date. Following the accident, Petitioner experienced constant and consistent pain in his lower back. Further, following the work-related accident of June 2, 2011, Petitioner underwent a course of medical treatment, including office visits, injections, physical therapy, work conditioning and surgery. Petitioner's ongoing symptoms in his spine are well documented in the medical records and have not resolved as of the time of the hearing. Further, since the accident of June 2, 2011, Petitioner has not sustained any new accidents to his low back.

The Arbitrator concludes that based on the medical evidence, including the medical records of Dr. Goldberg, Dr. Zindrick and Dr. Goodman, the work conditioning records from ATI physical therapy and the testimony of Petitioner, that Petitioner was not under active medical treatment and did not experience any low back pain prior to June 2, 2011. However, following the work-related accident of June 2, 2011, Petitioner received medical care for his low back. Petitioner also began experiencing symptoms, including pain, numbness and weakness, in his legs immediately following the work-related accident of June 2, 2011. Accordingly, the Arbitrator finds that the work-related accident of June 2, 2011 caused Petitioner's current condition of ill-being as it relates to his back, including the post-laminectomy syndrome with

ongoing back pain and aggravation of the multilevel degenerative disc disease, based on the chain of events analysis.

C. Medical Opinions of Dr. Zelby, Respondent's Section 12 Physician

The Section 12 report of Dr. Zelby was admitted into evidence. The Arbitrator considered the opinions of Dr. Zelby and accorded them little weight.

Dr. Zelby opined that the MRI showed changes that were a combination of a pre-existing degenerative changes and a foraminal herniated disc that appear to have been causally related to the work injury. Petitioner's pre-existing, asymptomatic, degenerative changes were made symptomatic by the work-related accident of June 2, 2011. The accident also caused a herniated disc. Dr. Zelby noted that the surgery was reasonable and necessary and had a satisfactory result. The medical treatment was reasonable and necessary through September 2012; however, he found the medical treatment from October 2012 through present was not a consequence of the work-related accident.

Dr. Zelby opined that Petitioner is capable of returning to full-duty work. He also set forth that the condition of Petitioner's spine was better than before June 2011. Dr. Zelby based his opinion on Petitioner's performance in work conditioning and in the FCEs of June 2012 and September 2012. He relies on Petitioner's ability to lift in work conditioning in comparison to his performance on the FCE in June 2012. He also put forth that the invalid FCE of September 2012 further supports his findings.

The Arbitrator accords little weight to the opinions of Dr. Zelby after reviewing the record as a whole. The Arbitrator first notes that the work conditioning progress notes admitted into evidence state: "please note the PDL is an estimate only; a FCE should be completed to

substantiate actual physical capabilities." The work conditioning records document that Petitioner had a decrease in lower extremity, upper extremity and abdominal strength with endurance and an increase in soreness of the muscles. The Arbitrator also notes that the FCE of June 2012 was valid and indicated that Petitioner was unable to return to his job as a maintenance worker for Respondent. The FCE also documented pain in his low back with lifting. The work conditioning notes do not include an analysis of Petitioner's full physical capabilities such as Petitioner's ability to bend, twist, stoop, kneel, walk or sit. Those physical activities are documented in the FCE.

The Arbitrator also relies on Petitioner's unrebutted testimony regarding work conditioning and the FCE. The Arbitrator notes that the difference in lifting can be credibly explained. First, Petitioner took pain medication during work conditioning, but not during the FCE, since he drove himself to the FCE. Second, Petitioner took several breaks during work conditioning, but was only allowed one break during the FCE. Lastly, Petitioner's physical abilities were tested differently in the FCE than in work conditioning. In work conditioning, Petitioner lifted weights and carried weights; however, during the FCE, Petitioner had to grip a box and lift and twist it. The twisting placed more stress on Petitioner's back and caused additional pain. Further, Petitioner also performed walking, standing, sitting, bending, stooping, kneeling and other physical activities during the FCE.

The Arbitrator does acknowledge the FCE performed in September 2012 was invalid. However, it is clear that Petitioner had not demonstrated the physical ability to return to full-duty work or that he had a normal back based on the objective MRI and x-ray reports and the

medical records of Dr. Goldberg, Dr. Zindrick and Dr. Goodman. Dr. Zelby's conclusions are contrary to the medical evidence.

Dr. Goldberg opined that Petitioner should remain under the permanent work restrictions of the original functional capacity evaluation. He documented that Petitioner continued to complain of low back pain without radicular symptoms. Further, the MRI study of August 16, 2012 showed that Petitioner had post-surgical changes of L2 and L4 laminectomies, mild multilevel lumbar spondylosis and facet arthrosis, right posterior annular tear at L1-L2, disc bulge at L2-L3, post operative granulation tissue at L3-L4, disc bulge, disc protrusion and annular tear at L4-L5, L4-L5 disc protrusion, mild lumbar levoscoliosis and retrolisthesis of L3 and L4. Moreover, the x-rays that Dr. Zindrick ordered show that Petitioner had motion with flexion and extension at L3-L4 with multilevel anterior spurring and degenerative changes. The objective evidence clearly supports a finding that Petitioner did not have a normal back and was not able to perform his full-duty job for Respondent.

Petitioner attempted to return to work, but the pain in his back increased. He tried to obtain authorization to have a second opinion or return to Dr. Goldberg, but authorization for a follow-up examination was denied by workers' compensation. Therefore, he sought treatment with Dr. Zindrick, who placed more work restrictions on him. It is clear that Dr. Zelby did not rely on the totality of the medical evidence or consider the facts of the case. Further, his opinions are not based on objective findings, subjective complaints or on Petitioner's physical abilities.

The Arbitrator also notes that Dr. Zelby opined that Petitioner's post-operative back condition was better than his condition before the June 2, 2011 accident. Dr. Zelby's opinions

are completely without medical basis. There is no evidence that Dr. Zelby reviewed any medical records for dates of service prior to June 2011. Additionally, the MRI study and x-rays taken after the surgery demonstrate that Petitioner did not have a normal back. Dr. Zelby's opinions are without evidence and high suspect. Accordingly, the Arbitrator accords them little weight.

Dr. Zindrick reviewed the report of Dr. Zelby. He did not agree with Dr. Zelby's opinions that Petitioner's back condition was better post-operatively than it was before the June 2, 2011 accident and that Petitioner is capable of returning to full and unrestricted work. Dr. Zindrick noted that Petitioner made several attempts to return to work with restrictions and was not able to do so. Dr. Zindrick opined that Petitioner has classic post-laminectomy symptoms with ongoing back pain. His diagnosis was confirmed by Dr. Goodman.

The Arbitrator instead relies upon the medical records and opinions of Dr. Zindrick and Dr. Goodman and the objective findings of the MRI and x-ray reports in finding that Petitioner's current condition of ill-being in his back is causally connected to the work-related accident of June 2, 2011. The Arbitrator also finds that the medical records document consistent and unresolved complaints of back pain and loss of function of his back following the surgery and in work conditioning. Based on *Sisbro*, 207 Ill.2d 193, and the overwhelming medical evidence, Petitioner has established that his current condition of ill-being of his lumbar spine is causally related to his accident of June 2, 2011.

In support of his decision with regard to issue (J) "Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?", the Arbitrator makes the following findings of fact and conclusions of law:

The Arbitrator concludes that the medical services provided to Petitioner were reasonable and necessary and that Respondent is liable for payment of the medical bill of Hinsdale Orthopedics ($1,247.00) and Greater Pain Specialists of Chicago ($196.00). Respondent's only defense to payment of the medical expenses was medical causation. As he has found that Petitioner's current condition of ill-being is causally connected to the work-related accident of June 2, 2011, the Arbitrator concludes that Respondent is liable for payment of the medical bills.

The Arbitrator finds that the medical bills are subject to adjustments consistent with the provisions of the Medical Fee Schedule, 820 ILCS 305/8.2. The Arbitrator orders Respondent to calculate the exact amount of benefits owed to the medical provider pursuant to Section 8.2. Any further disputes relating to the adjustment of the bill may be addressed at further proceedings, consistent with this decision. The Arbitrator further orders Respondent to make payment of the medical bills to Petitioner's attorney, pursuant to Section 7080.20 of the Rules Governing the Practice Before the Illinois Worker's Compensation Commission.

In support of his decision with regard to issue (K) "Is Petitioner entitled to any prospective medical care?", the Arbitrator makes the following findings of fact and conclusions of law:

The Arbitrator concludes that Petitioner is entitled to authorization of and payment for the medical treatment that Dr. Zindrick has recommended. The Arbitrator concludes that the treatment recommendation for the facet joint injections constitutes reasonable and necessary

medical care. In support of this finding, the Arbitrator relies on Petitioner's testimony and the medical records and opinions of Dr. Zindrick.

Although Dr. Goldberg treated Petitioner and performed the back surgery, Dr. Goldberg did not provide any treatment or offer any opinions after September 14, 2013.

In the instant case, Dr. Zindrick recommended that Petitioner undergo injections for the low back condition. Dr. Zindrick noted that Petitioner was a candidate for lumbar facet joint injections and possible facet rhizotomies. Petitioner was also evaluated by Dr. Goodman. Dr. Goodman set forth that Petitioner should undergo bilateral lumbar facet joint injections at L3-L4, L4-L5 and L5-S1.

Based on the medical records and opinions of Dr. Zindrick, the Arbitrator orders Respondent to authorize and pay for the medical treatment that Dr. Zindrick has recommended, including the lumbar facet joint injections. In support of his decision, the Arbitrator cites *Plantation Manufacturing Company v. Industrial Commission*, 294 Ill.App.3d 705, 691 N.E.2d 13 (2d Dist. 1997).

In support of his decision with regard to issue (L) "What temporary benefits are in dispute? TTD", the Arbitrator makes the following findings of fact and conclusions of law:

The Arbitrator concludes that Petitioner is entitled to temporary total disability benefits from June 3, 2011 through September 23, 2012, October 22, 2012 through January 20, 2013 and March 5, 2013 through September 10, 2013. The Arbitrator relies on Petitioner's testimony and the medical records of Dr. Zindrick and Dr. Goodman. The Arbitrator notes that Respondent does not dispute that Petitioner is entitled to temporary total disability benefits for the period of June 3, 2011 through September 10, 2012.

In *Freeman United Coal Mining Company v. Industrial Commission*, 318 Ill.App.3d 170, 741 N.E.2d 1144 (5th Dist. 2001), the Appellate Court set forth that "a claimant is entitled to TTD when a 'disabling condition is temporary and has not reached a permanent condition.'" (quoting *Manis v. Industrial Commission*, 172 Ill.Dec. 95, 595 N.E.2d 158 (1st Dist. 1992)). The dispositive test for determining whether a claimant is entitled to TTD is whether the condition has stabilized. *Id.* In *Freeman United Coal Mining Company*, the court held that the condition of the petitioner's knee had not stabilized and that the petitioner was thus entitled to TTD benefits. *Id.* The court based its decision on the fact that the petitioner had not been released to full-duty work and future medical care was being considered by the petitioner's treating physicians. *Id.* The Appellate Court has also held that a claimant can receive temporary total disability benefits based on a degeneration of the claimant's condition. *World Color Press v. Industrial Commission*, 188 Ill. Dec. 795, 619 N.E.2d 159 (5th Dist. 1993).

In the instant case, Petitioner has not been released to return to work without restrictions by any of his treating physicians. For the period of June 3, 2011 through September 23, 2012, Petitioner was under the active medical care of St. Joseph Medical Hospital, Dr. Chassin, Dr. Goodman, Dr. Zindrick and Dr. Goldberg. Petitioner underwent medical treatment that included injections, physical therapy, diagnostic tests, surgery and work conditioning. Petitioner then underwent three FCEs. Following the last FCE, the evaluator found the results to be INVALID and opined that this represented a manipulated effort by Petitioner. The evaluator further found that the physical demand levels identified by Petitioner represent less than their true safe capability level.

On September 14, 2012, Dr. Goldberg released Petitioner to return to work with permanent restrictions. Respondent accommodated the restrictions of Dr. Goldberg effective September 24, 2012. Accordingly, Petitioner is entitled to payment of temporary total disability benefits for the period of June 3, 2011 through September 23, 2012. Respondent does not dispute Petitioner's entitlement to benefits for this period.

Petitioner is also entitled to payment of temporary total disability benefits for the period of October 22, 2012 through January 20, 2013. Petitioner returned to work for Respondent with the restrictions of Dr. Goldberg on September 24, 2012. Petitioner testified that after he returned to work, he experienced an increase in pain in his low back. Further, Petitioner testified that some of the assigned tasks were not within the work restrictions of Dr. Goldberg. Specifically, Petitioner was assigned tasks that prevented him from changing positions from sitting to standing to walking every thirty (30) minutes. For example, removing the garbage from all tiers, cleaning the mechanical room basement, mopping the stairways and helping with work orders took longer than thirty (30) minutes. Petitioner could not take breaks while performing these job duties. Despite the fact that the work provided to Petitioner was not within his restrictions, he continued to perform work for Respondent.

Petitioner testified that the pain in his back became worse. He contacted the adjuster to obtain a second opinion or return to Dr. Goldberg. He was informed by the nurse case manager hired by the insurance company, Mila Kogan, that Dr. Goldberg was finished treating him and would not provide him with any further medical treatment. Further, the insurance company denied authorization for a second opinion. Accordingly, Petitioner followed up with Dr. Zindrick, who had treated him previously in connection with this work-related accident of June

2, 2011. Dr. Zindrick examined Petitioner and changed his work restrictions on October 22, 2012 due to the increase in back pain that Petitioner was experiencing. He also prescribed Tramadol for the pain. Petitioner remained under the active medical care of Dr. Zindrick.

Petitioner's testified that Respondent was unable to accommodate his work restrictions. Respondent's correspondence dated November 6, 2012 confirmed that Respondent was unable to accommodate the work restrictions of Dr. Zindrick.

Moreover, the Arbitrator notes that Respondent stated that "the workers' compensation claim was closed with the permanent work restrictions given to you. This is no longer an insurance issue." Petitioner's medical rights have not been closed and the case has not settled. Despite the fact that Petitioner returned to work with restrictions (but continued to experience pain), Respondent refused to authorize medical treatment with Petitioner's treating physician or to accommodate the new restrictions.

The Arbitrator relies on *World Color Press* in finding that Petitioner was entitled to further medical care after he returned to work since Petitioner's condition worsened upon his return to work. 188 Ill. Dec. 795 (holding that claimant was entitled to temporary total disability benefits where his condition worsened despite previously receiving an award of permanent partial disability benefits).

The Arbitrator specifically notes that Petitioner was not allowed to return to Dr. Goldberg following his return to work for Respondent. The Arbitrator finds, based on Petitioner's testimony and the medical records of Dr. Zindrick, Dr. Goodman and Dr. Goldberg, that Petitioner's low back condition worsened once he returned to work. However, Respondent did not authorize any further medical treatment or accommodate the work restrictions.

The Arbitrator relies on Petitioner's testimony in finding that the initial modified job provided to Petitioner was not within the work restrictions of Dr. Goldberg or Dr. Zindrick. Petitioner's testimony and the correspondence dated November 6, 2012 establish that for the period of October 22, 2012 through January 20, 2013, Respondent was not able to accommodate the work restrictions of Dr. Zindrick. The Arbitrator further notes that from October 22, 2012 through January 20, 2013, Petitioner was under the medical care of Dr. Zindrick, including follow-up office visits and prescription medication.

Respondent argues that Petitioner had Dr. Zindrick modify his work restrictions. However, Respondent failed to present any testimony to substantiate this claim. On cross-examination, Petitioner testified that he contacted Dr. Zindrick's office to clarify the work restrictions. Petitioner testified that he was advised by Dr. Zindrick to continue under the prior work restrictions from the prior office visit. Petitioner testified that the work status note faxed to Respondent had not been completely filled out. Petitioner testified that he did not request that Dr. Zindrick change his restrictions.

The Arbitrator notes that the medical records of Dr. Zindrick and the work status notes, which were admitted into evidence as Respondent's Exhibit 2, document an examination date of December 12, 2012. Further, the date of the electronic signature on the typewritten work status note is December 12, 2012. The correspondence from Respondent dated December 21, 2012 only sets forth that Respondent received a work status note stating that Petitioner's work restrictions were no lifting more than twenty (20) pounds and that Petitioner called the doctor's office to clarify the work restrictions.

Accordingly, based on the medical records and Petitioner's testimony that the modified job description was not within the restrictions of Dr. Goldberg and that Respondent failed to accommodate the work restrictions of Dr. Zindrick, the Arbitrator finds that Petitioner is entitled to temporary total disability benefits for the period of October 22, 2012 through January 20, 2013. The Arbitrator also notes that Dr. Zindrick opined that Petitioner had not reached maximum medical improvement as it relates to his back condition. Further, Petitioner was under the active medical care of Dr. Zindrick during this period of time.

The Arbitrator also finds that Petitioner is entitled to payment of temporary total disability benefits for the period of March 5, 2013 through September 10, 2013. Petitioner returned to work for Respondent within the restrictions that Dr. Zindrick imposed on January 21, 2013. Petitioner testified that the job was mostly within his restrictions. There appeared to be some misunderstanding with Petitioner as to his actual job duties, such as inspecting the light bulbs and propane gas tanks. Petitioner testified that when he returned to work in January 2013, he did not change any light bulbs. Petitioner did perform bending when he shredded paper. Respondent provided office work for one to two hours per day.

The Arbitrator questions the credibility of Ms. Brachmann. Ms. Brachmann testified and Petitioner confirmed that she advised him to take as many breaks as he needed. However, it was Petitioner's unrebutted testimony that on one occasion, Ms. Brachmann saw him taking a break and told him that he could not be sitting down and needed to be shredding paper. Petitioner testified that Mr. Nichols was also present during this conversation. Although Ms. Brachmann and Mr. Nichols testified on behalf of Respondent, they were not asked about this incident. Petitioner's testimony contradicts Ms. Brachmann's testimony.

Petitioner testified that when he returned to work at that time, his back pain increased.

On March 5, 2013, Dr. Zindrick opined that Petitioner could not return to work. Dr. Zindrick then recommended that Petitioner undergo further medical treatment, including injections. Petitioner was also examined by Dr. Goodman who recommended that he undergo lumbar facet joint injections. Based on the medical records of Dr. Zindrick and Dr. Goodman, the Arbitrator finds that Petitioner is entitled to payment of temporary total disability benefits for the period of March 5, 2013 through September 10, 2013. Petitioner was unable to work, was under medical care and further medical treatment had been recommended.

The Arbitrator once again notes that Dr. Goldberg has not treated Petitioner since September 14, 2012.

Based on the medical records, it is clear that Petitioner's condition worsened once he returned to work. Accordingly, the Arbitrator relies on the work restrictions and opinions of Dr. Zindrick as he has treated Petitioner since he returned to work for Respondent in September 2012. Furthermore, the Arbitrator finds the opinions of Dr. Zindrick to be credible.

The Arbitrator finds that Petitioner's condition of ill-being has not stabilized. Petitioner has not been released to return to work and has had future medical care recommended. Accordingly, based the foregoing, including the courts' holdings in *Freeman United Coal Company* and *World Press Color* (supra), the Arbitrator finds that Petitioner is entitled to TTD benefits from June 3, 2011 through September 23, 2012, October 22, 2012 through January 20, 2013 and March 5, 2013 through September 10, 2012.

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Aristeed Ashwood,

Petitioner,

vs.

Maitland Warne,

Respondent.

14IWCC0984

NO: 13 WC 17584

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed March 14, 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.

No bond is required for removal of this cause to the Circuit Court by Respondent. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: NOV 17 2014

David L. Gore

Stephen Mathis

Mario Basurto

DLG/gaf
O: 11/6/14
45

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

ASHWOOD, ARISTEED
Employee/Petitioner

Case# **13WC017584**

14IWCC0984

MAITLAND WARNE
Employer/Respondent

On 3/14/2014, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

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

0571 WITTENBERG DOUGHERTY & MAGLIONE LTD
DAVID MAGLIONE
105 W MADISON ST SUITE 600
CHICAGO, IL 60602-4672

2023 LAW OFFICES OF LORETTA M GRIFFIN
JOSEPH D DONNELLY SR
20 N CLARK ST SUITE 2725
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)

14IWCC098

ARISTEED ASHWOOD
Employee/Petitioner

v.

MAITLAND WARNE
Employer/Respondent

Case # 13 WC 017584

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 **Deborah L. Simpson**, Arbitrator of the Commission, in the city of **Chicago**, on **August 30, 2013**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

14IWCC0984

FINDINGS

On the date of accident, **May 23, 2013**, Respondent *was* operating under and subject to the provisions of the Act.

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

On this date, Petitioner *did 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 **$21,999.64**; the average weekly wage was **$423.07**.

On the date of accident, Petitioner was **28** years of age, *single* with **0** dependent children.

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

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

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

ORDER

The Arbitrator finds the Petitioner did not suffer an accident within the meaning of the Act, therefore no benefits are due and owing.

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

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

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

Deborah L. Simpson
Signature of Arbitrator

March 14, 2014
Date

ICArbDec19(b)

MAR 14 2014

14IWCC0984

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Aristeed Ashwood,	)	
	)	
Petitioner,	)	
	)	
vs.	)	**No. 13 WC 17584**
	)	
Maitland Warne,	)	
	)	
Respondent.	)	
	)	

FINDINGS OF FACTS AND CONCLUSIONS OF LAW

The parties agree that on May 23, 2013, the Petitioner and the Respondent were operating under the Illinois Worker's Compensation or Occupational Diseases Act and that their relationship was one of employee and employer. They agree that the Petitioner gave the Respondent notice of the accident which is the subject matter of the dispute within the time limits stated in the Act. They further agree that in the year preceding the injuries, the Petitioner earned $21,999.64, and that his average weekly wage was $423.07.

At issue in this hearing is as follows: (1) Did the Petitioner sustain accidental injuries that arose out of and in the course of her employment; (2) Is the Petitioner's current condition of ill-being causally connected to this injury or exposure; (3) Were the medical services provided to the Petitioner reasonable and necessary medical services. Has the Respondent paid for all reasonable and necessary medical treatment; and (4) Is the Petitioner entitled to temporary total disability benefits.

This is a hearing pursuant to Section 19(b) of the Act, nature and extent of the injury is not at issue at this point in time.

STATEMENT OF FACTS

On May 23, 2013 there existed an employer/employee relationship between the petitioner, Aristeed Ashwood, and the respondent, Boston Hannah Chicago, doing business as Maitland Warne. Petitioner was a salaried employee working as a sales representative. Petitioner testified that he reported to his work location at 8:00 a.m. on May 23, 2013. His work location was at an office suite located on the 7th floor at 730 North Franklin, Chicago, IL. He arrived at work between 8:00 a.m. and 8:15 a.m. He normally arrived between 8:00 a.m. and

8:15 a.m. The front door to the building was locked and petitioner did not have a key. Petitioner would gain access to the building by some other employee or other tenants allowing him in. Petitioner admitted on cross examination that his office may have been on the 6th floor, he stated it was an old loft building that had been converted. Other witnesses who testified at the hearing indicated the office was on the 6th floor.

On May 23, 2013, the petitioner took the elevator to the sixth floor and went to the Respondent's office. Petitioner found the office locked and could not access the office. He went back by the elevators where he was accompanied by a co-worker, Adam Bartz. Mr. Bartz did not have a key to the office either. Petitioner told Mr. Bartz that he was going to go to the Dunkin Donuts around the corner. As the petitioner decided to exit the building, he walked to the top of the stairs located on the sixth floor and slipped and fell down the stairs to the landing between the fifth and sixth floor.

After his slip and fall, Mr. Bartz came down to the petitioner and asked him if he was okay and if there was anything he could do for him. Mr. Bartz then called for a Chicago Fire Department ambulance. The petitioner does not know what caused him to fall, but he felt that there was something slippery on the step. He testified that Mr. Bartz and another employee said there was something on the step.

Petitioner testified that there was no policy that he had to use the stairs. Other employees of Respondent and the other tenants used the stairs as well. Petitioner was taken by ambulance to Northwestern Memorial Hospital where he received emergency treatment and was released after three or four hours. Petitioner testified that they gave him hydrocodene. Petitioner then sought care at Illinois Orthopedic Network because he was experiencing pain in his left big toe, his low back, his neck, his right knee and right elbow. Illinois Orthopedic Network prescribed medications and physical therapy. Illinois Orthopedic Network referred the petitioner to New Life Clinic which is a chiropractic clinic where petitioner received treatment.

Petitioner testified that a few days prior to May 23, 2013, the he was involved in an automobile accident. He testified that he received no injuries but did go to Swedish Covenant hospital to get examined. He did not receive any other medical treatment as a result of the motor vehicle accident.

On cross-examination the petitioner testified that he is a salaried employee, not hourly. There were 15 – 20 employees working at Maitland on May 23, 2013. There was no clock check-in for the petitioner. Petitioner stated he was told to be at work between 8:00 a.m. and 8:30 a.m. by Roosevelt Cobbs. Mr. Cobbs holds the same position, sales representative, as does the petitioner. Mr. Cobbs is not the supervisor of petitioner.

If a member of the public were to visit the building, they would be buzzed in by one of the tenants. The front door at the ground level remained locked.

No one at Maitland instructed the petitioner to use either the stairs or the elevator to access the sixth floor. It was strictly up to the petitioner's (and the other employees) own choosing what method to use to get to and from the sixth floor. Anyone using the building, even members of the general public, could use the stairs or elevator to access floors.

When petitioner got to his work location on May 23, 2013, he saw that the office doors were locked and he could not get in. He decided to leave and go to Dunkin Donuts to pick up some breakfast. No one instructed him to go and pick up breakfast and no one instructed him to pick up anything for anyone else. He did offer to pick up anything that Mr. Bartz wanted but Mr. Bartz did not request anything.

Adam Bartz testified in this matter. On May 23, 2013 he was employed as a sales representative by respondent and was on the sales team with petitioner.

On May 23, 2013, Mr. Bartz arrived at the building and saw petitioner on the sixth floor. Mr. Bartz could not recall who got there first and could not recall if he rode up on the elevator with petitioner but he does recall seeing petitioner on the sixth floor. They checked the office, which was still locked, neither of them had a key to the office. Petitioner then told Mr. Bartz that he was going to go to the Dunkin Donuts. Mr. Bartz watched as petitioner left. When the petitioner got to the top of the stairs he slipped and fell down the stairs to the next landing. Mr. Bartz went to assist him. He asked him if he was okay and if he could get him anything. When Mr. Bartz realized that petitioner was in pain, Mr. Bartz called for an ambulance and paramedics. The ambulance eventually arrived and transported petitioner to Northwestern Memorial Hospital. Mr. Bartz had inquired of the ambulance crew where petitioner was being taken.

Mr. Bartz testified that the starting time for all employees was 8:30 a.m... The office would be open anywhere between 8:00 a.m. and 8:30 a.m. and employees were free to access the office during that time but they were not required to be there. The starting time was 8:30 a.m. and nobody was told that they had to start early. There were 15 – 20 employees of Maitland on May 23, 2013. The employees were free to choose the method to access the sixth floor either by elevator or by stairs. Respondent did not have any provision requiring employees to use a certain access. Both the stairs and the elevators were open to the employees of Respondent as well as to the tenants and employees of the other suite locations in the building as well as to any member of the public using the building.

Mr. Bartz would normally try to get to work at 8:00 a.m. He testified that his decision to arrive at 8:00 a.m. was of his own choosing and for his own convenience. He liked to get to work early so that he could get a cup of coffee and smoke a cigarette if he wanted to. On cross-examination, Mr. Bartz testified that he was paid both a salary and commission. On those occasions when Mr. Bartz arrived at 8:00 a.m. he was not paid hourly for being there at 8:00 a.m.

Mr. Bartz is no longer employed by respondent. Mr. Bartz was laid off due to a lack of sales. Mr. Bartz appeared and testified as a result of being served with a subpoena to appear. Mr. Bartz testified that he was paid a $25.00 fee for his appearance and mileage. He was not paid anything else nor was he promised anything else to appear and testify.

Respondent then called Kathy Fishman to testify. Kathy Fishman is the administrative coordinator for Maitland Warne. Part of her job duties included opening the office on a daily basis. Five of the approximately 20 employees had keys to the office including her; however, Ms. Fishman was the person who was responsible for opening the office. She generally got to the office around 8:00 a.m. to open it. Other employees were free to come and go as they desired between 8:00 a.m. and 8:30 a.m. if she had the office open. All employees started at 8:30 a.m. No employee was required to work at 8:00 a.m. even if they arrived early. Ms. Fishman usually

arrived at the office around 8:00 as a matter of convenience and the scheduling of the public transportation she took to work. Ms. Fishman lives in the south suburbs and would take a Metra train to the Loop and from the Loop would take the CTA Elevated to Chicago Avenue to get to 730 North Franklin. Ms. Fishman arrived at the respondent's location on May 23, 2013 at approximately 8:15 a.m. She verified her time of arrival by making a print-out of her Chicago Transit Plan. That transit plan showed that she got to the Randolph and Wabash El Station at 8:05 a.m. and paid her fare. It would take her approximately 10 minutes to get to the office. Based upon that she estimated she arrived there approximately 8:15 a.m. - 8:30 a.m.

Upon her arrival at 730 North Franklin on May 23, 2013, Ms. Fishman was advised that petitioner had fallen on the stairs. She checked out the location and saw that Adam Bartz was attending to the petitioner. She went and opened the office and sent an e-mail to the owner advising him of Mr. Ashwood's fall. She then went back to the location of the fall. Mr. Bartz had warned her to be careful as petitioner had slipped. Ms. Fishman inspected the area and found a gel type substance on the top stair. She observed that it was not quite liquid but not solid. She felt that it presented a risk so she obtained some paper towel and wiped it up.

Ms. Fishman usually arrived at work at about 8:00 a.m. She believes on May 23, 2013, she first saw petitioner at approximately 8:20 a.m. when he was laying on the landing. The office officially opens at 8:30 a.m. and employees are expected to begin work at 8:30 a.m. Ms. Fishman testified that there is about a 10 minute leeway for employees that may be late due to late public transportation or finding a parking spot. On those occasions when she opened the office at 8:00 a.m. other employees were free to come and go until 8:30 a.m. At 8:30 a.m. they would be expected to be at work. An employee who arrived at work early could begin work but there was no requirement that they work. An employee could also work from home making phone calls, but again that was not expected. To her knowledge no employee has ever been disciplined or punished in any way for not beginning work before 8:30 a.m.

At the close of testimony, documents were admitted. Petitioner submitted seven documents. The first is the Chicago Fire Department ambulance record and bill which was admitted subject only to the objection of liability. Petitioner's Exhibit No. 2, the Northwestern Memorial Hospital records and bills were also admitted subject only to a liability objection. Petitioner's Exhibit No. 3 was the Northwestern Medical Faculty Foundation bill which was submitted and admitted subject only to liability. Petitioner's Exhibit No. 4 was the Illinois Orthopedic Network records and bills which were admitted subject only to liability objection. Petitioner's Exhibit No. 5 is the M & R Ruda New Life Medical Center records and bills which were also admitted subject only to liability. Petitioner's Exhibit No. 6 were the bills from MRI Lincoln Imaging Center which were admitted subject to a liability objection. Finally, petitioner admitted Exhibit No. 7, the IWP bill which was admitted subject to a liability objection. Thereafter petitioner rested.

Respondent submitted three exhibits into evidence with no objection to any of the exhibits. Respondent's Exhibit No. 1 was a floor plan of the sixth floor of 730 North Franklin, roughly drawn by witness, Adam Bartz, and identified by Adam Bartz and Kathy Fishman. Respondent's Exhibit No. 2 was a copy of the print-out of Ms. Fishman's Chicago Transit Plan itinerary. Respondent's Exhibit No. 3 was a copy of the Subpoena served upon Mr. Adam Bartz to appear at the hearing.

CONCLUSIONS OF LAW

The burden is on the party seeking the award to prove by a preponderance of credible evidence the elements of the claim, particularly the prerequisites that the injury complained of arose out of and in the course of the employment. *Hannibal, Inc. v. Industrial Commission,* 38 Ill.2d 473, 231 N.E.2d 409, 410 (1967)

An injury arises out of one's employment if it has its' origin in a risk that is connected to or incidental to the employment so that there is a causal connection between the employment and the accidental injury. *Technical Tape Corp. vs IndustrialCommission,* 58 Ill. 2d 226, 317 N.E.2d 515 (1974) "Arising out of" is primarily concerned with the causal connection to the employment. The majority of cases look for facts that establish or demonstrate an increased risk to which the employee is subjected to by the situation as compared to the risk that the general public is exposed to.

In support of the Arbitrator's decision with regard to whether Petitioner sustained accidental injuries that arose out of and in the course and scope of his employment with Respondent and the date of the accident, the Arbitrator makes the following conclusions of law:

After reviewing the testimony in this matter and carefully considering the law governing the Illinois Worker's Compensation Act, the Arbitrator comes to the conclusions that this Petitioner's accident, while unfortunate, did not arise out of and in the course of his employment.

In the Worker's Compensation Act the words "in the course of" refer to the time, place, and circumstances of an accident. It is axiomatic that the petitioner's accident must occur at a time and in a place where the petitioner is due to his employment. The Arbitrator notes that the petitioner was scheduled to start work at 8:30 a.m. The petitioner, by his own testimony, arrived at work early. After realizing that the office was closed and he could not access it, petitioner, on his own, chose to go to a nearby Dunkin Donuts to obtain coffee and breakfast. This was not a requirement of his employment. Nobody at his employer instructed him to do this.

Secondly, at the time of his fall the petitioner was located in a common area of the building where his employer was a tenant. This area was used not only by the petitioner but also by his co-workers, any of the other tenants and their employees or guests at this building. The petitioner was free to use either the stairs or the elevator to access the sixth floor. On this occasion he chose to use the stairs. Neither the stairs nor the building were owned or maintained by his employer. It appears from the evidence that some type of substance was spilled on the top of the stairs causing the petitioner to slip and fall down the stairs. The nature of the substance is not known. It also is not known how the substance came to be at the top of the stairs. What is known is that the petitioner had not yet started work and was not on any mission or errand for his employer. He chose himself to go and obtain breakfast and coffee before his starting time at work. The fact that the petitioner was able to, on his own, decide to leave the area of his employment and go to a different location to obtain coffee and breakfast is evidence in and of itself that the petitioner was not required to be at work at that time. Since the petitioner had not

yet started work and was not at a place or location at which his employment put him, this accident did not occur within the course of his employment.

The Arbitrator further finds that this accident did not arise out of petitioner's employment. There was no benefit to the petitioner's employer in the petitioner's own decision to leave the area where he worked and go to a different location in order to purchase coffee and breakfast. There must be a causal connection between a petitioner's employment and the accidental injury in order for the accident to be compensable. See *Technical Tape Corp v. Industrial Commission*, 58 Ill.2d 226, 317 N.E. 515 (1974); *Warren v Industrial Commission*, 61 Ill.2d 373, 335 N.E.2d 488 (1975). The Act is not intended to insure employees against all injuries. *Quarant v Industrial Commission*, 38 Ill.2d 490, 231 N.E.2d 397 (1967).

Petitioner's decision to leave the work area before work began and to go to a different location to purchase coffee and breakfast, did not provide any benefit to the employer. Accordingly the act of the petitioner in attempting to descend the stairs did not arise out of petitioner's employment.

The burden is on the petitioner to prove by a preponderance of the credible evidence all of the elements of his claim, and in particular the prerequisites that the injury complained of arose out of and in the course of his employment. *Hannibal, Inc. v Industrial Commission*, 38 Ill.2d 473, 231 N.E.2d 409 (1967); Illinois *Institute of Technology v Industrial Commission*, 68 Ill.2d 236, 369 N.E.2d 853, 12 Ill. Dec. 146 (1977).

The arbitrator has considered the "Personal Comfort Doctrine" and finds that it does not apply in this case. The Personal Comfort Doctrine stands for the proposition that while at work certain activities that do not have a connection to an individual's job duties will be covered as "incidental" to the employment. However, the employee must be actually at work or be involved in an activity before or after work that is sanctioned or approved by and benefits the employer. In *Christman v Illinois Industrial Commission*, 159 Ill. App.3d 479, 512 N.E.2d 804, 111 Ill. Dec. 415 (3rd Dist. 19878) the employer was liable where an employee was injured in a slip and fall accident in a construction site changing shack a half hour before his shift began. This case is clearly distinguishable from *Christman*. In *Christman*, the employer opened the shack prior to work in order to allow employees to be ready for work at the scheduled time, thus benefiting the employer. In this case, petitioner had not started work, the employer's premises was closed and locked, petitioner was leaving the premises on an errand for himself and petitioner fell in an area outside the control of the employer. In fact, the area where petitioner fell was a common area of a large, commercial converted loft building of which his employer was but one of many tenants

Simply being in the area of the workplace is not enough to cover a petitioner under the Act. To adopt such a position would be tantamount to adapting the "Positional Risk Doctrine" which is not part of the Act, and which was also specifically repealed by our Supreme Court in *Brady v Louis Ruffolo & Sons Construction Co.*,143 Ill.2d 542, 578 N.E.2d 921, 161 Ill. Dec. 275 (1991). In this case, petitioner was not in his workplace; he was in a common area. He had not yet started his workday. He was leaving the area to benefit himself, not his employer.

Even if the employer is aware that petitioner is involved in an activity, such acquiescence does not convert a personal risk into an employment risk. *Orsini v Illinois Industrial Commission*, 117 Ill.2d 38, 509 N.E.2d 1005, 109 Ill. Dec. 166 (1987). In *Orsini* petitioner was

repairing his personal vehicle, on company time and premises, when the vehicle lurched and struck petitioner. The *Orsini* Court found that if an employee's injuries result from a hazard to which the employee would have been equally exposed apart from the employment then it does not arise out of it. In this case petitioner was on common property, was leaving on a strictly personal errand and had not yet begun work when he fell and was injured.

This case is distinguishable from the holding in *Homerding v Illinois Industrial Commission*, 327 Ill. App.3d 1050, 765 N.E.2d 1064, 262 Ill. Dec. 456 (1st Dist 2002). In *Homerding* the Court found compensable injuries when petitioner, after reporting for work and setting up her work station, realized she needed more supplies and went to her car to retrieve them. She slipped on ice returning to her job station. Distinguishing factors between this case and *Homerding* include: in *Homerding* petitioner was carrying out a foreseeable and necessary task of her employment; she was required to park her car in the area she fell; the lot was partially maintained by the employer; and petitioner's employment required her to make the second trip to her car. In this case, petitioner came to work, found the office closed and locked and voluntarily chose to leave the area for a personal task and chose his own route. He was on a mission with no benefit to his employer.

Petitioner's testimony that Roosevelt Cobbs instructed petitioner to begin work at 8:00 a.m. as opposed to 8:30 a.m. is not credible for several reasons. Petitioner testified that he arrived at work between 8:00 – 8:15 a.m. on May 23, 2013. At that time the office door was locked. Mr. Bartz arrived at about the same time. If employees were expected to arrive at 8:00 a.m., why were Petitioner and Mr. Bartz the only two out of 20 employees there at 8:15 a.m.? Why weren't Mr. Cobbs and the rest of the 15- 20 employees already present? The only conclusion can be that work did not start until 8:30 a.m. and if the office was open earlier it was for convenience and not to begin work. The Arbitrator notes that Mr. Bartz appeared as a result of subpoena as he is no longer an employee of respondent. His testimony could be considered the only non-biased testimony on the issue of starting time. The Arbitrator further notes that Mr. Cobbs held the same position for respondent as did petitioner - sales rep per petitioner's testimony. Accordingly Mr. Cobbs is not in any supervisory position over petitioner. Finally, if they were to start at 8:00 a.m., why was the door still locked, and no employee there with a key to open it.

The Arbitrator notes that the method of accessing the sixth floor was of petitioner's own choosing. By petitioner's own testimony, he could use the elevator or the stairs and that choice was strictly his own decision. Respondent did not tell their employees that they must use one method of access. Petitioner chose whichever access was convenient for him. Accordingly, petitioner's employment did not put him at any greater risk than any other employee, tenant or guest to this building. Based upon the above, the Arbitrator finds that there is no causal connection between petitioner's accident and his employment. This incident did not arise out of or in the course of petitioner's employment. It is not an "accident" within the meaning of the Act.

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

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

What temporary total disability is the Petitioner entitled to?

The Petitioner failed to prove that he suffered and accidental injury that arose out of and in the course of his employment with the Respondent, therefore his injury is not compensable and the issues raised above are moot.

ORDER OF THE ARBITRATOR

The Petitioner failed to prove a compensable accident within the meaning of the Act. Benefits requested pursuant to Section 8 are therefore denied.

Deborah L. Simpson
Signature of Arbitrator

March 14, 2014
Date

STATE OF ILLINOIS)
) SS.
COUNTY OF DU PAGE)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Ismael Rodriguez,

Petitioner,

vs.

Daimler Trucks,

Respondent.

14IWCC0985

NO: 10 WC 49110

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed March 12, 2014 is hereby affirmed and adopted.

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

No bond is required for removal of this cause to the Circuit Court by Respondent. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: NOV 17 2014

David L. Gore

Stephen J. Mathis

Mario Basurto

DLG/gaf
O: 11/6/14
45

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

RODRIGUEZ, ISMAEL
Employee/Petitioner

Case# **10WC049110**

14IWCC0985

DAIMLER TRUCKS
Employer/Respondent

On 3/12/2014, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

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

3148 THERMAN LAW OFFICES LTD
AARON J BRYANT
8501 W HIGGINS RD SUITE 420
CHICAGO, IL 60631

0332 LIVINGSTONE MUELLER ET AL
D SCOTT MURPHY
P O BOX 335
SPRINGFIELD, IL 62705

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 14IWCC0985

Ismael Rodriguez
Employee/Petitioner

v.

Daimler Trucks
Employer/Respondent

Case # 10 WC 49110

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 **Joshua Luskin**, Arbitrator of the Commission, in the city of **Wheaton**, on **February 10, 2014**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS 14IWCC0985

On **10/19/10**, 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 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 **$39,520.00**; the average weekly wage was **$760.00**.

On the date of accident, Petitioner was **39** years of age, ***married*** with **2** 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 a credit of **$IF ANY** under Section 8(j) of the Act.

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

March 12, 2014
Date

MAR 12 2014

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

ISMAEL RODRIGUEZ,	)	
	)	
Petitioner,	)	14IWCC0985
	)	
vs.	)	No. 10 WC 49110
	)	
DAIMLER TRUCKS,	)	
	)	
Respondent.	)	

ADDENDUM TO ARBITRATION DECISION

STATEMENT OF FACTS

The petitioner is a warehouseman for the respondent. He described his job as filling orders for truck parts, such as clutches, rims, wheels, alternators, and engines. The petitioner acknowledged a relevant prior medical history significant for a left shoulder surgery in 2006. He testified that on October 19, 2010, he was reaching with his left arm to get an alternator off a skid and felt an immediate sharp pain in his left shoulder. He stopped work for twenty to twenty-five minutes, then finished his regular work day.

The petitioner presented to Dr. Komanduri, an orthopedist, on October 20, 2010. The history in Dr. Komanduri's records notes the left shoulder stabilization procedure in 2006, which had initially gone well, but the petitioner developed recurrent pain and discomfort in June or July and progressed since. He further noted "It is unclear if he had a traumatic injury. He has been working. He does not recollect a significant work injury. He works in a shipping receiving dock, which certainly could be a source of pain but as stated previously, there is no evidence for a work injury." Dr. Komanduri prescribed an MRI arthrogram to evaluate a potential loose body or recurrent tear, and gave the claimant pain medication. See PX1.

At trial, the petitioner disputed the history contained in Dr. Komanduri's records. However, the Arbitrator notes a handwritten intake report from that October 20, 2010 appointment, which was apparently prepared by the claimant. It notes left shoulder joint pain beginning in May, with a history of "it just did" regarding what, if anything, had caused the problem to start. See PX1, RX2.

On October 21, 2010 the petitioner presented for a physical therapy evaluation. The history there indicates a left shoulder injury on October 6, 2010, while fixing a skid. RX2. On cross-examination, the petitioner disputed this history as well.

The left shoulder MRI arthrogram took place on October 25, 2010. It noted a

history of five months pain in the left shoulder and revealed postoperative changes with degenerative joint disease, synovitis and tendinosis, as well as a loose body in the joint. See PX1, RX3. On October 27, 2010, Dr. Komanduri reviewed the MRI and recommended surgery to remove the loose body. PX1.

Dr. Komanduri filled out a pre-operative certification form for FMLA on November 8, 2010, noting a history of the condition commencing in 2006. PX1, RX4.

Dr. Komanduri performed left shoulder surgery on November 16, 2010. Postoperative diagnoses included a partial thickness rotator cuff tear and recurrent labral tearing with rupture of the prior sutures, as well as the loose body. PX1, RX5.

Following surgery, the petitioner underwent a postoperative course of physical therapy. PX1. On January 17, 2011, Dr. Komanduri released him to light duty and recommended additional strengthening. PX1, RX2. On February 4, 2011, Dr. Komanduri released the petitioner to full duty work effective February 8. PX1, RX2. On March 21, 2011, Dr. Komanduri noted no pain and full range of motion. He instructed the petitioner on home exercise and released him from care. PX1.

OPINION AND ORDER

Accident

A claimant has the burden of proving by the preponderance of credible evidence all elements of the claim, including that the alleged injury arose out of and in the course of employment. See, e.g., *Parro v. Industrial Commission*, 260 Ill.App.3d 551 (1st Dist. 1993). The claimant's treating orthopedist noted there was no evidence of an acute incident. Moreover, while a claimant may still be able to establish his case if only one note contradicted his history, here the petitioner's own handwritten intake report contravenes his trial testimony. The treating medical records clearly refute his description at trial. The Arbitrator reviews the medical records considering the principles expressed in *Shell Oil v. Industrial Commission*, 2 Ill.2d 590 (1954), where the Illinois Supreme Court stated contemporaneous medical records are more reliable than later testimony because "it is presumed that a person will not falsify such statements to a physician from whom he expects and hopes to receive medical aid." Id. at 602.

The claimant has failed to credibly prove accidental injuries. Benefits are denied.

Causal Connection, Medical Services, TTD, and Nature and Extent

These issues are moot given the above findings.

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

John Dahlman,

Petitioner,

14IWCC0986

vs.

NO: 12 WC 24390

Contract Installations,

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed March 6, 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.

14IWCC0986

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

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

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $4,100.00. 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: NOV 17 2014

David L. Gore

Stephen Mathis

Mario Basurto

DLG/gaf
O: 11/6/14
45

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

14IWCC0986

DAHLMAN, JOHN
Employee/Petitioner

Case# **12WC024390**

CONTRACT INSTALLATIONS
Employer/Respondent

On 3/6/2014, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

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

0222 GOLDBERG WEISMAN & CAIRO LTD
WALTER J MROZINSKI
ONE E WACKER DR 39TH FL
CHICAGO, IL 60601

1120 BRADY CONNOLLY & MASUDA PC
NICOLE L WIZA
10 S LASALLE ST SUITE 900
CHICAGO, IL 60603

STATE OF ILLINOIS)
)SS.
COUNTY OF Will)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

14IWCC0986

John Dahlman,
Employee/Petitioner

v.

Contract Installations,
Employer/Respondent

Case # 12 WC 24390

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 **December 17, 2013.** After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On the date of accident, **May 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 **$71,052.46**; the average weekly wage was **$1,362.65**.

On the date of accident, Petitioner was **42** years of age, ***married*** with **0** dependent children.

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

Respondent shall be given a credit of **$39,970.48** for TTD, $ for TPD, $ for maintenance, and **$35,337.72** for other benefits, for a total credit of **$75,308.20**.

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 $908.30 for 83-1/7 weeks, commencing May 15, 2012 through December 17, 2013, as provided in Section 8(b) of the Act.

Respondent shall pay reasonable and necessary medical services, pursuant to the medical fee schedule, of $3,846.00 to Dr. Edward Trudeau, as provided in Sections 8(a) and 8.2 of the Act. Respondent shall further authorize the surgical procedure as prescribed by Dr. Fletcher and Dr. Li.

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

3/5/14
Date

ICArbDec19(b)

MAR 6 - 2014

STATEMENT OF FACTS:

Petitioner, John Dahlman, is employed by Respondent, Contract Installations, as a carpenter. Petitioner testified that on May 14, 2012 he had started a one day job at Northern Illinois University in DeKalb. Petitioner stated that he was ascending a stair case, carrying two bags of tools that weighed between 100 and 125 pounds. He was carrying the bags one on top of the other with both hands. According to Petitioner his right hand slipped off the handle of one of the bags and all of the weight of the bags was shifted to his left arm, which was fully extended. He testified that when this happened, he was spun around although he did not fall down on the stairs and did not strike any part of the staircase with any other body part. Petitioner testified that immediately after this occurrence, he noticed a throbbing sensation in his left shoulder as well as a numbing and tingling sensation in the left middle, ring and little fingers. Petitioner provided that he notified his foreman, Ed Siweck, of the incident. He continued to work for six (6) hours before he left because he was in "too much pain." Petitioner testified that he then drove himself to the Christie Clinic in Champaign where he was examined, given medication for pain and referred to Safe Works, Dr. David Fletcher.

Petitioner initially presented to Safe Works on May 15, 2012. At this visit, Petitioner was examined by Physician's Assistant, Mr. James Blatzer. Records submitted show Petitioner reported that he was "...injured at work on 5/14/2012 when a bag weighing about 100 pounds pulled his left arm down and he fell on the stairs." Petitioner had complaints at that time of pain in the left shoulder as well as tingling in the second third and fourth fingers of the left hand. Petitioner was given a diagnosis of left shoulder sprain/strain, prescribed medication, and taken off work. (PX 2)

Petitioner followed-up with Physician's Assistant, Blatzer on May 22, 2012 with complaints of pain in the anterior aspect of the left shoulder. He also complained of tingling in the second, third and fourth fingers of the left hand. A left shoulder MRI was recommended and carried out on May 30, 2012. (PX 2)

Petitioner returned to Safe Works on June 5, 2012 and saw Dr. Fletcher for the first time. Dr. Fletcher reviewed the MRI indicating same showed no full thickness rotator cuff tear. There was mild tendinopathy of the supraspinatus and infraspinatus insertions without tear. Also noted were degenerative changes of the acromioclavicular joint with mass effect on the supraspinatus tendon. Dr. Fletcher diagnosed left shoulder impingement syndrome and noted that there was no full thickness rotator cuff tear. The doctor referred Petitioner to Dr. Li for consultation and issued modified work restrictions of no lifting over 20 pounds, no pushing or pulling more than 20 pounds, no overhead activities and limited use of his left arm. (PX 2)

Petitioner presented to Dr. Li on June 13, 2012. Records show Petitioner provided a history that "...he was carrying a bag at work and it fell twisting his Left arm. Bag of tools weighed 120lbs and jerked left arm." After performing an examination and reviewing the previously taken MRI, Dr. Li diagnosed left A/C joint injury and impingement. Dr. Li administered a cortisteroid injection in the left shoulder and continued ongoing physical therapy. (PX 4) Petitioner testified that he received temporary relief from the injection.

On June 13, 2012, Petitioner also saw Dr. Fletcher. Dr. Fletcher's office note reports Petitioner complained of constant aching, stabbing left shoulder pain. He also complained of numbness in the first three fingers of the left hand. Petitioner's work restrictions and medications were continued. (PX 2)

Petitioner returned to Safe Works on June 20, 2012 and saw Dr. Fletcher. Petitioner reported that his left shoulder pain was not too bad indicating same felt like a toothache. He continued with complaints of pins and needles in his left hand first three fingers. An examination that day revealed a positive Tinel's testing at the left

elbow. Dr. Fletcher noted Petitioner was failing conservative treatment; had no benefit with injection; and had numbness and tingling. Dr. Fletcher recommended diagnostic study to confirm or rule out ulnar neuritis. Modified work duty was continued. (PX 2)

On June 21, 2012, Petitioner returned to Dr. Li. The doctor diagnosed left A/C joint dysfunction in a high level working carpenter despite physical therapy, corticosteroid injection and NSAIDs. Dr. Li recommended surgery consisting of a left arthroscopic subacromial decompression and distal clavicle excision. (PX 4)

Petitioner returned to Dr. Fletcher on July 5, 2012. Petitioner continued to complain of shoulder symptoms as well as tingling in the first three fingers in his left hand. Dr. Fletcher added a diagnosis of left ulnar neuropathy. The doctor noted that same was not related to acute injury but could be due to cumulative trauma. The hope was that the condition would improve during the time Petitioner would be off work for the shoulder surgery. (PX 2)

On July 17, 2012, Dr. Li performed a left shoulder arthroscopy with arthroscopic subacromial decompression, excision of the distal clavicle and extensive debridement of anterior, superior and posterior type-1 labral tear. (PX 4)

Petitioner returned to Dr. Fletcher on July 26, 2012. Dr. Fletcher noted ongoing left shoulder pain. The doctor noted a positive Tinel's sign at the left elbow. Dr. Fletcher provided an ongoing diagnosis of left ulnar neuropathy which he again stated was not related to acute injury, but could be due to cumulative trauma. Dr. Fletcher recommended an EMG/NCV and referred him to Dr. Edward Trudeau. (PX 2)

Petitioner also saw Dr. Li on July 26, 2012. Dr. Li reported there was no swelling at the left shoulder and indicated Petitioner was neurovascularly intact at that time. Physical therapy was ordered and Petitioner was to follow-up in four weeks (PX 4)

Petitioner returned to Dr. Fletcher on August 23, 2012. Dr. Fletcher recorded that Petitioner was unable to lift his left arm above his left shoulder. Also recorded was that Petitioner reported a burning sensation down the left biceps area. Physical examination showed positive testing of Tinel's at the left elbow, Tinel's over the Scalene and positive Adsons/Roos testing. Dr. Fletcher included a diagnosis at that time of left thoracic outlet syndrome. He noted that Petitioner was making slow steady progress and recommended continued therapy. (PX 2) Petitioner also saw Dr. Li on August 23, 2012. Physical therapy was continued. (PX 4)

Dr. Li next saw Petitioner on September 20, 2012. Dr. Li noted typical postoperative pain complaints. He also noted Petitioner had numbness and tingling in the left ulnar nerve distribution which he states occurred after the work injury. On shoulder examination, there was no swelling noted and Petitioner was neurovascularly intact. Dr. Li found a positive Tinel's test at the cubital tunnel as well as decreased sensation at the ulnar nerve distribution. Dr. Li diagnosed left cubital tunnel syndrome and recommended an EMG/NCV study. (PX 4)

Petitioner returned to Dr. Fletcher on September 21, 2012. Dr. Fletcher diagnosed classic left ulnar neuropathy by way of objective findings of positive Tinel's and left elbow compression as well as loss of interosseous strength. Also diagnosed was left thoracic outlet syndrome. The doctor further assessed right ulnar neuropathy, early signs from overcompensating. Physical therapy was continued. (PX 2)

On October 3, 2012, an EMG/NCV was performed by Dr. Trudeau. Findings of the electrodiagnostic studies reveal ulnar neuropathy at the left elbow (cubital tunnel syndrome) moderately severe. (PX 1)

Petitioner next saw Dr. Fletcher on October 12, 2012. Dr. Fletcher noted in his assessment that Petitioner's objective findings was consistent with left thoracic outlet syndrome. He also noted that there were no electrical studies confirming this diagnosis. In his opinion, the EMG testing showed moderately severe cubital tunnel at the left elbow which he related to cumulative trauma. Dr. Fletcher provided a return to modified work duty with restrictions of no lifting more than 10 pounds, no vibration exposure and no constant overhead lifting. The doctor also recommended surgical intervention for the left ulnar nerve condition and ongoing physical therapy. (PX 2)

Petitioner returned to Dr. Li on October 18, 2012. Dr. Li reported that Petitioner's shoulder was doing well but he had moderate to severe left ulnar neuropathy at the cubital tunnel. Dr. Li recommended left cubital tunnel release and anterior transposition of the ulnar nerve. (PX 4)

Petitioner returned to Dr. Fletcher on November 1, 2012. Those records reflect that Dr. Fletcher had attempted to obtain authorization for the surgery on the left elbow but that no authorization had been given. At the time of that office visit, Dr. Fletcher continued Petitioner's work restrictions. (PX 2)

Petitioner saw Dr. Fletcher for subsequent office visits on December 13, 2012, January 14, 2013, February 14, 2013. On December 13, 2012, Dr. Fletcher noted that additional request for physical therapy had been denied and as such Petitioner was discharged from therapy. At each visit, the doctor continued to recommend surgery and continued Petitioner's work restrictions. Dr. Fletcher had also provided Petitioner with an elbow pad to wear on his left elbow. (PX 2)

Petitioner last saw Dr. Fletcher on March 14, 2013. At that visit, Petitioner complained of constant stabbing left shoulder pain, worse at bedtime. Petitioner also complained of numbness in his left fingertips. Dr. Flecher felt Petitioner had reached maximum medical improvement from the shoulder perspective. The doctor continued work restrictions consisting of no lifting over 10 pounds and no vibration exposure. Dr. Fletcher also continued his ongoing recommendation for left cubital tunnel release and anterior transposition of ulnar nerve. (PX 2)

Petitioner underwent a total of 37 physical therapy sessions at 217 Rehab and Performance Center from May 24, 2012, through November 1, 2012. Records show that at his first session on May 24, 2012, Petitioner provided a description that on May 14, 2012, "[he] was carrying a tool bag up a flight of stairs. One of the bags started to fall so he flipped it back toward him but his hand slipped off of the handle. It spun him around to the left and twisted the left shoulder. Onset speed; Sudden." At his last session on November 1, 2012, Petitioner denied any pain in his left shoulder. He described some popping in his shoulder that was not painful. He noticed the popping when reaching out to pick something up. It was noted that Petitioner would benefit from continual therapy once a week and that he should continue with a home exercise program. (PX 2)

At Respondent's request, Petitioner underwent a Section 12 examination with Dr. Prasant Atluri on March 1, 2013. Dr. Atluri prepared a report and also testified via deposition. Dr. Atluri testified that Petitioner reported that he was carrying a bag of tools weighing approximately 115 pounds in his right hand while climbing stairs when the bag he was carrying slipped out of his hand and he spun around on the stairs. The doctor indicated Petitioner reported that he did not fall down stairs; he twisted and suddenly felt extreme pain in the left shoulder and some neck pain. Petitioner also reported feeling tingling in his left middle, ring and small fingers. (RX 7, p. 9) After examining all of the medical treatment records provided to him as well as performing a physical examination, Dr. Atluri provided a diagnosis of left shoulder derangement status post left shoulder arthroscopy with subacromial decompression, distal clavicle resection and debridement of superior labral tear as well as cubital tunnel syndrome. (RX 7, p. 17) According to Dr. Atluri, while Petitioner demonstrated some residual stiffness and mild pain indefinitely in his left shoulder, his function was quite good. The doctor did not expect those residuals to be significantly limited. (RX 7, p. 18)

Dr. Atluri opined that Petitioner's left shoulder condition was not related to a work incident from May 2012. Dr. Atluri based his opinion on reported mechanics of the injury given to him as well as the initial objective findings. Dr. Atluri stated that "[w]hen I reviewed the records, there was documentation of some type of a traction injury to his left upper extremity. That mechanism can actually cause or contribute to a labral tear, but I was very careful and specific when asking him how he got hurt, because the descriptions in the record were not very detailed. And he told me very clearly...that there was no traction injury to his left upper extremity. He was not carrying his heavy tool bag in his left arm. He was carrying it in his right arm. He did not strike his left arm against anything...I wanted to know whether he fell down the stairs and was holding on to the rail with his left arm, which could have pulled it forcefully, but he denied that, so there was no plausible mechanism that he described for – that matched the findings from his MRI or his surgery." Dr. Atluri stated that the initial MRI neither showed signs of acute injury nor an acute aggravation of a chronic problem by way of edema or effusion. (RX 7, p. 20-21)

Dr. Atluri also provided a causation opinion for Petitioner's left elbow. Dr. Atluri testified that Petitioner's left elbow condition was not causally related to a May 14, 2012, incident. Dr. Atluri explained that acute cubital tunnel or trauma- related cubital syndrome requires direct impact to the nerve at the level of the elbow and Petitioner denied any direct impact to his elbow. Dr. Atluri also provided that occasionally there is an aggravation of underlying cubital tunnel syndrome from prolonged immobilization with elbow in a flexed position, such as following surgery, but in this case, Petitioner's symptoms were present before surgery. (RX 7, p. 22-23) Dr. Atluri opined Petitioner suffered from a chronic cubital tunnel syndrome. (RX 7, p. 25)

Dr. Atluri also provided an opinion with regard to the condition of thoracic outlet syndrome diagnosed by Dr. Fletcher. Dr. Atluri testified that Petitioner did have one of the classic findings for thoracic outlet syndrome, which was obliteration of his pulse with one of the maneuvers performed to test for same. The doctor however testified that because Petitioner had the same finding in the right arm, "[t]hat doesn't mean that he cannot have thoracic outlet syndrome, but it makes it less significant that he had that abnormality in the arm." Dr. Atluri added "...his clinical picture was much more consistent with a cubital tunnel syndrome, which can have overlapping symptoms...I can't definitely say he does not have thoracic outlet syndrome, but it is unlikely..." (RX 7, p. 23-24)

Dr. Atluri opined that although Petitioner had some shoulder symptoms, supervised therapy would not likely provide any further benefit beyond what a home exercise program would give him. He felt Petitioner was at maximum medical improvement. (RX, 7, p. 25-26). With regard to the left elbow, Dr. Atluri provided that he would recommend additional conservative treatment for what he described as chronic cubital tunnel syndrome. The doctor added that if the conservative measures failed, then surgery would be appropriate. (RX 7, p. 26) Dr. Atluri also added that Petitioner could return to work full duty. Dr. Atluri explained that the ongoing complaints that Petitioner had of the numbness and tingling in his left hand did not affect his ability to perform his work as a carpenter. He pointed out that Petitioner had no motor dysfunction with no loss of control of the muscles and although he would experience tingling, this would not interfere with his ability to do his work. (RX 7, p. 34)

On cross examination, Dr. Atluri testified that Petitioner had deficiencies in internal rotation in the left arm post-surgery, but he explained this is a common finding following shoulder surgery. (RX 6, p. 37-38) He also described that internal rotation involved actions such as reaching into ones back pocket, or behind their back. (RX 7, p. 38) Dr. Atluri testified that to his knowledge, Petitioner had no shoulder or elbow complaints prior to the May 14, 2012 incident. When asked what would have caused the sudden onset of complaints other than the incident, Dr. Atluri replied, "I don't know...I know that it was not the accident that he described to me..." (RX 7 p. 43)

Dr. Fletcher provided testimony by way of an evidence deposition on September 30, 2013. At his deposition, Dr. Fletcher testified that he is a board certified occupational medicine physician. (PX 5, p. 6) Dr. Fletcher opinied there was a causal relationship between the incident of May 14, 2012, and Petitioner's left shoulder condition. The doctor also provided an affirmative opinion regarding Petitioner's ulnar neuropathy and thoracic outlet conditions. Regarding his opinion relative to Petitioner's ulnar neuropathy, Dr. Fletcher testified the basis was twofold. Dr. Fletcher stated, "[f]irst of all, the type of job activities that he does can cause upper extremity cumulative trauma problems that lead to nerve entrapment conditions over time. Secondly, the fact that he developed and reported right away neurological complaints. The mechanism of injury such as a fall could aggravate a previously asymptomatic nerve entrapment condition. He's been consistently reporting this symptomatology since the date of accident..." (PX 5, p. 32-33)

On cross-examination, Dr. Fletcher testified that the history provided to him was that Petitioner fell down stairs. When questioned further about the mechanism of injury, Dr. Fletcher stated that he made an assumption that reference "fell on stairs" meant that Petitioner fell down the stairs. The doctor stated, "my focus when we first started seeing him was providing care and treatment for him. We didn't go into a long, in-depth history for accident investigation. So, I don't have all that information." Dr. Fletcher further added that he made an assumption that Petitioner fell on his left arm. (PX 5, p. 36-37)

Dr. Fletcher testified that there was no evidence of any acute injury at the time of his examination in June 2012. The doctor noted there was no soft tissue swelling, trauma, ecchymosis at the elbow. He stated there was no evidence of any acute injury that "de novo" caused the neuropathic condition. Dr. Fletcher also provided, "...I believe he had a previously asymptomatic ulnar neuropathy that was made symptomatic by the May 14, 2012 injury. I think there's a distinction. I'm making it clear that this was, in my opinion, a preexisting condition related to his work activities, and it manifested subsequent to the work injury." (PX 5, p. 39) According to Dr. Fletcher, Petitioner still had an ongoing ulnar neuropathy condition as of March 2013 and due to this, Petitioner was unable to do the full scope of his job activities as a union carpenter. (PX 5, p. 29) Dr. Fletcher testified that he would not place Petitioner at maximum medical improvement. (PX 5, p. 44-45)

Dr. Lawrence Li testified by way of evidence deposition in this matter on September 30, 2013. Dr. Li testified that when he initially saw Petitioner on June 13, 2012, the description he was given of the incident was that on May 14, 2012, Petitioner was carrying a bag at work when it fell, twisting his left arm. The bag of tools weighed approximately 120 pounds which jerked his left arm. (PX, 6, p. 7-8) Dr. Li testified that Petitioner not only complained of pain in the left shoulder, but also mentioned he had tingling in the left upper extremity, with no specific site of tingling given in the doctor's chart note. (PX, 6, p. 9-10) According to Dr. Li, the first time he noted numbness and tingling in the left ulnar distribution was on September 20, 2012. At that time, he diagnosed cubital tunnel syndrome. (PX, 6, p. 14-15)

Dr. Li testified that he felt there was a causal relationship between the work incident and Petitioner's cubital tunnel syndrome. Dr. Li basis was, "[n]umber one, the mechanism of injury. He did suffer a traction injury, the 120 pounds of traction on his left arm. He did have some tingling initially, which is consistent with a cubital tunnel. He also then underwent a shoulder surgery and was placed in a sling post-operatively...An since the surgery was because of a work-related injury, this would be also related." (PX 6, p. 19-20) Dr. Li also testified that Petitioner suffered a traction injury to his left shoulder and same could definitely cause a labral tear. The doctor also provided that during the operative procedure, he was unable to determine whether the labral tear or A/C joint dysfunction was chronic or acute in nature. (PX 6, p. 37-38)

Petitioner testified that upon being released to restricted duty, he contacted the operations manager, Mike Rowe, about returning to work. Petitioner stated that Mr. Rowe told him that he would not be able to return until he was 100%. Petitioner has not returned to work for Respondent. He also testified that his temporary total disability

benefits and medical benefits were terminated after his Section 12 examination with Dr. Atluri. Petitioner testified that he has attempted to find work stating, "I have looked at everything from clerks to shop clerks to cashiers, anything and everything between." He has not been able to find alternative employment. He testified that his job as a carpenter requires him to lift more than ten pounds and could involve lifting in excess of 100 pounds.

Concerning the left shoulder, Petitioner testified that he still gets muscle spasms that occur probably every fifteen minutes or so. He also testified that he still experiences the numbness and tingling in the left third, fourth and fifth fingers all of the time. He is currently following the home exercise program as provided to him by Dr. Fletcher. Petitioner denied ever injuring either his left shoulder or the left hand/elbow prior to May 14, 2012. He also testified that he has not been involved in any accidents or sustained any injuries involving these body parts since the date of accident, May 14, 2012.

With respect 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:

Based upon the credible and unrebutted testimony of Petitioner, the Arbitrator finds that he sustained accidental injuries arising out of and in the course of his employment on May 14, 2012. While there appear to be some inconsistency in the histories contained within some of the medical records, Petitioner testified credibly that he gave each of the physicians involved in this case the same history as testified to at arbitration. The Arbitrator also relies on the history Petitioner conveyed during his initial therapy session on May 24, 2012. Petitioner provided a description that "[he] was carrying a tool bag up a flight of stairs. One of the bags started to fall so he flipped it back toward him but his hand slipped off of the handle. It spun him around to the left and twisted the left shoulder. Onset speed; Sudden."

The Arbitrator finds that Dr. Li's opinion concerning a traction injury supports finding of an accident concerning the left shoulder. The fact that Petitioner testified that later on the day of the accident he developed the numbness and tingling in the left middle, ring and little fingers and continues to have it through the date of Arbitration is supported by the medical records offered into evidence.

With respect to (F.) IS PETITIONER'S CURRENT CONDITION OF ILL-BEING CAUSALLY RELATED TO THE INJURY, the Arbitrator finds as follows:

Based upon the evidence presented, the Arbitrator finds that there is a causally relationship between Petitioner's current condition of ill-being and the accident of May 14, 2012. There is no evidence that Petitioner was suffering from any problems involving his left shoulder prior to the date of the accident. There is also no evidence that he was suffering from any numbness and tingling in the last three fingers in the left hand prior to the same date of accident. Also, there was no evidence that Petitioner has sustained any subsequent, intervening accidents or injuries to the affected body parts.

Illinois courts have long held that proof of prior good health and a change immediately following and/or continuing after an accident may establish that an impaired condition was due to an injury. Waldorf v. Industrial Commission, 303 Ill.App.3d 477, 708 N.E.2d 476 (1st Dist, 1999). Also see Cook vs Industrial Commission, 176 Ill.App.3d 545 (1988) which again stands for the proposition that the chain of events which demonstrates previous condition of good health, accident, and subsequent condition of ill-being resulting in disability may be sufficient circumstantial evidence to prove causal nexus between accident and employee's injury for workers' compensation purposes.

Notwithstanding the above, the Arbitrator also relies on the opinions of Petitioner's treating physicans, Drs. Li and Fletcher. Dr. Li, who had a relatively accurate description of accident, testified there was a causal

relationship between the work incident and Petitioner's shoulder and cubital tunnel syndrome. Dr. Li testified his rationale was, "...the mechanism of injury. He did suffer a traction injury, the 120 pounds of traction on his left arm. He did have some tingling initially, which is consistent with a cubital tunnel. He also then underwent a shoulder surgery and was placed in a sling post-operatively...And since the surgery was because of a work-related injury, this would be also related." Dr. Li also testified that Petitioner suffered a traction injury to his left shoulder and same could definitely cause a labral tear. The Arbitrator also notes Dr. Fletcher testimony wherein he stated "...I believe he had a previously asymptomatic ulnar neuropathy that was made symptomatic by the May 14, 2012 injury. I think there's a distinction. I'm making it clear that this was, in my opinion, a preexisting condition related to his work activities, and it manifested subsequent to the work injury."

The Arbitrator does not find the opinions of Dr. Atluri persuasive. While the doctor agrees that Petitioner has left shoulder and left elbow conditions of ill-being, he felt that neither was related to an incident in May 2012. Dr. Atluri appears to base his opinion on the fact that Petitioner did not sustain a traction injury to his left arm. This opinion is contrary to that of his treating physicians which the Arbitrator found persuasive.

With respect to (J.) WERE THE MEDICAL SERVICES THAT WERE PROVIDED TO PETITIONER REASONABLE AND NECESSARY? HAS RESPONDENT PAID ALL APPROPRIATE CHARGES FOR ALL REASONABLE AND NECESSARY MEDICAL SERVICES, the Arbitrator finds as follows:

Based upon the evidence presented, the Arbitrator finds that the bill from Dr. Edward Trudeau in the amount of $3,846.00 for the EMG/ NCV performed on October 3, 2012 is reasonable and necessary. Accordingly, the Arbitrator awards this bill pursuant to the medical fee schedule.

With respect to (K.) IS PETITIONER ENTITLED TO ANY PROSPECTIVE MEDICAL CARE, the Arbitrator finds as follows:

Petitioner testified that both Dr. Fletcher and Dr. Li have prescribed a left ulnar nerve transposition. No authorization was given for this procedure, based upon the opinion of Dr. Atluri. Having found the requisite causal relationship, the Arbitrator finds that Respondent shall authorize the surgical procedure as prescribed by his treating physicians.

With respect to (L.) WHAT TEMPORARY BENEFITS (TTD) ARE IN DISPUTE, the Arbitrator finds as follows:

Petitioner claims that he has been temporary totally disabled from May 15, 2012 through the date of arbitration, December 17, 2013, a period of 83-1/7th weeks. Presently, Petitioner has been released for modified duty with a lifting restriction of nothing greater than ten pounds. He attempted to return to work for Respondent but was advised that he would be unable to do so until he was 100%. Since his job as a carpenter requires him to lift well in excess of ten pounds, the Arbitrator finds that he is unable to return to work as a carpenter at this time. Therefore, the Arbitrator finds that Petitioner is entitled to temporary total disability from May 15, 2012 through December 17, 2013, a total of 83-1/7th weeks. Respondent is entitled to a credit for payments previously made totaling $39, 970.48.

With respect to (N.) IS RESPONDENT DUE ANY CREDIT, the Arbitrator finds as follows:

Respondent is entitled to a credit in the amount of $35,337.72 for medical benefits prior to arbitration. As noted above, the bill from Dr. Edward Trudeau in the amount of $3,846.00 for the EMG/ NCV performed on October 3, 2012 is outstanding.

STATE OF ILLINOIS)
) SS.
COUNTY OF)
WILLIAMSON

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Larry David Gribble,

Petitioner,

vs.

NO: 12 WC 9479

Willow Lake Mine/Big Ridge,

14IWCC0987

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of accident, causal connection, medical expenses, prospective medical expenses, 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 pay to Petitioner interest under §19(n) of the Act, if any.

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

DATED: NOV 19 2014
TJT:yl
o 11/3/14
51

Thomas J. Tyrrell

Kevin W. Lamborn

Michael J. Brennan

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

GRIBBLE, LARRY DAVID
Employee/Petitioner

Case# **12WC009479**

WILLOW LAKE MINE/BIG RIDGE
Employer/Respondent

14IWCC0987

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:

1580 BECKER SCHROADER & CHAPMAN PC
TODD J SCHROADER
3673 HWY 111 PO BOX 488
GRANITE CITY, IL 62040

0180 EVANS & DIXON LLC
ROBERT N HENDERSHOT
211 N BROADWAY SUITE 2500
ST LOUIS, MO 63102

14IWCC0987

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)

Larry David Gribble
Employee/Petitioner

v.

Willow Lake Mine / Big Ridge
Employer/Respondent

Case # 12 WC 009479

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 **Herrin**, on **February 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 _____

14IWCC0987

FINDINGS

On the date of accident, **February 23, 2011**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

On this date, Petitioner ***did 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 **$50,164.39**; the average weekly wage was **$1,003.29**.

On the date of accident, Petitioner was **57** years of age, ***married*** with **3** dependent children.

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

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

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

ORDER

Petitioner has failed to meet his burden of proof with respect to the issues of accident and medical causation; therefore, no benefits for past medical treatment expenses or prospective medical treatment 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

3/24/14
Date

ICArbDec19(b)

APR 3 - 2014

IN SUPPORT OF THE DECISION, THE ARBITRATOR FINDS THE FOLLOWING FACTS:

Petitioner testified in February 2011 he was working for Respondent in its underground mine as a ram car operator. Petitioner testified a ram car is a vehicle used in underground mining to transport coal from the face of the mine to the field. Petitioner explained a ram car is approximately seventeen to eighteen feet long and ten to eleven feet wide, and further explained the ram car articulates in the middle. Due to the low ceiling in the mine and Petitioner's height of approximately six feet, three inches, Petitioner testified he was required to lower the ram car and sit in a semi-reclined position in order to operate it.

Petitioner explained the ram car was operated with levers and a joystick with six or seven buttons. Petitioner testified the levers controlled the bed of the ram car, and were operated the levers with his right hand. Petitioner explained he would push the levers with the flat palm of his hand and then pull them back with his fingers. Petitioner explained the joystick was the steering control for the ram car, used to control the direction and lights on the ram car. Petitioner testified he used his left hand to operate the joystick.

Petitioner testified while he spent most of his time running the ram car approximately eight hours per day, he did perform additional duties including moving miner cable, hanging curtains, building cinder block walls to control air flow, and shoveling. Petitioner stated he would have to shovel once or twice a week, and explained it would sometimes take up to 30 minutes to shovel. Petitioner also stated he only occasionally needed to build the cinder block walls. The job duties description submitted by Petitioner indicates his job duties also involved some cleaning as well as changing of "large batteries." (Pet. Ex. 5) Petitioner testified he would occasionally get breaks and typically would take only fifteen minutes for lunch.

Petitioner first sought medical treatment for a complaint of hand pain on August 24, 2011, when he presented to Dr. Knight. Dr. Knight noted Petitioner's complaint of gradual onset of hand pain of a moderate to severe nature. Specifically, Dr. Knight was concerned with Petitioner's right index finger, which he noted was "stiff and painful" while Petitioner was noted to be "concerned about possible arthritis". (Pet. Ex. 1) Dr. Knight's examination identified Dupuytren's contracture of the right hand, as well as swelling in the right second and left fourth fingers. Dr. Knight's diagnosis was generalized arthritis.

When Petitioner was seen by Dr. Knight on August 24, 2011, Petitioner's problem list was noted to include hypothyroidism, obesity, osteoarthritis, controlled diabetes mellitus type II, hyperlipidemia, hypertension, and diabetic neuropathy. At trial, Petitioner acknowledged his diagnoses of hypothyroidism and diabetes, testifying he has been treating for both conditions for approximately ten years. Elaborating, Petitioner testified his blood sugars became uncontrolled one to two years prior to hearing, causing Petitioner to be placed on insulin. Dr. Knight's records also show Petitioner was prescribed Neurontin on February 3, 2012 for his diagnosis of diabetic neuropathy.

On March 2, 2012, Petitioner presented to Dr. Rider in Dr. Knight's office for complaints of sharp pain and tingling in his hands, right worse than left, starting at the palmar side of his middle finger and traveling up the mid-forearm. Dr. Rider's examination indicated Petitioner had positive Phalen's and Tinel's signs on his right wrist as well as no pain with movement and full range of motion. Dr. Rider diagnosed carpal tunnel syndrome, and prescribed Petitioner a wrist cock-up splint. On March 14 Dr. Rider's office referred Petitioner to Dr. Richard Morgan for the carpal tunnel diagnosis.

Dr. Morgan testified the first time he evaluated Petitioner for his hands was June 26, 2012. (Pet. Ex. 5, 6-7) At that visit, Petitioner completed a handwritten history which contained the question "Is this a Workman's Compensation Claim?" to which Petitioner responded "No".

(Pet. Ex. 2) Petitioner also noted a ten year history of diabetes, but indicated he had "Recently started insulin shots." (Pet. Ex. 2) Dr. Morgan testified Petitioner complained of experiencing an intermittent numbness and tingling in both hands for the preceding several months. Dr. Morgan testified Petitioner's symptoms and physical examination were suggestive of carpal tunnel, and he recommended Petitioner obtain nerve conduction studies. (Pet. Ex. 5, 7) Dr. Newell performed the nerve conduction studies on July 17, which he interpreted to reveal mild median neuropathy at the right wrist with no evidence of neuropathy in the left wrist or upper extremity. Dr. Morgan reviewed the nerve conduction study and testified he thought Petitioner had "an element" suggestive of diabetic neuropathy. (Pet. Ex. 4, 9)

Petitioner returned to Dr. Morgan on July 31, at which time Dr. Morgan noted Petitioner "was still having trouble getting his diabetes under control". (Pet. Ex. 4, 8) Dr. Morgan testified he felt "there wasn't an urgency" to do surgery, and indicated he would proceed with surgery once Petitioner stabilized his blood sugars. (Pet. Ex. 4, 8)

On December 3, 2012, at the request of Respondent, Petitioner underwent an evaluation with Dr. Mitchell Rotman, a board-certified orthopedic surgery with added certification and qualifications in hand surgery. (Resp. Ex. 1, 5-6) Dr. Rotman testified Petitioner presented with complaints of numbness in his right hand and all of his fingers except the small finger as well as pain along the palmar aspect of his right thumb. (Resp. Ex. 1, 6) Dr. Rotman testified Petitioner "wasn't really having any troubles with the left." (Id.) Petitioner advised Dr. Rotman he believed the carpal tunnel syndrome was from his work at Respondent, where he felt the hardest activity he did with his right hand was operation of the levers. Dr. Rotman noted despite the fact Petitioner had not worked for "at least a few weeks" due to the closure of Respondent's mine, he complained of continuous numbness in his hand. (Id.) Petitioner also provided Dr. Rotman with a history of other medical conditions, including insulin-dependent diabetes and hypothyroidism. Dr. Rotman also discussed with Petitioner his job duties as a ram car operator, and noted Petitioner's report of the levers being "stiff at times." (Resp. Ex. 1, 7) Dr. Rotman further reviewed a description of Petitioner's job provided by Respondent, which Dr. Rotman testified provided "a little bit more activities." (Resp. Ex. 1, 9)

Dr. Rotman testified he reviewed Petitioner's records from Dr. Morgan and the nerve conduction study, and noted the nerve conduction study revealing findings of "the mildest type of carpal tunnel" on the right and normal findings on the left. (Resp. Ex. 10-11) Dr. Rotman performed an examination which returned atypical results for carpal tunnel syndrome as he was unable to either improve or worsen Petitioner's symptoms with certain hand maneuvers or tests. (Resp. Ex. 1, 12-13) The atypical examination findings combined with the mild nerve conduction study findings led Dr. Rotman to indicate he "wasn't completely convinced of the diagnosis of carpal tunnel syndrome". (Resp. Ex. 1, 13-14) Instead, Dr. Rotman indicated the most likely cause of Petitioner's symptoms was a combination of his diabetes and thyroid conditions. Dr. Rotman indicated he would be "hesitant to proceed with any surgical procedures"; although he felt Petitioner could benefits from a steroid injection on the right. (Resp. Ex. 1, Depo. Ex. 2) However, Dr. Rotman did not feel the need for the steroid injection would be due to Petitioner's work duties for Respondent.

At trial, Petitioner testified he has difficulties with picking up small objects and turning pages in a book. Petitioner stated he feels some pressure in his right hand with tingling and numbness, but does not experience those symptoms on a constant basis.

Petitioner testified since leaving Respondent, he helped rebuild a truck engine, which he acknowledged involved using his hands and operating power tools. Petitioner also testified he uses a riding mower and string trimmer, and also washes dishes and sweeps floors at home.

THEREFORE, THE ARBITRATOR CONCLUDES:

To support his claim for benefits, Petitioner submits the opinions and testimony of Dr. Morgan. Although Dr. Morgan had not expressed an opinion with respect to the cause of Petitioner's hand symptoms until his deposition, at that deposition Dr. Morgan testified he believed the types of activities Petitioner had done at work "can either, one be the proximate cause of carpal tunnel, or certainly an aggravating factor in carpal tunnel." (Pet. Ex. 4, 12, 29-30) Dr. Morgan testified he based this opinion on the description of Petitioner's duties in Dr. Rotman's report, as well as his experiences with miners and ram cars. (Pet. Ex. 4, 12)

However, the evidence does not support these opinions and testimony of Dr. Morgan. Dr. Morgan acknowledged Petitioner's job duties did not have "much requirement of flexion or extension" rather his duties were "more gripping." (Pet. Ex. 4, 26) Dr. Morgan further acknowledged Petitioner's job duties were not similar to using a vibratory tool. (Pet. Ex. 4, 26-27) In fact, Dr. Morgan was not even initially aware Petitioner was claiming a link between his job duties and his hand symptoms when he began treating Petitioner. Specifically, Dr. Morgan acknowledged Petitioner did not specifically relate his symptoms to his job duties, and had answered "No" when asked if Petitioner's condition was a workers' compensation claim. (Pet. Ex. 4, 20) Nor did Dr. Morgan obtain from Petitioner any history of the details of his job duties at the June 26, 2012 visit. (Id.) Dr. Morgan acknowledged a person could develop symptoms of numbness and tingling from other conditions, and further admitted Petitioner's symptoms of numbness and tingling could have been related to his conditions of diabetes, hypothyroidism, and obesity, and not related to his work as a ram car operator. (Pet. Ex. 4, 22)

Dr. Morgan's acknowledgment that Petitioner's symptoms could have been related to his conditions of diabetes, hypothyroidism, and obesity are actually more supportive of Dr. Rotman's opinions and testimony than of his own. Specifically, Dr. Rotman testified Petitioner "has probably the greatest risk factors for carpal tunnel medically than anyone" as Petitioner has "almost all the strong risk factors for carpal tunnel syndrome" including diabetes, hypothyroidism, obesity, and age. (Resp. Ex. 1, 15, 18) Dr. Rotman explained testified if Petitioner did have carpal tunnel syndrome, the cause of that condition would not be Petitioner's work for Respondent, as his work was "too light", meaning "it doesn't involve heavy repetitive gripping forces to the hands." (Resp. Ex. 1, 15-16). Dr. Rotman explained "repetition alone is not a risk factor"; rather carpal tunnel syndrome requires "repetition with high forces." (Resp. Ex. 1, 16) Dr. Rotman testified aggravating factors for carpal tunnel syndrome include heavy gripping activities for several hours a day, heavy use of vibratory tools, or something involving heavier forces to the hands; activities Petitioner did not engage in at work. (Resp. Ex. 1, 16-17) Although Dr. Rotman did not know specifically how many hours Petitioner performed his various duties, even Dr. Morgan agreed Dr. Rotman's description and understanding of Petitioner's work as a ram car operator, specifically the description of the joystick and levers, "is pretty accurate." (Pet. Ex. 4, 11)

Dr. Rotman's opinion and conclusion that the cause of Petitioner's carpal tunnel syndrome would be "his diabetes, thyroidism, heavy weight condition, and age" are supported by Petitioner's treatment records. (Resp. Ex. 1, 16) Those records show Petitioner has been treating for hypothyroidism and diabetes for ten years, and in fact was noted to have diabetic neuropathy by Dr. Knight on August 24, 2011, months before the onset date alleged by Petitioner. Dr. Morgan even testified he observed findings of diabetic neuropathy on the nerve conduction study. Further supportive is the fact that, as Dr. Rotman explained, Petitioner's symptoms did not

improve when Petitioner was not using his hands or during the examination. (Resp. Ex. 1, 17-18)

As Dr. Rotman's opinions and testimony are better supported by the evidence and the medical records than those of Dr. Morgan, I find Dr. Rotman's conclusions with respect to the issue of causation to be more credible than those of Dr. Morgan. I therefore find Petitioner has failed to meet his burden of proof with respect to the issues of accident and causation, and accordingly award Petitioner no benefits for past medical treatment expenses or prospective medical treatment.

STATE OF ILLINOIS)
) SS.
COUNTY OF McLEAN)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Roosevelt Nicholas, Jr.,

Petitioner,

vs.

NO: 11 WC 07216
13 WC 22609

Stark Excavating,

14IWCC0988

Respondent.

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed March 4, 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.

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

DATED: NOV 19 2014
TJT:yl
o 11/3/14
51

Thomas J. Tyrrell

Kevin W. Lamborn

Michael J. Brennan

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

NICHOLAS JR, ROOSEVELT
Employee/Petitioner

Case# **11WC007216**
13WC022609

STARK EXCAVATING
Employer/Respondent

14IWCC0988

On 3/4/2014, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

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

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

0264 HEYL ROYSTER VOELKER & ALLEN
JAMES J MANNING
600 CHASE BLDG 124 SW ADAMS ST
PEORIA, IL 61602

14IWCC0988

STATE OF ILLINOIS)
)SS.
COUNTY OF MCLEAN)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Roosevelt Nicholas, Jr.
Employee/Petitioner

Case # 11 WC 7216
13 WC 22609

v.

Stark Excavating
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 **Bloomington**, on **January 28, 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. [x] Was timely notice of the accident given to Respondent?
F. [x] Is Petitioner's current condition of ill-being causally related to the injury?
G. [ ] What were Petitioner's earnings?
H. [ ] What was Petitioner's age at the time of the accident?
I. [ ] What was Petitioner's marital status at the time of the accident?
J. [x] Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. [ ] What temporary benefits are in dispute?
[ ] TPD [ ] Maintenance [ ] TTD
L. [x] What is the nature and extent of the injury?
M. [ ] Should penalties or fees be imposed upon Respondent?
N. [ ] Is Respondent due any credit?
O. [ ] Other

14IWCC0988

FINDINGS

On **September 17, 2008 and July 28, 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 not*** sustain an accident that arose out of and in the course of employment.

Timely notice of these accidents ***was not*** given to Respondent.

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

In the year preceding the alleged injuries,Petitioner earned **$22,613.76**; the average weekly wage was **$869.76**.

On the dates of accident, Petitioner was **44** years of age, ***single*** with **6** dependent children.

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

ORDER

Petitioner's claim for compensation is denied.

No benefits are awarded herein.

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

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

Arbitrator Anthony C. Erbacci

February 24, 2014
Date

MAR 4 - 2014

14IWCC0988

In Support of the Arbitrator's Decision relating to (C.), Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent, (F.), Is Petitioner's current condition of ill-being causally related to the injury, and (L.), What is the nature and extent of the injury, the Arbitrator finds and concludes as follows:

On September 17, 2008, (11 WC 7216), and July 28, 2010, (13 WC 22609), the Petitioner was employed by the Respondent as a construction laborer. The Petitioner testified that on September 17, 2008 he was on a jobsite "doing concrete" when he started to get light headed and tired. He testified that he told his supervisor, Brett Whitecotton, that he wasn't feeling well and that he left work early and went to the emergency room at St. Joseph Medical Center.

The emergency room record from OSF St. Joseph Medical Center demonstrates that the Petitioner presented to the emergency room at 19:35 (or 7:35 p.m.) on the evening of September 17 2008. The nursing notes document a history which provides as follows: "Patient states he had large amounts of caffeine d/t overnight shift of 18 hours with 8 hours rest and 8 more hours of work. Patient works outside in direct heat. Dizzy, diaphoretic at time of incident. Chest felt funny. Started at noon today." The discharge note documents that the Petitioner was diagnosed with dehydration and instructed to increase his fluid intake while at work and decrease his caffeine intake. The emergency room records do not contain any indication or opinion that the Petitioner's condition was related to his employment. (PX 1, RX 2)

Respondent's Exhibit 4 is a Daily Job Report which reflects that the temperatures on September 17, 2008 were between 60 degrees and a high of 75 degrees. The report also reflects that the Petitioner worked 9.5 hours that day with 1.5 hour of overtime. Although the Petitioner initially testified that he reported his symptoms to his supervisor, Brent Whitecotton, he later testified that it was either Brent Whitecotton or Rob Ditchens to whom he reported his condition. Respondent's Exhibit 4 indicates that Brent Whitecotton was not working with the Petitioner on September 17, 2008, nor was Rob Ditchens his supervisor. Respondent's Exhibit 4 indicates that the supervisor on this jobsite was Zachary Kuethe. Ultimately, the Petitioner testified that he did not remember who his supervisor was that day or to whom he reported that he wasn't feeling well.

The Petitioner testified that on July 28, 2008, he was on another job site "doing concrete" when he became weak and pale. He testified that he told his boss he wasn't feeling well and he sat in a truck for a while and then attempted to return to work. The Petitioner testified that he returned to some light duty work but that he became light headed, tired, and weak, and he began to experience cramping. He testified that he then went to the emergency room at BroMenn Healthcare where he was admitted and treated.

The records of BroMenn Healthcare demonstrate that the Petitioner was seen there on July 28, 2010 with complaints of dizziness and lightheadedness which began when he was working outside in the heat. He was examined in the emergency department and he was diagnosed with acute renal failure secondary to prerenal dehydration. The Petitioner was

admitted to the hospital for rehydration and monitoring and he was administered IV fluids. He was discharged from the hospital on July 30, 2010 and the discharge diagnosis was acute renal failure secondary to dehydration. The emergency room records do not contain any indication or opinion that the Petitioner's condition was related to his employment. (PX 4)

The Petitioner testified that he has had no subsequent medical treatment for dehydration or renal failure since his discharge on July 30, 2010.He also testified that currently "everything is fine" although he "gets tired" some days. The Petitioner testified that he returned to work as a laborer and that he continues to work as a laborer at the present time.

Neither the Petitioner nor the Respondent offered any medical testimony, report, or opinion regarding causation into the record.

It is axiomatic that the Petitioner bears the burden of proving all of the elements of his claim by a preponderance of the credible evidence. The Petitioner did not meet that burden here.

The Arbitrator notes that it was clear from the Petitioner's testimony that his recollection of the events of September 17, 2008 and July 28, 2010 was unclear, at best. With regard to the events of September 17, 2008, the Petitioner's testimony was contradicted by the contents of Respondent's Exhibit 4 which demonstrated that the Petitioner worked 9.5 hours that day with 1.5 hour of overtime and, thus, he did not leave work early as he testified. That exhibit also indicates that the temperatures on September 17, 2008 were relatively mild; between 60 degrees and a high of 75 degrees.

Additionally, the Arbitrator notes that the Petitioner presented no testimony or evidence as to the weather conditions or his specific activities or exertional levels on either September 17, 2008 or July 28, 2010. He merely testified to an onset of symptoms while he was working on those dates. No medical opinion, testimony, or report relating to the cause of the Petitioner's symptoms or any relationship between the Petitioner's symptoms and his work activities was offered or introduced into the record. The mere onset of symptoms while working is not, in itself, sufficient to satisfy the burden of proving an accidental injury arising out of and in the course of the employment occurred.

Similarly, other than the Petitioner's testimony that his symptoms began while he was working, there is no competent evidence from which to conclude that there was a causal relationship between the Petitioner's diagnosed conditions of dehydration and renal failure and his work activities on either September 17, 2008 or July 28, 2010.

Based upon the foregoing, and having considered the totality of the credible evidence adduced at hearing, the Arbitrator finds that the Petitioner failed to prove that an accidental injury which arose out of and in the course of his employment with the Respondent occurred on either September 17, 2008, (11 WC 7216), or July 28, 2010, (13 WC 22609). The Arbitrator further finds that the Petitioner failed to prove a causal relationship between the Petitioner's

conditions of dehydration and renal failure and his work activities on either September 17, 2008 or July 28, 2010.

Even assuming, arguendo, that the Petitioner did sustain a compensable work injury, the Petitioner has failed to prove that he sustained any permanent partial disability as a result of the claimed occurrences. The Petitioner was treated and released from the hospital on September 17, 2008, (11 WC 7216), for dehydration. He returned to work the following day to regular duty and he continued working for the Respondent without any further incident. Following the alleged injury on July 28, 2010, (13 WC 22609), the Petitioner was again treated for dehydration and that condition resolved. The Petitioner returned to full duty work for the Respondent and he has continued to work full duty as a laborer through the union hall without any restrictions or further incident. The Petitioner testified that currently "everything is fine" except that he gets tired on occasion. Based upon the foregoing, the Arbitrator finds that the Petitioner has failed to prove that he sustained any permanent partial disability as a result of the alleged injuries.

In Support of the Arbitrator's Decision relating to (E.), Was timely notice of the accident given to Respondent, the Arbitrator finds and concludes as follows:

With regard to the alleged accident of September 17, 2008, (11 WC 7216), the Petitioner initially testified that he reported his symptoms of dehydration to his supervisor, Brent Whitecotton. He then later testified that it was either Brent Whitecotton or Rob Ditchens to whom he reported his condition. Ultimately, the Petitioner testified that he did not remember to whom he reported his symptoms. Respondent's Exhibit 4 demonstrates that Brent Whitecotton was not working with the Petitioner on the day of the occurrence, nor was Rob Ditchens his supervisor. Respondent's Exhibit 4 indicates that the supervisor on this jobsite was Zachary Kuethe.

Regardless of who the Petitioner's supervisor was on the day in question, Wayne Clayton, Respondent's Safety Director, testified regarding Respondent's policy and procedure for the reporting of any work-related injuries or illnesses. He testified that all supervisors are instructed to document all reported injuries and communicate any reported injuries directly to him. Mr. Clayton testified that the Petitioner's alleged heat exposure or dehydration was never documented in a First Report of Injury nor was any information communicated to him by Zachary Kuethe, or any other supervisors. Mr. Clayton testified that the first notice that he received of the claimed occurrence was in January, 2011 shortly after the Petitioner filed his Application for Adjustment of Claim.

Notice of a work-related accident is required to be given to the employer no later than 45 days after the accident in accordance with Section 6(c) of the Act. The Petitioner failed to demonstrate that the notice requirements of Section 6(c) were satisfied in the instant matter, as the evidence shows that the Respondent's first notice was not received until after the

14IWCC0988

Application for Adjustment of Claim was filed in January, 2011, over two years after the claimed accident.

With regard to the alleged accident of July 28, 2010, (13 WC 22609), the Petitioner's claim fails on similar grounds. Wayne Clayton testified that no incident involving heat exposure sustained by the Petitioner was ever reported or brought to his attention until after Petitioner filed his Application for Adjustment of Claim in July, 2013, nearly three years after the claimed exposure.

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 timely notice of either the alleged accident of September 17, 2008, (11 WC 7216), or the alleged accident of July 28, 2010, (13 WC 22609) was given to the Respondent.

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:

Based upon the Arbitrator's findings that the Petitioner failed to prove that an accidental injury which arose out of and in the course of his employment with the Respondent occurred on either September 17, 2008 or July 28, 2010, and failed to prove a causal relationship existed between his conditions of dehydration and renal failure and his work activities on either September 17, 2008 or July 28, 2010, the Arbitrator finds that the Respondent shall have no responsibility for payment of any medical services related to treatment of Petitioner's dehydration or acute renal failure on September 17, 2008 or July 28, 2010.

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

Leon Smith, Jr.,

Petitioner,

14IWCC0989

vs.

NO: 11 WC 19541

University of Illinois at 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 accident, notice, temporary total disability, causal connection, medical expenses, prospective medical expenses, permanent partial disability, and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed April 17, 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.

14IWCC0989

No bond is required for removal of this cause to the Circuit Court by Respondent. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: NOV 19 2014

David L. Gore

Stephen Mathis

Mario Basurto

DLG/gaf
O: 11/13/14
45

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

SMITH JR, LEON
Employee/Petitioner

Case# **11WC019541**

UNIVERSITY OF ILLINOIS AT CHICAGO
Employer/Respondent

14IWCC0989

On 4/17/2014, 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:

2221 VRDOLYAK LAW GROUP LLC
MICHAEL P CASEY
741 N DEARBORN 3RD FL
CHICAGO, IL 60654

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

1408 HEYL ROYSTER VOELKER & ALLEN
BRAD ANTONACCI
120 W STATE ST 2ND FL
ROCKFORD, IL 61105

0902 UNIVERSITY OF IL/CLAIMS MGMT
CHUCK HUTCHISON
1737 W POLK ST M/C 940 STE B
CHICAGO, IL 60612

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

APR 17 2014

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

STATE OF ILLINOIS)
)SS.
COUNTY OF Cook)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION 14IWCC0989

Leon Smith, Jr.
Employee/Petitioner

Case # 11 WC 019541

v.

Consolidated cases: _____

University of Illinois at 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 **Kurt Carlson**, 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. ☒ 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

14IWCC0989

On **March 30, 2011**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$30,484.48**; the average weekly wage was **$586.24**.

On the date of accident, Petitioner was **32** years of age, ***married*** with **3** dependent children.

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

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

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 SEE ATTACHED RIDER

Respondent shall pay Petitioner temporary total disability benefits of $390.82/week for 21 6/7 weeks, commencing 03-31-11 through 7-15-11 and 08-09-11 through 09-19-11, as provided in Section 8(b) of the Act.

Respondent shall pay Petitioner the temporary total disability benefits that have accrued from 03-30-11 through 03-06-14, and shall pay the remainder of the award, if any, in weekly payments. Respondent shall be given a credit of $0 for temporary total disability benefits that have been paid.

Respondent shall pay reasonable and necessary medical services, pursuant to the medical fee schedule, as provided in Attached Rider as provided in Sections 8(a) and 8.2 of the Act

Respondent shall pay Petitioner permanent partial disability benefits of $351.74/week for 50 weeks, because the injuries sustained caused the 10 % loss of the person as a whole, as provided in Section 8(d)2 of the Act.

No penalties are awarded in this matter.

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

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

Signature of Arbitrator

04-17-14
Date

APR 17 2014

STATEMENT OF FACTS

14IWCC0989

Petitioner testified in open hearing before the Arbitrator who had opportunity to observe his demeanor under direct and cross-examination. The Arbitrator considered the testimony of the petitioner in light of all of the other evidence in the record. The Arbitrator finds petitioner to be a credible witness.

Petitioner is 6 feet tall and weighs approximately 310 pounds. On the accident date, March 30, 2011 he weighed between 295 and 300 pounds. Prior to the accident date he had no problems with his low back or any complaints of pain in his side or leg. In 2008 he had injured his back lifting at work. He had no medical treatment but was sent home with orders to take ibuprofen. He sought no medical treatment for his back after the 2008 incident up to the date of this accident on March 30, 2011. On that date he was an employee of the University of Illinois at Chicago. He had worked for respondent for 3 to 4 years prior to that date. His job description was a laboratory animal caretaker. He worked in that job throughout the period he worked for respondent. His job duties included husbandry of the laboratory animals.

On March 30, 2011 he was working at the University of Illinois. He had been off with a medical condition prior to that. He had a bunion osteotomy of his left foot. He came back to work on March 28, 2011. He was advised by Health Service of respondent that his blood pressure was too high and was sent home. He returned on March 29, 2011 and was advised by respondent University Health Services that his blood pressure was under control and he was sent to work. He started work that date. He started work as his normal duty in the rat room. He had been off work for approximately 6 to 7 months because of the foot problem prior to returning to work on this date. He was assigned two rooms to change rat cages which totaled approximate 198 rat cages. His job required him to bring three totes of cages into the room; bring two cases of water bottles; enclose himself in a hood. His job required him to bend and twist his body to the right to reach down to the floor to get the cage, comeback straight up with the cage, reach down to get a clean cage then stand up to put the clean cage in front of him; change the rats into the clean cage; get the dirty cage and put it down on the floor on the cart and then put the clean cage back up. He did that 198 times. Each rat cage weighs about 10 to 15 pounds. Petitioner started work at 7:30 AM. As petitioner was reaching down to the floor turning to his right to pick up a rat cage it felt like something popped. Petitioner thought that this was a result of him not having worked in a while. He completed work, went home, took a hot bath, took some Advil and rested. The next day he returned to work at 7:30 AM on March 30, 2011. He was assigned again to the cage room. This required him to work on the belt which means that dirty equipment is brought to him. He would have to reach down to the ground pick up the dirty equipment place it on a stand in the cage room. He would dump the cages and then put them back on the belt and continually do that all day long. Towards midday he felt a sharp pain come in his back as he was reaching down to the floor to get cages. He thought it was the same thing as had happened the day before. He continued on because he needed to work because he had been off for six months because of his foot problem. He did not report that he had pain that day to anybody. He finished work. When he got home he again took a hot bath and more medication and

came back to work the next day. On March 31, 2011 he returned to work. The first thing in the morning he tried to do his job to bend down and he felt pain like a shot from his back all the way down to the back part of his buttocks down to the knee of his left leg. He was unable to continue work and reported the incident to Scott Hauff , the supervisor of the department, who sent him to Health Services. This was at approximately 7:50 AM. Petitioner went to Health Services and gave history of having pain in the lower left back all the way down to his thigh. He was directed to see his family doctor and was given paperwork which he took back to Scott Hauff. Petitioner left work and went straight to see his family physician, Dr. Paul Rustow. After examination Dr. Rustow gave him a prescription for medication.

The medical records of University of Illinois at Chicago University Health Services were admitted in evidence as Petitioner's Exhibit Number 1. These records reveal petitioner was examined on March 31, 2011 at 8:09 AM. History reveals that petitioner stated that he returned to work on 3/29/11 was off work from surgery to the left foot. States as of yesterday afternoon now has sharp pain to left side, (both extremities) and lower back. Pain is 8 to back on a scale of 0-10 and is constant. Pain to arm and leg is a 5 that comes and goes. Denies any numbness or tingling. Gait limping guarding to left side and back. PX 1, p 44. These records further reveal that on March 28, 2011 petitioner presented to University Health Services at 8:17 AM and was declared unable to return to work at this time secondary to elevated blood pressure. PX 1, p 47. On March 29, 2011 petitioner presented to University Health Services and was found to have blood pressure which allowed him to return to work. PX 1, p 46.

The medical records of Paul Rustow, M.D., Sykes Center were admitted in evidence as Petitioner's Exhibit Number 2. These records reveal that petitioner was examined on March 31, 2011 at 9:45 AM giving history of Tuesday was working; had just returned to work after bunionectomy on left foot; he was lifting 5-10 pound rat cages and pushing/pulling cart with 20-30 cages; pain began in lower back radiating down left buttock to left hamstring area; no pain below knee; some pain at night. PX 2, p 16. After examination the diagnosis was lower back pain. The plan was sciatica-new onset of symptoms; discussed risks, benefits of surgery, prednisone, epidural injections, observation; lifestyle changes reduce pressure on discs discussed in detail; will avoid prednisone for now; he has a history of borderline blood sugar. PX 2, p 18. Medications were ordered. PX 2, p 18. Petitioner testified Dr. Rostow ordered sedentary work.

On April 4, 2011 petitioner was examined at the University of Illinois at Chicago University Health Services. Petitioner gave history of presenting on 3/31/11 stating that as of 3/30/11, he had severe sharp pain to the left side, (both extremities) and low back. Pain was 8 to the back of a scale of 0-10 and was constant. Pain to arm and leg was at 5, and intermittent. He states numbness and tingling are restricted to left lower extremity. PCP has him on sedentary work restrictions for the next four weeks. The record indicates that he will be temporarily off work, as his department cannot accommodate current modified duty. He will continue meds and start PT. He will follow-up with his primary care physician as scheduled and return UHS for follow-up visit on 5/2/11. PX 1, p 43.

On April 28, 2011 petitioner returned to Dr. Rostow. His gait was steady, denies paresthesia denies dysuria and states relief from pain at present but will reproduce upon standing for a long period of time. Pain in left buttock and leg which was present before has improved. If he stands for 20 min. or more he has pain in the left low back. Also hurts to sit. Symptoms for the last month. The diagnosis was low back pain. The record indicates that Plan was: sciatica generally improving; he is unable to begin working his full-time job at this time; work restrictions were ordered as follows: no lifting more than 15 pounds and no standing more than 20 min. He was ordered to follow-up in three months. PX 2, p 13-15.

On April 29, 2011, petitioner was examined at the University of Illinois at Chicago Health Services. The record reflects that petitioner was requesting to return to work with restrictions as per M.D. note. Current M.D. note will allow for 15 pound lift, and no standing greater than 20 min. NP called supervisor Scott Hauff, he cannot provide work for the employee with the restrictions as listed above. PX 1, p 41. Examination revealed restricted range of motion flexion 40° rotation 25° extension 170° and lateral bending 20° right and left; palpation of the spine did reveal complaints of tenderness left L/S area with radiculopathy into left buttocks; straight leg raise positive on the left negative on the right. The assessment was low back pain with radicular signs and symptoms. PX 1, p 41.

Petitioner testified that his pain was not improving and the medication he was taking made him go to sleep and if he was not on medication, the pain would still be there. He saw a TV commercial and sought treatment from Herron Medical Center.

On May 4, 2011, petitioner was seen at the Herron Medical Center whose records were admitted in evidence as Petitioner's Exhibit Number 3. These records reveal that petitioner gave history of accident and onset of symptoms consistent with his testimony at hearing and consistent with the history given to previous treating physicians. He was examined by Ravi Barnabas, M.D., who ordered MRI of the lower back, pain medications and physical therapy with EMS hot packs soft tissue massage and ultrasound. Dr. Barnabas noted that since the patient has already had one month of physical therapy with no apparent difference in the level of pain, he was referred to a pain specialist, Dr. Chami. He was ordered off work and ordered a back brace once he sees Dr. Chami PX 3, p 19-20.

On May 4, 2011 MRI lumbar spine was performed at Delaware Place MRI whose medical records and bill were admitted in evidence as Petitioner's Exhibit Number 4. The MRI was interpreted to reveal at L4-L5 diffuse disc dehydration with a very mild generalized disc bulge and a small focal annular tear at the posterior margin of the L4-L5 disc without significant central or foraminal stenosis; at L5-S1 there is prominent epidural lipomatosis within the spinal canal which can be acquired or developmental in nature. The thecal sac is significantly tapered at this level, most likely on a developmental basis. There is a mild broad-based central disc protrusion or disc bulge which, along with posterior element degenerative changes, creates a very mild degree of

foraminal narrowing bilaterally without any evidence for acquired central stenosis. PX 4, p 7.

On May 5, 2011 petitioner was examined by Antoine Chami, M.D.. The records and bill of Dr. Chami/Chicagoland Advanced Pain Specialists were admitted in evidence as Petitioner's Exhibit Number 5. Petitioner gave history essentially consistent with history given to prior medical providers. Dr. Chami examined petitioner and reviewed the MRI which he interpreted to reveal facet joint ticketing and disc herniation at the level of L5-S1 central with a question of involvement of the right S1 nerve root. There is also a central disc bulge at the level of L4-5 noted. Dr. Chami noted that petitioner is suffering with persistent symptoms related to the work injury of March 29, 2011. He recommended a trial of epidural steroid injections addressing the nerve roots of L5 and S1 bilaterally through the foraminal of L5-S1 and S1 bilaterally, to treat the discogenic pain component as well as the radiculopathy identified by physical examination and reported by history. PX 5, p3-4.

On May 10 2011 through September 19, 2011 petitioner underwent a course of physical therapy at Alevio Physical Therapy and Chiropractic LLC. PX 3, p4-18.

On May 25, 2011 petitioner returned to the University of Illinois/Chicago Health Service. He was noted to have updated medical form from his treating provider with restrictions of lifting no more than 15 pounds no bending, stooping; supervisor cannot accommodate return to work employee will remain off. The plan notes that petitioner remains off work and unable to accommodate work restrictions; the employee's supervisor cannot provide work with the listed work restriction; the employee will remain off work until reevaluated by his treatment provider and work restrictions are adjusted. He was ordered to return to clinic June 1, 2011 with updated medical certification. PX 1, p 40.

On June 1, 2011 University of Illinois/Chicago Health Service note indicates petitioner remains off work unable to accommodate work restriction; the employee's supervisor cannot provide work with the listed work restriction; the employee will remain off work until reevaluated. He was ordered to return to UHS on June 10, 2011 after pain clinic consult. Assessment was low back pain slowly resolving. PX 1, p 38-39.

On June 9, 2011 Dr. Chami administered bilateral transforaminal epidural steroid injection at L5-S1 and S1 on diagnosis of lumbosacral radiculopathy, lumbar disc herniation; lumbar facet joint syndrome. PX 5, p 5.

On June 16, 2011 petitioner was examined by Dr. Chami. Petitioner reported 80% improvement in his symptoms after the transforaminal epidural steroid injection. The record reflects that petitioner is requesting that he be allowed to resume working and indicates that his job only accepts him back with the 25 pound limit at a minimum. Petitioner reports that his radiating symptoms have decreased. Pain in the low back is diminished. Petitioner experiences flareups on occasion with the range of motion and expects some worsening as he returns to work. Dr. Chami allowed petitioner to resume working at the modified medium level capacity with the weight restriction at 25 pounds.

A second epidural steroid injection was discussed and petitioner requested it to maximize the duration of the benefit. Dr. Chami made recommendation for a second transforaminal epidural steroid injection. PX 5, p 8.

On June 20, 2011 petitioner presented to University of Illinois/Chicago Health Services requesting return to work with modified work restriction of 25 pound lift/carry frequent, 30 pound occasional bending and twisting. The assessment was resolving low back pain status post left epidural steroid injection on June 9, 2011. The Plan was petitioner would return to work with restrictions if supervisor cannot provide work with restrictions the employee will be off until restrictions are adjusted. PX 1, p 37.

On June 23, 2011 Dr. Chami performed a second bilateral transforaminal epidural steroid injection at L5-S1 and S1. PX 5, p 9.

On July 14, 2011 petitioner returned to Dr. Chami. Petitioner reported significant ongoing improvement from the first epidural steroid injection to the second with 85% improvement after the last injection. He described occasional radiation of his symptoms into the posterior aspect of the left calf and into the plantar aspect of the right foot. He denied numbness, tingling or weakness. Requested to be allowed to resume working but indicates that his job will not accept him with anything less than full capacity. Examination revealed that he was ambulating without difficulty or gait disturbance. There is minimal interference with sleep reported. There is minimal tenderness to palpation of the lower lumbar spine. There is full range of motion without any discomfort reported. A third epidural steroid injection was ordered and petitioner was allowed to resume work at the high level capacity with clear instructions to stop working if his symptoms flare up. Additional physical therapy was ordered. PX 5, p 12.

On July 15, 2011 petitioner presented to University Health Services with return to work on a trial basis with restrictions of the pain doctor. The record indicates that petitioner was in continuing physical therapy and both the therapy and the injections are helping and he feels he can perform his regular job. The note indicates that supervisor has been unable to accommodate past work restrictions due to the nature of the job. Examination revealed very mild tenderness to left low back musculature. No midline tightness. Good range of motion, flexion to 90°, extension and side bending without difficulty. Straight leg raise negative bilaterally. Squats without difficulty. The assessment was low back pain, disc herniation, improving. The note indicates that petitioner stated he had very minimal pain and can perform his regular duties at work. The note further indicates that the physician, Amy Allegretti, M.D., discussed this with petitioner's supervisor, Scott Houff, and obtained description of work activities. These were discussed with petitioner who stated he would like to go back to work on a trial basis as per his pain doctor. He was allowed to return to work with no restrictions and follow-up in one week with instruction that he should return sooner if he experiences worsening pain on the job to prevent further injury. PX 1, p 35-36

On July 21, 2011 Dr. Chami performed a third bilateral transforaminal epidural steroid injection at L5-S1 and S1. PX 5, p 13.

On July 27, 2011 Petitioner presented to the University of Illinois Health Service complaining of dizziness and fatigue and change in vision. He was a newly diagnosed diabetic. After one piece of candy and 15 min. interval petitioner reported feeling better and reported he was ready to return to work. PX 1, p 33.

On July 28, 2011 petitioner was examined by Dr. Chami. He reported significant improvement with the series of transforaminal epidural steroid injections at L5-S1 and S1. Nonetheless, his symptoms returned soon after the injection at a decreased level of severity and intensity, where the residual pain interferes with his ability to do his job duties. It is noted that petitioner was sent back to work on a trial basis at the heavy level, as a compromise between his wishes to continue working due to his financial circumstances, and his job's insistence that he need not return at less than full capacity. Petitioner described cramping and a Charlie horse sensation in the posterior thighs and in the low back with tingling in the plantar aspect of the feet. He denies any weakness. It is noted that his job is very intensive involving repetitive bending twisting while lifting cages. It was noted that his employer is not cooperating with the patient to allow him time off to obtain physical therapy treatment, subsequently the patient has not presented for physical therapy in the past three weeks. It was noted that the patient has not been able to obtain his medication for the same reason. It was noted that petitioner stated his attorney is working diligently to secure the workers compensation coverage necessary to afford him the prescribed medically necessary treatment. Examination revealed tenderness to the palpation of the lower lumbar spine in the midline, full range of motion in the lumbar spine, motor and sensory examination grossly within normal limits. Physical therapy was ordered. Medication management was ordered to be performed by his primary care physician, Dr. Barnabas. The note indicates that patient is reluctant to take time off from work because his job expects him at full capacity and any unexcused absences go against the total of six that he is allowed per year, he is already at four for the year and he is concerned about losing his job as he has no other source of income. He was again allowed to return working full capacity on a trial basis and instructed to stop working immediately should his pain symptoms flare up. PX 5, p 16-17.

On August 8, 2011, petitioner was treated at the University of Illinois/Chicago Health Service. He was complaining of low back pain. He requested an icepack and ibuprofen. PX 1, p 32

Petitioner testified that on August 10, 2011 he was working with guinea pigs that day and had to reach down constantly to the right to the floor to get the guinea pig cages as he had done with the rat cages and he felt the pain come back.

On August 10, 2011 petitioner returned to the University of Illinois/Chicago Health Service. He reported that on August 8, 2011 he had an acute exacerbation of low back pain sustained while pulling a rack of cages. Examination revealed restricted range of motion ; flexion 45°, 30° right and left rotation, extension slowed upright posture, and lateral bending 20° of spine. Palpation of the spine revealed complaint of tenderness over LS paraspinal musculature left greater than right with intermittent complaints of

numbness into the left buttock and upper posterior thigh. The assessment was acute exacerbation of low back pain reportedly sustained while pulling a rack of cages on August 8, 2011. Petitioner was ordered off work until August 15, 2011. He was ordered to continue medications as directed by treating provider. PX 1, p 29.

On August 11, 2011 petitioner was examined by Dr. Chami. He gave history of having to stop work due to a severe flareup of the back symptoms. He reported pain working even with lighter rat cages because the job involves repetitive lifting of heavy cages containing multiple animals. Petitioner reported resumption of participation in physical therapy because his job is no longer conflicting with that schedule. Examination revealed tenderness over the L3-4 through L5-S areas. Majority of the pain symptoms are on the left side. It was noted that radiculopathy had resolved completely since the series of injections. The patient nonetheless is describing flareup of the low back subsequent to his return to work. It was noted that patient suffers with an element of facet joint syndrome, which was identified in the past by history and physical examination. Dr. Chami ordered petitioner to remain off work and continue in physical therapy. He recommended work conditioning after successful facet joint treatment and recommended a facet joint injection in the low back bilaterally at L 4 through L5-S. Dr. Chami indicated that if the residual back pain did not respond to the facet joint treatment protocol, it would need to be addressed with a microdiscectomy. PX 5, p 18-19.

On August 15, 2011 petitioner presented to the University of Illinois Chicago Health Services. Examination revealed restricted range of motion flexion 60°, 30° right and left rotation, extension slowed upright posture. Tenderness over the LS spinous process pain and numbness in left buttock and upper posterior thigh. Straight leg raise from seated position negative bilaterally. The assessment was low back pain strain, needs bilateral steroid injection for L3-4, L 5, and L5-S1. He was ordered to follow with treatment provided as scheduled. It was ordered that lumbar epidural steroid injection ASAP. Physical therapy scheduled to three times per week for 3 to 4 weeks. Work conditioning was recommended before return to work. PX 1, p 26-27.

On August 18, 2011 Dr. Chami performed bilateral intra-articular facet joint injection at L3-4, L4-5, and L5-S1. PX 5, p 20.

On August 25, 2011 petitioner followed with Dr. Chami in an office visit. Petitioner reported 80% improvement of symptoms. Petitioner was concerned that a return to work with repetitive bending, twisting and lifting would aggravate the condition as occurred in the past. Petitioner was participating in physical therapy and requested more active physical therapy and work conditioning. Petitioner indicated that work was requiring that he return to work on September 9, 2011. Dr. Chami performed examination which indicated that petitioner was able to ambulate without difficulty or gait disturbance. There is pain with extension of the lumbar spine at 20° localized to the left side. Side to side flexion does not elicit low back pain. Motor and sensory examination and the lower extremity is within normal limits. Work conditioning was ordered and return in two weeks. Dr. Chami's notes indicate that abnormalities noted on the MRI may or may not have predated his work injury; however the pain syndrome and disability are clearly and

discreetly work related, precipitated by the injury reported on March 29, 2011 to reasonable degree of medical certainty. PX 5, p 23.

On August 29, 2011 petitioner was examined at the University of Illinois/Chicago Health Services. It was noted that he had been off work since August 8, 2011. After examination the assessment was resolving low back pain with radicular signs and symptoms, marked improvement in function noted by the nurse practitioner. Employee to begin work hardening program August 30, 2011. He was ordered to remain off work at present and return to clinic after the next medical appointment. PX 1, p 24-25.

On September 1, 2011 Dr. Chami noted on examination that petitioner had significant pain with extension of the lumbar spine at less than 20° and left-sided pain with side to side flexion. There was tenderness to palpation of the lower lumbar areas bilaterally. Dr. Chami allowed petitioner to return to work with restrictions at petitioner's request because of the threat loss of his job. He was ordered to resume work conditioning. PX 5, p 24

On September 16, 2011 petitioner presented to the University of Illinois at Chicago Health Service. He reported pain reduction and increased mobility since receiving this six injections. After examination the nurse practitioner indicated resolving low back pain with radicular signs and symptoms, improvement noted in mobility, strength, and functionality noted by nurse practitioner since last exam. The plan was to return to work full duty. PX 1, p 21

On September 19, 2011 petitioner presented to Alevio Physical Therapy with complaints of pain and low back at about 1-2/10. He feels improved. He has been performing range of motion exercises. Range of motion was full with some complaints of pain at the end range of flexion, extension with decreased tenderness into the lumbar paraspinal muscles, the lumbar spine. Petitioner was discharged from physical therapy with a full duty return to work on September 20, 2011. PX 3, p4.

On September 20, 2011 petitioner returned to University of Illinois/Chicago Health Service on scheduled follow-up of back injury. He was released return to work full duty. PX 1, p 18.

Petitioner testified he returned to work for respondent on September 20, 2011 and continued to work there until he was terminated in April of 2013. He now works for a security company as a security officer in a bank. The job entails walking around the bank. He does not have to do any squatting or bending or reaching down to pick up things on a repeated basis in his new job. He does not have to do any lifting. He started the new job 30 days before the hearing date.

At hearing petitioner testified if he sits too long he has to get up to stretch his back. If he stands too long he will feel pain in his back. He does home exercises that he learned in physical therapy. These help relieve the pain. He continues to get Charlie horses in his

lower buttocks and the back of his left leg. This is the same area where he was having pain from the accident. He gets the Charlie horses once or twice a week.

Petitioner testified he told his supervisor Scott on March 31 about his back pain and that it started when he was working and bent down. He also had to give Scott forms from Health Service. Every time he went to Health Service, petitioner gave Scott Hauff a form to let him know what was going on. Petitioner completed an accident report on April 29, 2011 at the request of respondent. Petitioner identified Respondent's Exhibit Number 1 as a copy of the report. It was signed by petitioner. Before petitioner returned work on March 29, 2011 he was off work due to a foot injury and did not do any lifting activities during the period he was off work. Petitioner continued to go to therapy for his toe when he was returned to work on March 29, 2011. He was not having any difficulty walking because of the toe. When he had the back pain in April 2008 he had no treatment other than ibuprofen. Petitioner had no current work restrictions at hearing. He worked his regular duties for respondent from September 2011 up to his termination in April 2013. When he saw Dr. Rostow in January 2012 it was for diabetic medication and not for any treatment of his back. He has had no medical treatment of his low back since September 19, 2011. He takes no prescription medication at hearing for his low back. He does take Aleve occasionally. Petitioner received no payments for missed time from work from respondent after March 30, 2011. Petitioner never had an MRI of his low back before the one that he had when he was sent by Herron Medical Center.

Scott Hauff was called as a witness by respondent. He is associate director of husbandry at the University of Illinois at Chicago. That was his position on March 30, 2011. He oversaw staff that handles the care and feeding and treatment of laboratory animals. He testified petitioner was an employee of respondent until March of 2013 working in the position of lab animal caretaker. The witness was his direct supervisor. Scott Hauff testified that petitioner's duties were cage cleaning, cage washing, sterilizer on occasion, animal checks, basic animal care. The physical demands for hiring he believed were able to lift 25 or 50 pounds, reach low shelves, reach high shelves, push and pull 50 pounds. He was the person to whom petitioner was to report any work injury. He was working on March 29, March 30 and March 31. The witness testified petitioner did not report a work injury to him on any of those days. He testified petitioner did not have any conversation with him about a work injury around that time and did not request that an accident report be completed at the end of March 2011. The witness testified the first time petitioner reported that he hurt his back at work was a month later, April 28, 29 something in that area. A report was completed. The first page is for the employee and the second two pages are for the supervisor. The witness testified he always prepares a first report of injury of work accident if a work injury is reported to him. The witness testified that Respondent's Exhibit Number 1 was the first report of injury from the University of Illinois the witness completed pages 2 and 3of the report. He should have completed the report the same day that petitioner sent it in. Scott Hauff indicated on the report that the date petitioner reported the accident was April 28, 2011. For the lines that indicates the date of the accident and the time of accident Scott Hauff put it a question mark. The witness testified on the line indicating what activity was employee doing just before incident occurred, he wrote "unknown" because after 30 days there was no way for him

to determine what the employee was doing when he injured himself because it was not reported to him at the time so he had no way to know. He noted there was no witness to the accident. Scott Hauff testified the cages are approximate 15 x 24" x 10 or 12 inches deep and weigh between eight and 15 pounds. He described the process to change rat cages: take the cage off the dirty rack, spray it with disinfectant, put it in the hood, take the clean cage off the rack, spray with disinfectant, put it in the hood; open both cages, take the water bottle out, put it in a rack for dirty bottles, remove the animal from one cage into the clean cage, add food and water, place a lid on them, put the dirty cage on a rack and put the clean cage back where the dirty cage originally was. The rack bottom shelves are 10 to 12 inches off the floor the top shelves are 5 1/2 feet above the floor. The cages would have been on the racks and not on the floor. The largest rat room had 100 cages. There was no single room with 189 cages. He considered changing the rack cages to be a light assignment because normally you would change rat cages plus mouse cages plus have a series of animal checks to do as well. The witness testified that a normal day would be 200 to 300 combined rat and mouse cages to be changed. The witness testified that either he gave the light duty assignment to Mr. Smith or he would have talked to the supervisor on the first floor and instructed him to give a light duty assignment. The witness testified he gave petitioner a light duty assignment because his foot had not completely healed and he wasn't walking correctly. This was either before he returned or when he returned. He does not recall whether the petitioner was limping. He recalls petitioner saying he could not straighten his toes and was undergoing therapy. The witness testified he noted on the report that he was concerned about the validity of petitioner's claim because what petitioner was saying on page 1 of the form does not match the witness's recollection of what had happened on the day he was there. He does not recall petitioner mentioning a back injury. The witness testified petitioner had somewhere in the neighborhood of 20 absences before March 28, 2011, some were excused and some weren't. The witness' recollection is that somewhere in the neighborhood of nine were unexcused in 2010. By nine, petitioner should have received both the verbal and written warning. Scott Hauff testified that petitioner never told him he felt a sharp or severe pain in his back going down his leg or legs during March. When petitioner returned to work in September 2011 he returned to his regular duties as a lab animal caretaker working full-time. The witness did not recall whether petitioner complained of pains in the back or any issue with his back after returning to work in September 2011. Petitioner would have had to present him with notes from the University Health Services to return to work. Any time an employee goes to University Health Services for evaluation the witness testified a standard form saying whether not they are cleared to return to work is given. The form would indicate restrictions.

The witness testified he knew he was coming to the hearing to testify about petitioner's employment with University of Illinois but he did not bring his file. He did not know how many unexcused absences petitioner had. The witness did not recall whether on March 31, 2011 petitioner told him or a different supervisor that he was having pain and he needed to see a doctor. He was aware on March 31, 2011 that petitioner was going to University Health Services. The witness testified that petitioner did not return to work for some time after that and his understanding was that petitioner was injured. He did not know what petitioner was doing when he was injured and he did not inquire. The witness

testified the reason he did not inquire is because it's medical information and he's not supposed to inquire. He testified that he did not ask petitioner to fill out any forms because petitioner did not indicate it was a work injury. He testified that he was sure he did talk to other supervisors about why Leon Smith was not coming back to work but he did not have an exact recollection. The witness testified that he did not know why petitioner did not come back to work during that period other than he went to University Health Service; he was hurt; he did not return. The witness testified he did not recall the circumstances or where or when the form, Respondents Exhibit Number 1, was filled out. The witness would be notified every time an employee would be seen at Health Services as far as his work status. The witness testified when he got the forms indicating that petitioner was off work he did not know whether there was anything on the form to indicate what body part was affected; he would have to see the form. The witness testified that he would be called by Health Services to discuss restrictions on petitioner's return to work but that he would not inquire what was the injury because that was covered by HIIPA. The witness testified he did inquire as to why petitioner was off work but he did not recall of whom. The witness testified that at the time of the form his recollection was that he believed petitioner was off because of complications to his foot. The witness testified that if petitioner reported a work injury to a supervisor, either that supervisor or he would have required petitioner to fill out an accident report. The witness testified it is standard practice. The witness testified that an unexcused absence could either be because he was out of benefits or he failed to provide the department with an acceptable documentation to substantiate the absence. Some of the unexcused absences were when petitioner called in but he didn't have any vacation time left so it was designated as an unexcused absence. Even if petitioner provided documentation that had to take time off because of medical reasons if he had no time left that would still be considered an unexcused absence. The witness testified that the form he completed indicated that petitioner was scheduled to change rat cages on March 29 and March 30 but he was not scheduled in the cage room on those days. The witness testified that petitioner should have changed cages on those days. The witness testified that the form, Respondent's Exhibit Number 1, indicates that petitioner stopped his work at 7:48 A.M. on March 30, 2011. The witness testified the precise time was determined when somebody either wrote it down or it was on the work status report that comes from University Health Service or it was the time he punched out to go home after being sent home. The report indicates that petitioner was paid eight hours for both days on the 29th and 30th of March. The witness testified that it may have been on March 31 that he stopped work at 7:48 AM. The witness admitted that the form says that the last day he worked was March 30 but that he was paid eight hours for that day even though he worked for only 48 minutes according to what is on the form. The witness could not explain the discrepancy in the form other than a mistake in the date which should be March 31. The witness testified that he did not instruct petitioner to come in to fill out the form and it is possible that the petitioner came in and did it on his own.

Petitioner testified that Marisol Albino a secretary in the laboratory department called him to come in to complete the form on April 29, 2011. As soon as he received the telephone call from her, he went up to complete the form. Petitioner never saw page 2 or 3 of the form.

The medical records and bill of University of Illinois at Chicago University Health Services were admitted in evidence as Petitioner's Exhibit Number 1. The bill indicates charges as follows:

08-29-11	$77.59	PX 1, p4;
09-09-11	$77.59	PX 1, p 6;
08-15-11	$77.59	PX 1, p 8;
11-04-11	$124.56	PX 1, p 10;
08-10-11	$125.82	PX 1, p 12
TOTAL	$483.15	

The medical records of Paul Rustow M.D., Sykes Center were admitted in evidence as Petitioner's Exhibit Number 2.

The medical records and bill of Herron Medical Center were admitted in evidence as Petitioner's Exhibit Number 3. Bill for Herron Medical Center totals $1,363.67 for treatment dates of 5/4/11, 8/30/11. PX 3, p 58-59. Bill of Alevio Physical Therapy and Chiropractic LLC totals $6,135.47 for service dates from 05-10-11 through 09-19-11. PX 3, p 60-66.

Admitted in evidence as Petitioner's Exhibit Number 4 are the medical records and bill of Delaware Place MRI. Bill is in the amount of $1761.73 for services rendered on 05-04-11. PX 4, p 8.

Admitted in evidence as Petitioner's Exhibit Number 5 are the medical records and bill of Chicagoland Advanced Pain Specialists/Dr. Chami. Bills for service dates from 05-05-11 through 09-01-11 TOTAL $33,647.77. PX 5, p 29-41.

Admitted in evidence as Petitioner's Exhibit Number 6 are the medical records and bill of Lakeshore Surgery Center. Bill for service dates of 6/23/11 through 7/21/11 total $37,990.64. PX 6, p 55-56. Bill for Lakeshore Surgery Center Physicians service dates 06-23-11 through 08-18-11 total $900. PX 6, p 57. Bill for Western Touhy Anesthesia for service dates 6/23/11 through 08-18-11 total $3,690. PX 6, p 58.

Admitted in evidence as Petitioner's Exhibit Number 7 is the bill of Prescription Partners for service dates 05-04-11 and 08-16-11 totaling $2,618.26. PX 7.

Admitted in evidence as Respondent's Exhibit Number 1 is the first report of injury or illness dated April 29, 2011.

Admitted in evidence as Respondent's Exhibit Number 2 is the report dated August 10, 2011 of respondent section 12 examining physician, Dr. Julie Wehner.

Admitted in evidence as Respondent's Exhibit Number 3 are the records of University of Illinois at Chicago University Health Services.

The medical report dated August 10, 2011 of respondent's Section 12 examining physician Julie Wehner, M.D. notes that petitioner gives history of onset of low back and left leg symptoms while unloading 30 to 50 rat cages. The report notes that petitioner denied any previous back problems. Dr. Wehner reviewed medical records of Chicago Advanced Pain Specialists/Dr. Chami, Alevio Physical Therapy and Dr. Barnabas in addition to the University Health Service records and the records of Dr. Rues at Advocate Center. She examined petitioner and found: gait and heel/toe pattern normal; complains of left low back pain with light palpation; no pain with axial compression or axial rotation; can bend to his mid tibia level with his fingertips; extension is 20°; hip range of motion is without pain; straight leg raising is negative; motor strength shows giving way weakness. Dr. Wehner's diagnosis is low back pain while being at work after being off work. She notes there is no specific injury such as a fall or a particular lifting accident. She reviewed the MRI and concluded there were no acute findings therefore the diagnosis is low back pain. She did not see any evidence of a specific injury to his back and concluded he merely felt onset of low back pain while being at work. She indicated the treatment would be 6-12 physical therapy or chiropractic visits. She indicated that petitioner could return to work full duty and there is no need for any further diagnostic or therapeutic intervention. She stated there is no medical need for any type of injection treatment for mechanical low back pain. She concluded he had reached MMI from any particular work related activity as of 03-29-11.

CONCLUSIONS OF LAW

C. Did an Accident Occur That Arose out of and in the Course of Petitioner's Employment by Respondent?

D. What Was the Accident Date?

The weight of credible evidence in this record demonstrates that petitioner returned to work with respondent on March 29, 2011 after 6 to 7 months absence because of a foot injury. He returned to his job as a lab animal caretaker. His job required him to move carts of animal cages and required repetitive bending and lifting of rat cages to transfer the animals from dirty cages to clean cages. Petitioner testified credibly that the job required him to twist his body to the right to reach down to get the dirty cage come back up with the dirty cage and place that in front of him, twist again to reach down to get a clean cage then straighten up to put the clean cage in front of him; change the rats into the clean cage; put the dirty cage back down on the cart, straighten up and then put the clean cage back on the cart. Each rat cage weighs about 10 to 15 pounds. He did 198 cages the first day he returned to work. As he was reaching down turning to the right to pick up a rat cage he felt something pop in his back. Petitioner credibly testified that he thought it was a result of him not having worked in a while so he completed work, went home took a hot bath took some Advil and rested. The next day he returned to work at 7:30 AM on March 30, 2011. He was assigned to the cage room and was again required to work on the belt where equipment is brought in and he would have to reach down to the ground pick up the dirty equipment place it on a stand in the cage room dump the cage and then put the cage back on the belt and continually do that all day long. Towards midday he felt a sharp pain in his back as he was reaching down to get a cage. He thought it was the same as had happened the day before and he continued to work because he needed to work because he had been off for six months because of his foot problem. He did not report that he had pain that day to anybody at work. When he finished work he went home and again took a hot bath and more medication. When he came back to work the next day, March 31, 2011, as he was doing his job he bent down and he felt pain he described like a shot from his back all the way down to the back part of his buttocks down to the knee of his leg. He was unable to continue work and reported the incident to Scott Hauff, his supervisor. He was sent to Health Services at respondent. The record of this first medical treatment at University Health Services on March 31, 2011 reflect history that he returned to work on 3/29/11 was off work from surgery to the left foot. States as of yesterday afternoon now has sharp pain to left side, both extremities and lower back. Pain is eight to back on a scale of 0-10 and is constant. History given that day to Dr Rostow and by petitioner and to all of his medical providers is consistent with his testimony at hearing. But respondent's witness, Scott Hauff, testified that petitioner never advised him about a work injury. He testified he did not ask petitioner why he needed to go to Health Services. He testified that he thought it was because of petitioner's prior foot problem. The arbitrator finds that petitioner testified credibly and consistent with the histories given in the medical records. The arbitrator finds the weight of credible evidence demonstrates that on March 30, 2011 petitioner sustained a work accident which arose out of and in the course of petitioner's employment with respondent.

E. Was Timely Notice of the Accident Given to Respondent?

Petitioner credibly testified that he advised Scott Hauff, the supervisor, on March 31, 2011 that he injured his back and needed to go to Health Services. Scott Hauff, testified that the first time Petitioner reported that he hurt his back at work was a month later on April 28, 2011 or April 29, 2011. Scott Hauff completed a first report of injury or illness report on April 29, 2011. The weight of credible evidence in this record demonstrates that petitioner gave timely notice of the accident to respondent within 45 days of the date of the accident on March 30, 2011.

F. Is Petitioners Current Condition of Ill Being Causally Related to the Injury?

Petitioner had no complaints of low back or leg pain prior to the work accident of March 30, 2011. He had been off work for 6 to 7 months because of a foot injury. However, for three years prior to the accident date petitioner was able to do his job which required repetitive lifting and bending without any complaints of back pain or leg pain. The onset of the symptoms was precipitated by his work activity and as the work activity continued the symptoms were exacerbated to the point where he was unable to proceed with work. History given to all of his medical providers is consistent with the onset of symptoms with the work activity. Dr. Chami and Dr. Barnabas records relate the symptoms and condition to the work activity. Under a chain of events analysis petitioner's condition of ill being of his back is causally related to his work activity. Respondent's section 12 examining physician states there was no specific injury such as a fall or a particular lifting accident. Petitioner testified that initial onset of pain was gradual with work activity on March 29, 2011, on March 30, 2011 midday as he was continuing to do his repetitive lifting and bending he felt a sharp pain come in his back as he was reaching down to get cages. And on March 31, 2011 in the morning as he was bending down to pick up cages he felt a shot of pain in his back all the way down to the back part of his buttocks down to the knee of his left leg. He was unable to continue work. He reported to University Health Service that day and gave history consistent with his testimony at trial. The arbitrator finds that the weight of credible evidence demonstrates that petitioners current condition of ill being of his low back and leg are causally related to the work accident of March 30, 2011.

J. Were the Medical Services That Were Provided to Petitioner Reasonable and Necessary? Has Respondent Paid All Appropriate Charges for All Reasonable and Necessary Medical Services?

Respondent's section 12 examining physician, Dr. Julie Wehner, after review of records and examination of petitioner diagnosed the condition as low back pain which would require 6 to 12 physical therapy or chiropractic visits. Dr. Wehner examined petitioner

on August 10, 2011 after petitioner had undergone a course of three epidural steroid injections on June 9, 2011, June 23, 2011, and on June 21, 2011. Dr. Wehner's examination results reflected improvement derived from the course of epidural steroid injections. The arbitrator finds that the weight of credible evidence in this record demonstrates that all medical treatment provided to petitioner was reasonable and necessary and respondent is ordered to pay the bills of the medical providers subject to the Fee Schedule as follows: University of Illinois at Chicago University Health Services $483.15; Herron Medical Center $1,363.67; Alevio Physical Therapy and Chiropractic LLC $6,135.47; Delaware Place MRI $1,761.73; Chicagoland Advanced Pain Specialists/Dr. Chami $33,647.77; Lakeshore Surgery Center, $37,990.64; Lakeshore Surgery Center, Physicians, $900; Western to Anesthesia $3,690; Prescription Partners $2,618.26.

K. What Temporary Benefits Are in Dispute? TTD.

Petitioner claims TTD from March 31, 2011 through July 15, 2011 and from August 9, 2011 through September 19, 2011. The medical records reflect that petitioner was ordered off work with restrictions March 31, 2011 and that respondent was unable to accommodate the restrictions. The records of University Health Services reflect that medical providers had direct conversations with Scott Hauff regarding respondent's ability to accommodate petitioner's work restrictions and that Scott Hauff indicated he could not accommodate the restrictions. The arbitrator finds that the weight of credible evidence in this record demonstrates that petitioner was off work from March 31, 2011 through July 15, 2011 and from August 9, 2011 through September 19, 2011 as result of the work injury and respondent is ordered to pay TTD for that period.

L. What Is the Nature and Extent of the Injury?

Petitioner's condition of ill being is described in the University of Illinois records as disc herniation and described by Dr. Chami as disc herniation at the level of L5-S1 with a question of involvement of the right S1 nerve root and a disc bulge at the level of L4-5. Medical records reflect findings of radicular symptoms into the left leg. Epidural steroid injections and facet injections were effective in relieving the complaints of severe low back pain and radiation to the left leg. At hearing petitioner testified that if he sits or stands for a long period of time he has an increase in back pain. He performs home exercises which help relieve the pain. He continues get Charlie horses in his lower buttocks and the back of his left leg once or twice a week. He has not seen a physician for his back pain or leg pain since September of 2011. He was released to return to work full duty and did return to work full duty with respondent performing all of his job activities. The arbitrator finds that petitioner sustained work injury on March 30, 2011 resulting in 10% loss man as a whole.

M. Should Penalties or Fees Be Imposed upon Respondent?

In reviewing the totality of the evidence, the Arbitrator has ruled in favor of the Petitioner but writes no penalties on the matter for the following six reasons. First, the timing of the work accident would raise an eyebrow of any trier of fact. The Petitioner had just returned work after being off for seven months due to a bunionecomy that was unrelated the work accident. The Petitioner had returned to work only because he ran out of disability. Second, the mechanism of injury as described by the Petitioner was poorly articulated at trial. Third, the first clear medical history of the accident was delayed and did not show itself in the medical records until over a month after the occurrence. Fourth, the Respondent had some medical basis to deny the claim by obtaining a Section 12 exam. Fifth, the Petitioner was uncertain as to the date of the accident. Sixth, the Petitioner had a prior back problem that he received medical attention for in 2008, but denied ever having doing so. As a result of the above, no penalties are awarded on this matter.

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

Gale Peters,

Petitioner,

vs.

NO: 12 WC 10256

MBI,

Respondent,

14IWCC0990

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed March 24, 2014 is hereby affirmed and adopted.

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: NOV 19 2014

Mario Basurto

David L. Gore

Stephen Mathis

MB/mam
o:9/24/14
43

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

PETERS, GALE
Employee/Petitioner

Case# **12WC010256**

14IWCC0990

MBI
Employer/Respondent

On 3/24/2014, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

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

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

2795 HENNESSY & ROACH PC
DAVID A DOELLMAN
415 N 10TH ST SUITE 200
ST LOUIS, MO 63101

14IWCC0990

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)

Gale Peters
Employee/Petitioner

v.

MBI
Employer/Respondent

Case # **12** WC **010256**

Consolidated cases: **N/A**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Nancy Lindsay**, Arbitrator of the Commission, in the city of **Collinsville, IL**, on **January 27, 2014**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

14IWCC0990

FINDINGS

On the date of accident, **02/10/12**, 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 **$57,200.00**; the average weekly wage was **$1,100.00**.

On the date of accident, Petitioner was **48** years of age, ***single*** 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** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$0**.

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

ORDER

Petitioner failed to prove he sustained an accident on February 10, 2012 that arose out of and in the course of his employment or that his condition of ill-being in his shoulders is causally related to his employment or his accident of February 10, 2012. Petitioner's claim is denied and no benefits are awarded.

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

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

Nancy Lindsay
Signature of Arbitrator

02/20/2014
Date

ICArbDec19(b)

MAR 24 2014

Findings of Fact and Conclusions of Law

At the time of arbitration Respondent requested leave to file a response to Petitioner's Petition for Immediate Hearing within the time period for submitting proposed decisions. Leave was granted. A copy of Respondent's Response to Petitioner's Petition for Immediate Hearing has been marked as "AX 7" and included in the record. In addition, the parties entered into a stipulation after the arbitration hearing was concluded in which they agreed that Petitioner's Application for Adjustment of Claim should be amended to allege bilateral shoulder injuries. A copy of the "Agreement" has been marked as "AX 6" and made a part of the record. Per their joint request Petitioner's Application for Adjustment of Claim has been amended instanter to allege bilateral shoulder injuries.

The Arbitrator finds:

The medical records from Petitioner's primary care physician, Dr. Harms, were admitted into evidence. Petitioner began seeing Dr. Harms in 2007. Between then and February 10, 2011, there are no records reflecting any visits with Dr. Harms regarding either of Petitioner's shoulders.

The records do indicate that Dr. Harms saw Petitioner on February 11, 2011 in "follow up" for bilateral shoulder pain described as sharp, aching, and radiating. He noted, "There was no injury." Petitioner reported his pain was aggravated by climbing (and descending) stairs, lifting, pushing, sitting and standing. Petitioner's other symptoms included decreased mobility, night pain, night-time awakening and tenderness. Pertinent "negatives" included locking, popping, spasms, swelling and weakness. Petitioner also reported his condition was markedly improved since he no longer tarped vehicles. Petitioner was now driving over the road and having improved success. On examination Petitioner was tender to palpation over his bilateral upper outer arms and had minimal signs of impingement. Petitioner's condition was recorded as "chronic." Petitioner was given a note "To Whom It May Concern" that the doctor was currently treating him and he could return to work but with no changing of tires or use of an air impact wrench." (PX 2; RX A)

Petitioner returned to see Dr. Harms on August 22, 2011, regarding his hunting permit. Dr. Harms noted Petitioner's "longstnading [sic] [history] of bilateral shoulder pain and referenced his prior recommendations for orthopedic evaluation and follow-up. Petitioner's condition was listed as a limitation for his bowhunting permit and he displayed positive impingement signs but no evidence of a tear. (PX 2; RX A)

Petitioner next saw Dr. Harms on February 10, 2012 reporting ongoing difficulty with pain in his shoulders bilaterally. Petitioner reported significant discomfort when raising his arms above the head but he denied any shoulder instability. Dr. Harms noted Petitioner's past evidence of impingement syndrome and that he "[w]orks very physical work." On examination Petitioner had full range of motion at the shoulder and marked impingement signs but no laxity or instability noted. Dr. Harms' assessment was chronic impingement syndrome. He referred Petitioner to Dr. Omotola for further evaluation.

Petitioner presented to Dr. Omotola on March 7, 2012. In conjunction with the examination Petitioner completed an Orthopedic History form in which he stated his shoulders had been bothering him for three months with a worsening in the previous month. Petitioner reported that the problem began at work and he was a truck driver. (PX 3)

When seen by Dr. Omotola, Petitioner reported a three month history of persistent and progressive pain in both shoulders which was interfering with his sleep at night. Petitioner also advised that he had been noting a "popping sensation" in both shoulders, especially with overhead reaching, in the past month. Petitioner also described being required to climb a ladder on an 18-wheeler semi truck multiple times throughout the day and that this caused increased discomfort. Following x-rays and a physical examination, Dr. Omotola assessed Petitioner with impingement syndrome and biceps tenodesis bilaterally as well as a possible rotator cuff tear in his left shoulder. Petitioner received a Cortisone injection in his right shoulder at that time, and Dr. Omotola recommended an MRI of the left shoulder be obtained. (PX 3)

Petitioner returned to see Dr. Harms again on December 3, 2012 for several issues, including his shoulder pain. At that time Dr. Harms noted Petitioner had no change in baseline symptomatology and "marked soreness with phsyical [sic] labor/work in waste management." Dr. Harms assessed Petitioner's condition as impingement syndrome with no change of symptomology. Again, Petitioner was given pain medication. (PX 2; RX A)

At the request of Respondent Petitioner underwent an examination with Dr. Nogalski on May 29, 2013.

Dr. Omotola's deposition was taken on August 16, 2013. (PX 1) Dr. Aaron Omotola is board certified in sports medicine and orthopedic surgery. Dr. Omotola confirmed that he only saw Petitioner on one occasion – March 7, 2012. As such, he admitted he was relying on his records and the information provided by Petitioner. Dr. Omotola testified that if this information was inaccurate it could change his opinions.

Dr. Omotola testified that at the time of his evaluation, Petitioner presented with complaints of bilateral shoulder pain. Petitioner told him his shoulder problems have been present for three months and had become worse in the last month. Dr. Omotola stated that Petitioner described his work activities as being a truck driver and that he climbed up and down ladders at work. However, he could not recall whether Petitioner described any additional work activities at the time of his evaluation, nor could he recall whether he reviewed a written job description.

Dr. Omotola performed a physical examination as part of his evaluation of Petitioner and his formal diagnosis was bilateral impingement syndrome and biceps tendonitis along with a possible rotator cuff tear in the left shoulder. He recommended an MRI of the left shoulder for further evaluation and also administered an injection in Petitioner's right shoulder.

Dr. Omotola further acknowledged that he did not know if Petitioner underwent the MRI. In addition, with respect to the injection, Dr. Omotola testified that normally this would provide relief in approximately one week. However, in this instance since Petitioner did not follow up with him for additional treatment, he had no idea whether this injection provided any

relief. Dr. Omotola further stated he had no idea why Petitioner did not follow up with an additional appointment. (PX 1)

Dr. Omotola also testified that since he had not seen the Petitioner for over a year and a half, he was unaware of any current complaints of pain that Petitioner might be having. In addition, he was unaware of Petitioner's day to day difficulties or any problems he might be having at work. Dr. Omotola went as far as to state he was not even aware if Petitioner was still working at this point in time, or if Petitioner was even alive. He also admitted that, hypothetically, it was possible that Petitioner's condition could have improved since his evaluation, and that his recommendations could change based on Petitioner's current condition. (PX 1)

During his deposition, Dr. Omotola was presented with a hypothetical set of facts regarding alleged work activities of Petitioner. He was then asked within a reasonable degree of medical certainty, if he had an opinion as to whether those work activities might have caused or aggravated the condition diagnosed as bilateral shoulder pain. The extent of the explanation Dr. Omotola gave with respect to his opinion was a single word, "yes." (PX 1, p. 14)

Finally, Dr. Omotola testified that Petitioner would need further diagnostic evaluation of his left shoulder and this would be causally related to the activities described in the hypothetical. In addition, the treatment that was provided at the time of March 2012 would also be related to the work activities. (PX 1, p. 15)

Dr. Nogalski was also deposed. He is an orthopedic surgeon who is board certified and has been practicing for approximately 20 years in the St. Louis area. Dr. Nogalski indicated that approximately 40% of his practice is due to shoulder related issues. He sees approximately 60 to 80 patients a week and performs surgery on average of six to ten times per week. He also estimated approximately 5% of his patients have bilateral shoulder problems, often related to intrinsic issues that are not specifically related to a discreet injury, including metabolic problems, frozen shoulders, thyroid problems, diabetes, and nerve problems. (RX B)

Dr. Nogalski testified that he evaluated Petitioner on May 29, 2013 at the request of the employer and its insurance company. Petitioner described his alleged work injuries and Dr. Nogalski testified that he also questioned Petitioner as to his medical history. Initially, Petitioner only recalled seeing Dr. Harms for care. However, Dr. Nogalski then specifically reminded Petitioner he has been Dr. Omotola, and Petitioner then recalled seeing him after being prompted. (RX B)

Regarding Petitioner's job activities, Dr. Nogalski testified that Petitioner continued to work at his regular job. Petitioner believed his activities involved climbing on waste, hauling trucks, and then rolling a tarp over the load on the truck. Specifically, Petitioner indicated he would roll the tarp out and then walk behind it as it was unrolled. In addition, he informed Dr. Nogalski that he had to drive a large container truck with multiple stops throughout the day and then also engage in tarping and unloading the waste material. Petitioner estimated he had to do this type of activity approximately 12 to 18 times per day.

After his physical examination and review of Petitioners' medical records, Dr. Nogalski indicated he did not believe Petitioner sought any treatment since being evaluated by Dr. Omotola on March 7, 2012. He reached a diagnosis of bilateral shoulder pain with probable mild to moderate rotator cuff tendonopathy. However, there were no clear findings suggesting significant impingement on exam or on the x-ray. Dr. Nogalski also testified that Petitioner symptoms were vague and nebulous due to the fact he did not have good classic findings in the exam for the impingement process. In addition, he also believed Petitioner was being evasive during the exam. He testified that obtaining accurate information regarding a patient's symptoms was important, as this helps to make a clear medical determination regarding diagnoses and treatment options. (RX B)

Dr. Nogalski testified he did not believe the work injury or claimed injury of February 10, 2012 was a cause or specific aggravation of the shoulder conditions, nor did he believe that his occupational activities were the cause for any aggravation of Petitioner's shoulder conditions as observed at the time of his examination. Specifically, he could not say within a reasonable degree of medical certainty that the job activities which Petitioner described were a greater stress on his shoulders than activities of daily living. (RX B)

Dr. Nogalski also did not believe that climbing up and down the side of a semi-truck 12 to 18 times a day placed Petitioner at a greater risk of injury to his shoulders than daily living activities. In addition with respect to the tarp, Dr. Nogalski indicated it would not matter how much the tarp weighed, but instead how much force Petitioner had to use to push the tarp. Nevertheless, he testified that he could not say that rolling the tarp such as Petitioner described, especially below shoulder level, would be a greater stress on the shoulders. (RX B)

Dr. Nogalski did believe that Petitioner's treatment received was reasonable and necessary; however, he did not believe that this was needed as a result of the work injury or his work activities. Dr. Nogalski further opined Petitioner did not need any additional treatment as related to Petitioner's work activities or the claimed injury. He also did not believe Petitioner required any work restrictions. (RX B)

At arbitration Petitioner testified he is currently 58 years old and employed by Respondent, a trash hauling outfit. Petitioner drives a semi-truck hauling waste and doing "transfers." Petitioner testified that on a day to day basis he climbs in and out of the semi about six times. Petitioner also testified that he climbed up and down the ladder on the waste containers located behind the semi twelve times (or 12 - 18 times per day total climbing up or down the truck or ladder). Petitioner testified he uses his arms to pull himself up and into the truck as there are two steps and a bar to grab hold of.

Petitioner further testified that he has to get on top of the trailer to place a fifty-three foot long tarp over the trailer contents (trash) so it doesn't fly out onto the road. To do this, Petitioner removes the tarp from a holder situated in front of the trailer behind the semi cab. Petitioner is on a ladder using his arms to push the tarp up on top of the trailer so he can roll it on by hand. According to Petitioner the tarp can vary in weight from 50 - 100 lbs. as it becomes heavier with certain weather conditions (ex. rain). Petitioner testified that once he has pushed the tarp to the top of the trailer, he then gets on top of the trailer and assumes a "bent knee position" (like hiking a football) and begins rolling out the tarp across the uneven trash surface. Once the tarp is laid out Petitioner steps down on another ladder, braces

himself with his left arm and pulls with his right arm to clip the tarp down on one side (rubber tie downs). He then reverses the process to clip down the other side. Petitioner testified that, altogether, he hooks 28 clips.

Petitioner also testified that he believed when the tarp was completely rolled up, it was approximately a half of a foot in thickness. Petitioner confirmed that when unrolling and rolling up the tarp, he would be reaching downwards. Petitioner testified that he handles six loads a day.

Petitioner testified that he has been performing these same job activities since 2002.

Early in his testimony Petitioner was asked if he had any problems with his arms or shoulders between the time he started with Respondent in 2002 and until around 2012. Petitioner testified, "No."

Petitioner was later asked to describe what he noticed about his shoulders between 2010 and February of 2012 to which Petitioner responded he was coming off the ladder "like a couple of years ago" and noticed a pop which kept getting worse over time in his left arm. The Arbitrator notes that as Petitioner attempted to continue his testimony on this subject (something about tendinitis and trouble lifting his arm up) his attorney stopped him and directed his attention to the year or so before his claimed accident date of February 10, 2012. When asked if he noticed anything about his shoulders while unrolling tarps in the "year or so" before February 10, 2012 Petitioner testified he noticed his shoulder blades were weak and he couldn't lift his arm up very far, and "it just kept on getting worse."

Petitioner subsequently testified that on February 10, 2012 he was coming off the ladder swinging and holding and he noticed an "unusual pop" in his left shoulder. Petitioner testified that he told his supervisor, David Bults, who told him to "take it to Blue Cross and Blue Shield." Petitioner testified he completed an accident report.

Petitioner testified that after the alleged incident of February 10, 2012 he was seen at Alton Memorial Hospital for treatment. Petitioner also testified that he received an injection into his right shoulder while at the hospital. He further testified that he was told his left shoulder couldn't be injected because it was "more out of place."

Petitioner also testified that he saw his family physician, Dr. Harms, that same day and acknowledged that he had seen Dr. Harms before for shoulder problems. Petitioner denied being referred to an orthopedic surgeon or needing anything more for his shoulder than medication prior to February 10, 2012.

Petitioner testified Dr. Harms then referred him to Dr. Omotola for further treatment. Dr. Omotola administered a right shoulder cortisone injection and also recommended an MRI of the left shoulder. Petitioner, however, testified he did not have the MRI performed and did not seek out any additional treatment for his shoulders since Dr. Omotola's evaluation. Petitioner could not recall if Dr. Omotola ever discussed surgery with him. He recalled discussing his job with the doctor and his staff and, according to Petitioner, they were "almost positive" his problem was work-related. Petitioner testified he got a right shoulder cortisone injection which only lasted two months and Dr. Omotola has recommended an MRI but it hasn't been approved.

Petitioner also testified as to hunting regularly during shotgun season for three days per year. Petitioner indicated he rests the shotgun under his right arm.

Petitioner testified that he finds vibrations and shifting gears at work to be painful to his shoulders. Petitioner shifts with his right arm. Petitioner also testified that his shoulders have continued to worsen since the last time he saw Dr. Omotola. He has trouble washing his hands or putting on a t-shirt. Petitioner sleeps in a recliner to avoid sleeping on his shoulders.

Petitioner underwent his DOT physical in December of 2012. Petitioner continues to work full duty for Respondent and hasn't missed any time from work. In his own words, he is "just barely performing."

Petitioner denied any further injuries to either shoulder since February of 2012.

The Arbitrator concludes:

WITH RESPECT TO DISPUTED ISSUES (C) AND (F) AND WHETHER PETITIONER SUSTAINED AN ACCIDENT THAT AROSE OUT OF and IN THE COURSE OF HIS EMPLOYMENT WITH RESPONDENT; AND WHETHER PETITIONER'S CURRENT CONDITION OF ILL-BEING IS CAUSALLY RELATED TO THE INJURY:

Petitioner failed to prove he sustained an accident on February 10, 2012 that arose out of and in the course of his employment with Respondent. Furthermore, even if Petitioner proved accident, Petitioner failed to prove that his current conditions of ill-being in his shoulder are causally related to his work activities and/or the claimed work accident of February 10, 2012.

Petitioner's Application for Adjustment of Claim alleges repetitive trauma; however, Petitioner testified to a very specific event on February 10, 2012 -- coming down the ladder and noticing an "unusual pop" in his left shoulder. He said nothing about his right shoulder. Petitioner claims an accident report was completed; however, it was not admitted into evidence. Petitioner testified he went to Alton Memorial Hospital for treatment to both shoulders but that record is not in evidence. Petitioner then "followed up" with his family doctor, Dr. Harms. He denied any injury. Finally, when seen by Dr. Omotola, Petitioner says nothing about a specific accident on February 10, 2012 involving both shoulders. Additionally, his presenting history is completely at odds with the medical records in evidence. Petitioner's problems did not begin in January of 2012; as Dr. Harms' records illustrate, they go back to February of 2011. In sum, Petitioner's testimony concerning an accident on February 10, 2012 is not credible as it was not corroborated by, or consistent with, the medical records.

The Arbitrator further notes that other aspects of Petitioner's testimony also negated his credibility. For example, he clearly denied any shoulder or arm problems between the time he began working for Respondent and early 2012 and then later on acknowledged having problems with his shoulder(s) prior to 2012 -- as early as 2010. Dr. Harms' records also show well documented problems with Petitioner's shoulders prior to February of 2012.

Petitioner also testified that throughout the time he worked for Respondent his job duties included "tarping" and, yet, Dr. Harms' records clearly indicate that in 2011 Petitioner was not engaged in that particular activity. Under these circumstances, Petitioner's testimony alone does not suffice to prove accident because it was contradicted by itself and by the medical records submitted into evidence.

On the issue of causation the Arbitrator notes the opinion of Dr. Omotola which was based upon inaccurate information and history. Petitioner did not describe his job activities in detail as he did with Dr. Nogalski. Dr. Omotola acknowledged during his deposition that Petitioner only described his activities as being a truck driver and climbing up and down ladders. He did not recall any additional work activities described or reviewing a written job description.

The Arbitrator also notes that Dr. Omotola's causation opinion was limited to a single word, "yes," in response to a hypothetical posed by Petitioner's attorney. Dr. Omotola did not explain the basis for his causation opinion. As such the Arbitrator does not find Dr. Omotola's single-word causation opinion to be sufficient for Petitioner to be entitled to medical benefits and prospective medical care in this instance. Moreover the Arbitrator notes the specifics of Petitioner's attorney's hypothetical to Dr. Omotola were not verified through the evidence submitted at trial. Dr. Omotola was asked about causation based upon a repetitive trauma theory (PX 1, p. 13) and not on a specific trauma theory as testified to by Petitioner. Additionally, the "facts" contained in the hypothetical were not established at trial.

Even, assuming arguendo, that Petitioner could establish a manifestation date for a repetitive trauma accident, Petitioner's claim must be denied as he failed to prove his bilateral shoulder condition was caused by his work duties and arose out of his employment with Respondent as Dr. Omotola's causation opinion is unpersuasive and premised upon inaccurate information regarding Petitioner's medical history and onset of problems.

For the forgoing reasons Petitioner's claim for compensation is denied and no benefits are awarded. All other issues are moot.

****

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

Douglas Coffey,

Petitioner,

vs.

State of Illinois/Menard Correctional Center,

Respondent,

NO: 13 WC 17872

14IWCC0991

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of permanent partial disability, causal connection, and credit from Illinois Workers' Compensation claim in case number 11WC 1100 and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed March 7, 2014 is hereby affirmed and adopted.

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

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

No bond or summons for State of Illinois.

DATED: NOV 19 2014

Mario Basurto

David L. Gore

Stephen Mathis

MB/mam
o:9/25/14
43

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

COFFEY, DOUGLAS
Employee/Petitioner

Case# **13WC017872**

14IWCC0991

SOI/MENARD CORRECTIONAL CENTER
Employer/Respondent

On 3/7/2014, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.08% 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:

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

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

0558 ILLINOIS ATTORNEY GENERAL
FARRAH L HAGAN
601 S UNIVERSITY AVE SUITE 102
CARBONDALE, IL 62901

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

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

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

MAR 07 2014

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

14IWCC0991

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

DOUGLAS COFFEY
Employee/Petitioner

v.

STATE OF ILLINOIS/
MENARD CORRECTIONAL CENTER
Employer/Respondent

Case # 13 WC 17872

An *Application for Adjustment 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 **Herrin**, on **January 15, 2014**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **April 18, 2013**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$57,369.00**; the average weekly wage was **$1,103.25**.

On the date of accident, Petitioner was **29** years of age, ***married*** with **3** dependent children.

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

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

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

Respondent is entitled to a credit for all medical bills paid under Section 8(j) of the Act.

ORDER

Respondent shall pay Petitioner permanent partial disability benefits of $661.95/week for 63.25 weeks because the injuries sustained caused the 12.65% loss of use of the person as a whole pursuant to Section 8(d)2 of the Act. Respondent's request for credit for a prior award on the basis of a Section 8(e) injury in Case Number 11 WC 1100 is denied.

Respondent shall pay Petitioner compensation that has accrued from October 16, 2013 through January 15, 2014, and shall pay the remainder of the award, if any, in weekly payments.

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

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

Signature of Arbitrator

03/04/2014
Date

MAR 7 - 2014

14IWCC0991

STATE OF ILLINOIS)
)SS
COUNTY OF WILLIAMSON)

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

DOUGLAS COFFEY
Employee/Petitioner

v. Case # 13 WC 17872

STATE OF ILLINOIS/
MENARD CORRECTIONAL CENTER
Employer/Respondent

MEMORANDUM OF DECISION OF ARBITRATOR

FINDINGS OF FACT

At the time of the undisputed accident, Petitioner, Douglas Coffey, was a right-hand-dominant 29-year-old Correctional Officer. He sustained a right supraspinatus tendon tear on April 18, 2013, when his right arm became pinned underneath another officer during an inmate assault. (Petitioner's Exhibit (PX) 5). Petitioner testified to a prior right shoulder injury which he sustained while playing high school sports in 2001. He testified that he recovered fully and had no further right shoulder problems until the incident of April 18, 2013.

Petitioner sought treatment with Dr. George Paletta, who recommended an MRI. Dr. Paletta noted that if there was no significant structural injury, such as a tearing, then Petitioner could benefit from conservative care such as injection and physical therapy; however, if Petitioner sustained a significant tear of an aspect of his rotator cuff, then he would be a surgical candidate. (PX 4). Following the results of the MRI, which showed partial thickness tearing of the supraspinatus tendon of the rotator cuff, Petitioner underwent a rotator cuff repair with debridement on July 9, 2013. (PX 5; PX 6). The post-operative diagnosis was right shoulder pain, rotator cuff tear, and impingement syndrome with subacromial bursitis, as well as a labral tear of the posterior-superior labrum. (PX 6). Petitioner's condition improved following physical therapy, and he was released to return to work light duty on August 12, 2013, and full duty on October 16, 2013. (PX 5).

Petitioner testified that despite the improvement from surgery, he continues to experience soreness and stiffness in the mornings and in the evenings after a full day's work. He testified that these symptoms significantly disturbed his ability to sleep, and that he wakes through the night to change positions in the attempt to get comfortable. He testified that he has suffered a loss of range of motion and strength which negatively affects his ability to care for his family and his hobby of coaching little league baseball. He takes Aleve or Ibuprofen on a daily basis for his symptoms.

CONCLUSIONS OF LAW

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

Based upon the medical records and testimony, Petitioner's right shoulder condition is causally related to the accident on April 18, 2013.

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

Issue (N): Is Respondent due any credit?

Petitioner's date of accident after September 1, 2011, and therefore Section 8.1b of the Act shall be discussed concerning the permanent partial disability (PPD) award being issued. It is noted when discussing the permanency award being issued that no PPD impairment report pursuant to Sections 8.1b(a) and 8.1b(b)(i) of the Act was offered into evidence by either party. This factor is thereby waived.

Concerning Section 8.1b(b)(ii) of the Act (Petitioner's occupation), Petitioner continues to be employed as a Correctional Officer for Respondent, and he continues to be at risk for injury due to inmate assaults. The Arbitrator places great weight on this factor when determining the permanency award.

Concerning Section 8.1b(b)(iii) of the Act (Petitioner's age at the time of the injury), Petitioner was 29 years old on April 18, 2013. The Arbitrator considers Petitioner to be a younger individual, who will have to live and work with the disability longer than an older individual. Great weight is afforded this factor when determining the PPD award.

Concerning Section 8.1b(b)(iv) of the Act (Petitioner's future earning capacity), there is no direct evidence of diminished future earning capacity in the record. Accordingly, no weight is placed on this factor when determining the PPD award.

With regard to Section 8.1b(b)(v) of the Act (evidence of disability corroborated by Petitioner's treating medical records), Petitioner sustained a right supraspinatus tendon tear which necessitated a rotator cuff repair with debridement on July 9, 2013. The post-operative diagnosis was right shoulder pain, rotator cuff tear, and impingement syndrome with subacromial bursitis, as well as a labral tear of the posterior-superior labrum. Petitioner testified that despite the improvement from surgery, he continues to experience soreness and stiffness in the mornings and in the evenings after a full day's work. He testified that these symptoms significantly disturbed his ability to sleep, and that he wakes through the night to change positions in the attempt to get comfortable. He testified that he has suffered a loss of range of motion and strength which negatively affects his ability to care for his family and his hobby of coaching little league baseball. He takes over-the-counter pain medication daily for his symptoms. Although the record of Petitioner's last visit with Dr. Paletta on October 16, 2013 does not completely mirror Petitioner's testimony at trial, Petitioner was not released to work full-duty until that very day of October 16, 2013; the record of Petitioner's final visit shows that Petitioner had resumed neither his full occupational duties nor his non-occupational activities. Petitioner confirmed same during cross-examination. Therefore, neither Petitioner nor Dr. Paletta could have had a true and accurate impression of the extent of Petitioner's permanent disability or working functionality at the time of the October 16th visit. Hence, Petitioner's testimony of continued symptoms following his return to full activity is reasonable. The Arbitrator places significant weight on this factor when determining the PPD award.

Based upon the foregoing, the Arbitrator finds that Petitioner sustained serious and permanent injuries that resulted in the 12.65% loss of the person as a whole, the equivalent of the 25% loss of an arm, pursuant to *Will County Forest Preserve Dist. v. Ill. Workers' Comp. Comm'n*, 2012 IL App (3d) 110077WC, 970 N.E.2d 16, 23-24, (3d Dist. 2012). With regard to the credit Respondent requests for a previous arm award received by Petitioner, the Arbitrator finds that such a request is not permissible under the Act. As the Commission noted in *Dobczyk v. Lockport Township Fire Protection Dist.*, 12 IWCC 1367 (Dec. 10, 2012), in the matters of *Consolidated Freightways v. Industrial Comm'n*, 237 Ill. App. 3d 549, 553-554, 604 N.E.2d 962, 964-965 (3d Dist. 1992), and *Killian v. Industrial Comm'n*, 148 Ill. App. 3d 975, 978, 500 N.E.2d 450, 453 (1st Dist. 1986), the Appellate Court narrowly construed Section 8(e) of the Illinois Workers' Compensation Act, 820 ILCS 305/1 *et seq*. (hereafter the "Act") as only providing credit against permanency for losses to a "member" listed under Section 8(e); since a shoulder is not a "member" under Section 8(e), the Commission stated that the employer could not claim credit for a prior recovery under Section 8(e)17 of the Act. *Dobczyk*, cited *supra*. Similarly, Respondent cannot claim credit for payment of an award for a scheduled injury against an award under Section 8(d)2 of the Act for which no credit provision exists. Respondent's request for credit is 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

Steve Maynard,
Petitioner,

vs.
Danville Housing Authority,
Respondent,

NO: 12 WC 25946

14IWCC0992

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 the nature and extent of petitioner's disability, and whether the award should be based on §8(e) or 8(d)2 of the Act 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 10, 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: NOV 19 2014

Mario Basurto

David L. Gore

Stephen Mathis

MB/mam
o:9/24/14
43

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

MAYNARD, STEVE
Employee/Petitioner

Case# **12WC025946**

14IWCC0992

DANVILLE HOUSING AUTHORITY
Employer/Respondent

On 1/10/2014, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.08% 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:

1551 STOKES LAW OFFICES
GARY J STOKES
200 N GILBERT
DANVILLE, IL 61832

RUSIN MACIOROWSKI & FRIEDMAN LTD
MARK COSIMINI
2506 GALEN DR SUITE 108
CHAMPAIGN, IL 61821

14IWCC0992

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
NATURE AND EXTENT ONLY

Steve Maynard
Employee/Petitioner

v.

Danville Housing Authority
Employer/Respondent

Case # **12** WC **025946**

Consolidated cases: **N/A**

The only disputed issue is the nature and extent of the injury. An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Douglas McCarthy**, Arbitrator of the Commission, in the city of **Urbana**, on **December 20, 2013**. By stipulation, the parties agree:

On the date of accident, **03/20/12**, Respondent was operating under and subject to the provisions of the Act.

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

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

Timely notice of this accident was given to Respondent.

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

In the year preceding the injury, Petitioner earned **$25,812.80**, and the average weekly wage was **$496.40**.

At the time of injury, Petitioner was **59** years of age, ***married*** with **1** dependent children.

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

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

ORDER

Respondent shall pay Petitioner the sum of **$297.84**/week for a further period of **87.5** weeks, as provided in Section **8(e) and 8(d)(2)** of the Act, because the injuries sustained caused a **17.5% loss of use of the person as a whole.**

Respondent shall pay Petitioner compensation that has accrued from **03/20/12** through **12/20/13**, and shall pay the remainder of the award, if any, in weekly payments.

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

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

D. Dylan McCarthy
Signature of Arbitrator

Jan. 3, 2014
Date

JAN 10 2014

In support of the Arbitrator's decision relating to the nature and extent of the injury, the Arbitrator makes the following findings:

On the date of accident Petitioner was a 59 year old renovation specialist for the Danville Housing Authority. Petitioner's job was to repair housing units or apartments and generally prepare them for the occupants of public housing. Petitioner's job duties included stripping and scrubbing floors, mopping and waxing, hanging doors, hanging, finishing and painting drywall and installing or repairing plumbing and electrical within the apartments.

Prior to the date of accident Petitioner had never experienced any problems with his right arm and shoulder. Petitioner is right-hand dominant and he typically performed overhead duties like painting, changing light fixtures, etc. without problems of any sort. Petitioner had never experienced weakness in the right upper extremity or seen a physician for any complaint relative to the right shoulder or right arm.

On March 20, 2012, Petitioner was cleaning out an apartment. Petitioner carried a set of metal bed rails out to the dump truck. When Petitioner tried to throw the rails onto the truck he experienced a sharp pain in his right shoulder. Petitioner finished his shift, however, his right shoulder continued to hurt so he reported the injury to his work. On the following day the right shoulder pain persisted and Petitioner asked for permission to see a physician. Respondent sent Petitioner to see Dr. Allison Jones at the Carle Clinic (PX1).

Dr. Jones initially diagnosed an acute shoulder strain, ordered work restrictions and directed Petitioner to take Tylenol and Advil (PX1). When Petitioner's pain failed to improve, Dr. Jones referred Petitioner to an orthopedic surgeon, Dr. Paul Plattner. Dr. Plattner injected Petitioner's right should and ordered an MRI of Petitioner's right arm and shoulder (PX2).

The MRI report of April 17, 2012 reported a "complete tear of the supraspinatus tendon with a large fluid gap. . . . The long head of the biceps tendon is severely torn with little if any appreciable intact tendon within the bicipital groove . . ." (PX3). Dr. Plattner recommended surgery. Respondent, in turn, scheduled an independent medical examination with another orthopedic surgeon, Dr. Mitchell Rotman, in St. Louis.

Petitioner saw Dr. Rotman on May 10, 2012. Dr. Rotman's report included the following findings "He most likely sustained a biceps rupture which was not completely visualized at the time of the initial exam, but was made apparent later on. He might have had a few fibers of intact biceps initially after the incident and then those fully ruptured especially after the steroid injection was given . . ." (PX4, p.4). In addition to the ruptured biceps tendon, Dr. Rotman confirmed that Petitioner sustained a tear of the rotator cuff in his right shoulder. Though Dr. Rotman believed the thinness of the rotator cuff tissue may have pre-existed the incident, "This particular incident on March 20, 2012 would be equivalent to the straw that broke the camel's back." (PX4, p. 4). Dr. Rotman described the tear as ". . . a good sized tear, greater than a half dollar, and may not even be repairable." (PX4, p. 4).

Petitioner felt more comfortable with Dr. Rotman and agreed to let him perform the right shoulder surgery. Surgery was performed on June 13, 2012. Dr. Rotman described the surgery as a subacrominal decompression and rotator cuff repair with the placement of anchors and sutures through holes in the greater tuberosity. He was able to reattach the torn tendon to its normal insertion point. He went on to describe some fraying of the biceps tendon, which he treated by debridement. (PX5).

Petitioner participated in approximately six months of post-operative physical therapy and work hardening before being released from care in January, 2013 (PX6-9). Dr. Rotman, in his final exam, noted Petitioner's ongoing weakness and losses in range of motion (PX9). Though Dr. Rotman thought Petitioner might see

improvement in both areas over the succeeding six months, Petitioner testified that there has been no improvement.

On August 5, 2013 Petitioner was sent by Respondent to Dr. Richard Katz, for an AMA impairment rating (RX1). Dr. Katz noted Petitioner's ongoing weakness, pain and diminished range of motion in the right arm and shoulder. Petitioner completed a Quick Dash Report, at Dr. Katz' instruction, acknowledging moderate to severe difficulty in nine of the eleven relevant activities (PX11). Dr. Katz assessed Petitioner's AMA impairment rating to be 6% of the arm (RX1). The highest impairment rating available under the AMA guidelines for full thickness tears of the rotator cuff is 7% (PX10, p. 3).

Petitioner testified to the ongoing difficulties he has experienced since being released from care by Dr. Rotman in January, 2013. Petitioner now suffers constant pain in his right upper extremity at a level of approximately '2' on a 0 to 10 scale with pain progressing to a '4' while performing his daily job duties. Petitioner takes Advil and hot showers to moderate his pain.

Normal daily activities have been compromised significantly. Petitioner now uses his left arm and hand, for instance, to lift milk containers from the refrigerator or to snap his seat belt in the car. Petitioner notices the right arm and shoulder are too weak to do either. Petitioner has difficulty dressing him-self and washing his hair because of losses in the normal range of motion in the right arm and shoulder. Pain and numbness in the right arm and right shoulder interrupt Petitioner's sleep. Petitioner can no longer bowl or play catch with his 15 year old son because of pain in the right shoulder.

Petitioner notices considerable difficulties at work as well. He said that although he was released without restrictions by Dr. Rotman, the Respondent allowed him to perform lighter work for an unspecified period of time. Installing a light bulb causes extreme fatigue in the right arm and shoulder if performed overhead. Petitioner must now use his left upper extremity to lift lids on garbage containers and place trash into the containers. Using a screw driver or drill with his right hand and arm causes his biceps to immediately tighten and appear deformed. Petitioner estimates that he now performs three times more with his left arm and hand then he did before the injury. Petitioner credibly testified that he experienced none of these problems prior to the accident and injury on March 20, 2012. Petitioner also acknowledged that his pay had increased due to an across the board raise since his return to work.

For injuries occurring on and after September 1, 2011 the Commission shall base its determination of permanent partial disability on five listed factors:

(1) Reported level of impairment in accordance with the AMA impairment ratings. Petitioner was judged by Respondent's medical evaluator to have a six percent (6%) AMA impairment rating of the upper extremity. Seven percent (7%) impairment of the arm is the maximum impairment rating available in cases of full thickness rotator cuff tears (PX10).

The Arbitrator has some issues with the impairment rating found by Dr. Katz. The rating is premised on the Petitioner having a normal range of motion in the right shoulder. In his exam, Dr. Katz reported such a finding. However, it appears from the report, that Dr. Katz only tested the Petitioner's right shoulder. The AMA Guides require the examiner to test both shoulders so as to accurately determine what is normal for each individual. See AMA Guide, Sixth Edition, Section 15.7 (a), p. 461. More importantly, Dr. Katz' numbers are inconsistent with those found on several occasions by Dr. Rotman, who did examine both shoulders. On January 28, 2013, Dr. Rotman found 140 degrees of flexion and abduction of the right shoulder and 150 on the left. He found 45 degrees of external rotation on the right shoulder and 60 degrees on the left. (PX 9)

The Arbitrator cannot see how Dr. Katz was able to produce 180 degrees of flexion and 90 degrees of external rotation during his exam. Those numbers greatly exceed those found by Dr. Rotman on the Petitioner's good arm.

It is much more likely that the Petitioner experiences a restricted range of shoulder motion. He testified to a number of overhead activities both at work and at home which cause him problems. His physical therapy evaluation of November 29, 2012, after nearly six months of therapy, show some limits in flexion, adduction and external rotation. (PX 7) Dr. Rotman's abnormal findings are referenced above. If the Petitioner were to achieve a normal ROM, it is much more likely that it would be seen by his treating providers immediately after therapy than by Dr. Katz in his exam eight months later. While Dr. Rotman did suggest that the Petitioner might improve his strength and endurance with a home exercise program, the Petitioner testified that he did not receive any instruction on such a program and he did not engage in one.

Dr. Katz' range of motion findings are suspicious for the above reasons. The impairment rating used presumes a normal range of motion. For those reasons, the Arbitrator places very little weight on the rating.

(2) The occupation of the injured employee. Petitioner's job is physically demanding and obviously involves significant use of Petitioner's upper extremities on a daily basis. Fortunately, for now, Petitioner has been able to partially compensate for his disability by using his left upper extremity approximately three times as much as he did pre-injury. This is a factor maximizing his disability.

(3) The age of the employee at the time of injury. Petitioner was 59 years of age at the time of injury. Though Petitioner testified that he has no plans to retire at age 65, his advanced age is a factor to minimize his disability.

(4) The employees' future earning capacity. The Petitioner has substantial functional limitations of which he testified. He is at a point of maximum medical improvement. If his job were to end, it is not likely that he would be able to handle unrestricted full construction work. The Arbitrator believes this is a minor factor in maximizing his disability.

(5) Evidence of disability corroborated by the treating medical records. The Arbitrator has had the opportunity to observe Petitioner and finds his testimony to be credible and consistent with his extensive injuries. In addition to the biceps tendon damage, Dr. Rotman found a large, retracted rotator cuff tear. In his post operative office note, the doctor said it would take five to six months of rehab since it was such a big chronic tear. (PX 9) He did the therapy, showed good attendance, and is still left with restrictions of motion and decreases in strength.

After applying the five factors set forth in the statute, the Arbitrator finds the Petitioner disabled to the extent of 17.5 % Person As A Whole.

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

Angela Dillinger,
Petitioner,
vs.

NO: 10 WC 29630
14IWCC0993

Rides Mass Transit 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 temporary total disability, causal connection, permanent partial disability, medical expenses and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed November 18, 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.

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: NOV 19 2014

MB/mam
o:9/24/14
43

Mario Basurto

David L. Gore

Stephen Mathis

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

DILLINGER, ANGELA
Employee/Petitioner

Case# **10WC029630**

14IWCC0993

RIDES MASS TRANSIT DISTRICT
Employer/Respondent

On 11/18/2013, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.09% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

2500 WOMICK LAW FIRM CHTD
CASEY VANWINKLE
501 RUSHING DR
HERRIN, IL 62948

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

14IWCC0993

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

Angela Dillinger
Employee/Petitioner

v.

Rides Mass Transit District
Employer/Respondent

Case #**10** WC **29630**

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 **Molly Dearing**, Arbitrator of the Commission, in the city of **Herrin**, on **October 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 _____

14IWCC0993

FINDINGS

On **June 23, 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 **$16,745.52**; the average weekly wage was **$398.70.**

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

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

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

Respondent shall be given a credit of **$0.00** 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 for any bills paid through its group medical plan under Section 8(j) of the Act.

ORDER

Petitioner's current condition of ill-being is not casually related to the accident of June 23, 2010. Respondent shall pay all reasonable and necessary medical services for the date of service of June 23, 2010, as provided in Sections 8(a) and 8.2 of the Act, subject to the fee schedule. All other medical bills with dates of service after June 23, 2010 are denied. All temporary total disability and permanent partial disability 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

11/8/13
Date

ICArbDec p. 2

NOV 18 2013

STATE OF ILLINOIS)
)SS.
COUNTY OF WILLIAMSON)

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Angela Dillinger,
Employee/Petitioner

v. Case 10 WC 29630

Rides Mass Transit District,
Employer/Respondent.

MEMORANDUM OF DECISION OF ARBITRATOR

FINDINGS OF FACT

On June 23, 2010, Petitioner was employed as a bus driver for Respondent. On that date, Petitioner testified that a Blue Bird Bus, which is similar to a large Greyhound Bus, had a broken lift, which contains a hydrolic arm and weighs approximately two hundred pounds. Another bus driver assisted her in disassembling the lift, but the two were still unable to fix it. Petitioner called to Respondent's base location and began speaking to the mechanic, who talked her through how to fix the lift. Petitioner performed the steps to fix the lift as the mechanic had instructed her, and after she hoisted the lift up and pushed the lift into the bus to lock it into place, she felt pain near her belly button. Petitioner then radioed Respondent's base location and reported that she was not feeling well. She was transported to the hospital at Harrisburg Medical Center by another employee.

At the Emergency Room at Harrisburg Medical Center, Petitioner complained of lower left quadrant pain after lifting a gate on a Rides Bus. Radiographs of her chest revealed mild thoracic spondylosis, and a sonogram of the abdomen was negative. She was given Toradol and Zofran, and diagnosed with an abdominal wall strain. She was discharged on the same day with instructions to rest and follow-up with her primary care physician. Pet. Ex. 2.

On July 6, 2010, Petitioner underwent a CT of the abdomen and pelvis with and without contract enhancement and with 2D and 3D reconstruction for abdominal pain and trauma, and incontinence, which revealed a mildly prominent appendix with no signs of inflammatory changes. Pet. Ex. 2. On July 12, 2010, Petitioner underwent a radiograph series of the lumbar spine with a history of a lumbar injury and urinary incontinence, which revealed degenerative changes throughout the spine, and a mild curve to the upper lumbar spine convexed to the right. Pet. Ex. 2.

On July 13, 2010, emergency medical personnel transported Petitioner to the Emergency Room at Wabash General Hospital with complaints of chest pain and pressure radiating to

abdomen, tingling in the left arm, and nausea. Petitioner reported to the medical personnel that she was outside standing when the pain started. Upon arrival to the Emergency Room at Wabash General Hospital with complaints of chest pain beginning forty five minutes prior to her arrival at the hospital. The hospital records indicate a prior history of abdominal pain "for weeks from pulled muscle at work," anxiety and breathing into a paper bag prior to the emergency medical personnel arriving. A radiograph of her chest was negative, and an EKG taken was within normal limits with the exception of a short PR interval. Petitioner was taken off work through July 16. She was ordered to rest, stop smoking, and was prescribed Ativan. Pet. Ex. 1.

On July 13, 2010, Petitioner returned to the Emergency Room at Harrisburg Medical Center with complaints of left chest wall pain, worse on expiration, which began on the morning of July 13, 2010. Hospital notes indicate that Petitioner received an injection this morning at another hospital. Radiographs taken of her chest showed no active cardiopulmonary disease. She was given Toradol, discharged with a driver, and ordered to follow with her primary care physician in the morning. Pet. Ex. 2.

On August 4, 2010, Petitioner presented to Dr. Lawrence Hatchett at Southern Illinois Urology with complaints of incontinence. She indicated to Dr. Hatchett that she is a Rides Mass Transit driver, and injured herself when she pushed a wheelchair lift overhead and felt something pull in her lower abdomen. Petitioner reported that she urinates when she bends or squats, and fells a burning sensation when forced to hold in the urine. Dr. Hatchett diagnosed her with mixed incontinence, and recommended she undergo a cystourethroscopy with pelvic exam and an urodynamic study. Dr. Hatchett also noted that he "will not be able to say if this is due to work injury, bc [sic] it is a very common condition." Pet. Ex. 3. The cystoscopy performed on August 18 revealed a grade I cystocele with some slight hyper mobility of the bladder neck, slight paravaginal defects bilaterally, and some bladder leakage upon straining. Dr. Hatchett's impression was mixed incontinence, and he gave her samples of Vesicare. Pet. Ex. 3. Dr. Hatchett performed an urodynamic study the next day, which indicated a normal exam with a possible type O stress urinary incontinence. Dr. Hatchett's physician's assistant, Kelly Hester, ordered Petitioner to continue with Vesicare. Petitioner again presented to Dr. Hatchett on September 7, 2010 for continued evaluation and management of her mixed incontinence. Petitioner indicated that the Vesicare prescription helped, and Petitioner again indicated that her symptoms began after she got hurt at work on June 23, 2010. Dr. Hatchett gave Petitioner samples of Toviaz to try instead of Vesicare to ascertain which prescription she likes better. She was to call back with her preference for Dr. Hatchett to issue a prescription. Pet. Ex. 3.

On October 11, 2010, Petitioner underwent a radiograph series of the lumbar spine for a history of a slip and fall, which was compared to the prior study of July 12, 2010. The studies revealed degenerative facet arthropathy bilaterally throughout the lumbar spine, grade 1 degenerative spondylolisthesis of L4-5 unchanged, moderate disc space narrowing at L4-5 with additional loss of height when compared to the prior study, and degenerative anterior marginal spurring from T10-11 through L4-5. On October 13, a referral was made for Petitioner to undergo physical therapy with a diagnosis of grade 1 spondylolisthesis. The physical therapy evaluation performed on October 13 indicated that Petitioner had reported falling off her porch last week, injuring her shoulder and back, which at Arbitration, Petitioner concurred with the history given. The history indicated that Petitioner's shoulder pain had resolved, but she was

complaining of a spasm and shocking sensation in her low back when she reached overhead. The history further indicated a prior history of a bladder injury of June 2010 after lifting a lift gate. Petitioner underwent physical therapy from October 13 to October 28. Pet. Ex. 2.

On February 21, 2011, Petitioner presented to the Emergency Room at Harrisburg Medical Center with complaints of lower left abdominal pain and problems urinating, that began the night before. Petitioner was diagnosed with pelvic pain, given Bentyl, and discharged with instructions to follow-up with her family physician on February 22. Pet. Ex. 2. Petitioner testified at Arbitration that if her medical records indicated she had abdominal pain that began the day before, she would take issue with same.

On February 24, Petitioner underwent a CT scan of the abdomen and pelvis with and without IV contract and with 2D coronal reformatting, with a comparison of the prior study of July 6, 2010. The study revealed benign chronic changes, and a tiny omental umbilical hernia. Pet. Ex. 2.

Petitioner presented to Dr Clay DeMattei on September 13, 2012 for evaluation of a left ingenuinal hernia. She reported to Dr. DeMattei that she injured herself in June 2010 while straining to lift a malfunctioning lift gate on a bus. Petitioner indicated to Dr. DeMattei that there was an immediate onset of pain to her left abdomen. She stated that she had undergone treatment, which included 2 prior CT scans and an ultrasound of the abdomen, which she was told indicated a hernia. Petitioner reported continued intermittent pain upon lifting objects or when she jolts herself riding a lawnmower. Dr. DeMattei recommended she bring in her prior two CT scans for a second opinion from Dr. DeMattei's radiologist. He was to see her in two weeks. A single page of what appears to be a multi-page treatment record of September 24, 2012 appears in Petitioner's Exhibit 4. It indicates that Dr. DeMattei spoke to Petitioner regarding her CT scans, and indicated she has a small umbilical hernia, which is not clinical. Dr. DeMattei indicated he would generally make a referral to a pain management specialist for a possible local injection. Petitioner wanted to consider her options, and no follow-up appointment was made at that time. Pet. Ex. 4.

Petitioner returned to Dr. DeMattei on May 29, 2013 with complaints of continual abdominal discomfort in the umbilical area and in the epigastric region. She had undergone a CT on April 2, 2013, which showed a small umbilical hernia containing preperitoneal fat which was unchanged from a prior study of 2011. Dr. DeMattei opined that Petitioner has a small, nonclinical umbilical hernia which requires no surgical therapy. He saw no evidence of any other hernia. Dr DeMattei stated that "I am not convinced that the small umbilical hernia was the result of any type of injury." Pet Ex. 4.

On August 22, 2013, Petitioner returned to Dr. Mehta, who noted that Petitioner suffered from upper abdominal pain associated with anorexia and nausea. He scheduled an upper endoscopy and gallbladder ultrasound for August 29. The upper endoscopy was unremarkable, and Petitioner's gallbladder ultrasound was negative. Dr. Mehta noted the HIDA scan to be very abnormal with injection fraction of only 4%. Dr. Mehta diagnosed Petitioner with a tiny umbilical hernia, which Dr. Mehta would consider repairing at the time of surgery. Pet. Ex. 5.

On September 9, 2013, Petitioner underwent a laparoscopic cholecystectomy and intraoperative cholangiogram, during which time the umbilical hernia was repaired as part of the primary closure of the fascia. Her final diagnoses were chronic symptomatic cholecystitis, biliary dyskinesia, ejection fraction of 4%, and exogenous obesity. Following her procedure, Petitioner returned to Dr. Mehta with no complaints. Pet. Ex. 5.

Petitioner testified that following surgery, she is still sore, and her pants remain down below her belt area. She stated that she still suffers from incontinence, for which Dr. Hatchett only recommended medications, which she cannot afford.

According to Petitioner, because her doctor was not available, she went to see Dr. Doran in Carmi, who placed light-duty restrictions on her following her accident. Petitioner also testified that Dr. Doran tried to return her to work with no restrictions on July 16, 2010, but she sought a second opinion that placed additional work restrictions on her. Petitioner stated that Respondent decided not to honor her work restrictions in March 2011.

Petitioner tendered a Telephone and Visitor Log from Respondent, Rides Mass Transit District, for the month of March 2011, which indicates that Petitioner requested light duty from Respondent, which was denied based upon their position that the hernia was not work related. Pet. Ex. 7. Petitioner testified that her work told her to go home and did not pay temporary total disability benefits thereafter. She has not tried to work other places because she has a 10 lb. weight restriction.

Petitioner tendered a medical bill summary and medical bills from Community Health & Emergency Services for Dr. Thao Doran and Elizabeth Bebout with dates of service of February 22, 2011 and July 26, 2010 respectively, however, no medical records corresponding to those bills were offered into evidence. Petitioner also tendered medical bills for Dr. Nathaneal Dolan of Southern Illinois Primary Care with dates of service of July 2, 2010, July 9, 2010 and July 16, 2010, but no medical records corresponding to those bills were offered into evidence. Pet. Ex. 6.

CONCLUSIONS OF LAW

In regard to disputed issue (F), the Arbitrator finds that Petitioner's current condition of ill-being is not casually related to the accident of June 23, 2010.

There is no dispute that Petitioner sustained accidental injuries that arose out of and in the course of her employment with Respondent on June 23, 2010. Petitioner immediately sought treatment following her accident at the Emergency Room at Harrisburg Medical Center. Although the emergency room nurse ordered Petitioner to follow-up with her primary care physician soon after being discharged on June 23, Petitioner did not do so. Instead, the next date of service indicated in the record is approximately two weeks later, on July 6, 2010, when Petitioner underwent a CT of the abdomen and the pelvis for complaints of abdominal pain and incontinence. The CT revealed no umbilical hernia at that time. It was not until the CT of February 24, 2011 that Petitioner was diagnosed with an umbilical hernia.

Further, two of Petitioner's treating physicians, Dr. DeMattei and Dr. Hatchett, indicated in their medical records that Petitioner's umbilical hernia and incontinence, respectively, are not related to her work injury. Specifically, Dr. DeMattei indicated in his record of May 29, 2013 that he is "not convinced that the small umbilical hernia was the result of any type of injury." Pet. Ex. 4. Similarly, Dr. Hatchett stated in his record of August 4, 2010 that he "will not be able to say if this [Petitioner's mixed incontinence] is due to work injury, bc [sic] it is a very common condition." Pet. Ex. 3. Although medical testimony is not required to establish causation, *University of Illinois v. Industrial Commission*, 365 Ill. App. 3d 906, 912 (1st Dist. 2006) and *International Harvester v. Industrial Commission*, 93 Ill. 2d 59, 63 (1982), the Arbitrator finds it probative that, after having taken respective histories from Petitioner of her work accident of June 23, 2010, Petitioner's treating physicians declined to find a causal relationship between same and her conditions of an umbilical hernia and incontinence. Therefore, the Arbitrator finds that Petitioner's current condition of an umbilical hernia and incontinence to be unrelated to the accident of June 23, 2010.

Additionally, Petitioner sought treatment at two emergency departments – Harrisburg Medical Center and Wabash General Hospital – both on July 13, 2010, for complaints of chest wall pain. Petitioner reported to the medical personnel that she was outside standing when the pain started, and upon arrival to the Emergency Room at Wabash General Hospital, she reported that the chest pain beginning forty five minutes prior to her arrival at the hospital. Pet. Ex. 1. Petitioner also received treatment for low back and shoulder complaints on October 11, 2010, in which Petitioner reported to physical therapy personnel that she injured same when she fell off the front porch in the prior week. Pet. Ex. 2.

Petitioner's complaints of chest wall pain, and shoulder and low back pain are disparate from her complaints arising from her work injury, and are attributable to histories and dates of onset different from the lifting mechanism of injury of June 23, 2010. Therefore, the Arbitrator finds Petitioner's chest wall pain, shoulder and low back conditions to be unrelated to Petitioner's work accident of June 23, 2010.

In regard to the disputed issue (J), the Arbitrator awards medical bills for the date of service of June 23, 2010. The treatment received on the date of the accident immediately followed the lifting incident at work, and is reasonable and necessary in light of Petitioner's unrebutted testimony of the mechanism of accident. Respondent shall pay all reasonable and necessary medical services for the date of service of June 23, 2010, as provided in Sections 8(a) and 8.2 of the Act, subject to the fee schedule. All medical bills for services rendered after June 23, 2010 are denied as unrelated to Petitioner's work injury, given the Arbitrator's conclusions in regard to disputed issue (F).

In regard to disputed issues (K) and (L), the Arbitrator makes no conclusions of law as these issues are rendered moot because of the Arbitrator's conclusions in regard to disputed issue (F).

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

Jacqueline Camacho,

Petitioner,

14IWCC0994

vs.

NO: 12WC 10751

Bar Toma,

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, 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.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed January 31, 2014 is hereby affirmed and adopted.

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

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

14IWCC0994

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $31,000.00. 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:
MJB/bm
o-11/18/14
052

NOV 2 1 2014

Michael J. Brennan

Kevin W. Lamborn

Thomas J. Tyrrell

ILLINOIS WORKERS' COMPENSATION COMMISSION

NOTICE OF ARBITRATOR DECISION

CAMACHO, JACQUELINE
Employee/Petitioner

Case# **12WC010751**

BAR TOMA
Employer/Respondent

14IWCC0994

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:

0059 BAUM RUFFOLO & MARZAL LTD
JOEL HERRERA
33 N LASALLE ST SUITE 1710
CHICAGO, IL 60602

0210 GANAN & SHAPIRO PC
ELAINE T NEWQUIST
210 W ILLINOIS ST
CHICAGO, IL 60654

STATE OF ILLINOIS)
)SS.
COUNTY OF Cook)

14IWCC0994

☐ Injured 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

Jacqueline Camacho
Employee/Petitioner

v.

Bar Toma
Employer/Respondent

Case # **12** WC **10751**

Consolidated cases: **D/N/A**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Molly C. Mason**, Arbitrator of the Commission, in the city of **Chicago**, on **11/22/13 & 1/6/14**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

14IWCC0994

FINDINGS

On **3/14/12**, 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 **$16,432.52**; the average weekly wage was **$316.01**.

On the date of accident, Petitioner was **30** years of age, ***single*** with **0** dependent children.

Petitioner ***has in part*** received reasonable, necessary and causally related medical services.

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

Respondent shall be given a credit of **$1,760.00** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$1,760.00.**

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

ORDER

Temporary Total Disability

Respondent shall pay Petitioner temporary total disability benefits of $220/week from March 15, 2012 through March 20, 2012, from March 22, 2012 through May 3, 2012 and from June 7, 2012 through November 27, 2012, a total of 31 6/7 weeks, with Respondent receiving credit for the $1,760.00 in benefits it paid prior to trial. Arb Exh 1.

Maintenance Benefits

Respondent shall pay Petitioner maintenance benefits of $220/week from June 12, 2013 through June 19, 2013, from July 10, 2013 through July 17, 2013, from August 11, 2013 through August 12, 2013 and from August 29, 2013 through November 21, 2013, a total of 14 5/7 weeks, as provided in § 8(a) of the Act.

Medical Benefits

See pages 14-15 of the attached decision for the Arbitrator's medical award.

Permanent Partial Disability

Respondent shall pay Petitioner permanent partial disability benefits of $220.00/week for 112.5 weeks, because the injuries sustained caused the 22.5% loss of use of the person as a whole, as provided in § 8(d)2 of the Act.

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

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

Molly C Mesa
Signature of Arbitrator

1/31/14
Date

Jacqueline Camacho v. Bar Toma
12 WC 10751

14IWCC0994

Arbitrator's Findings of Fact

Petitioner testified she obtained an associate's degree in baking and pastry preparation from Kendall College in 2009. She began working as a pastry chef for Respondent's parent organization, Levy Restaurants, in May of 2011. She began working in the same capacity at Respondent restaurant in November of 2011. She began her workday at 4:30 or 5:00 AM and stopped working at 2:30 or 3:00 PM.

Petitioner testified she injured her back while lifting a gelato base at work in December 2011. She testified she did not lose time from work or undergo any treatment as a result of this injury. She denied sustaining any other back injuries prior to March 14, 2012.

Petitioner testified she felt good when she woke up on March 14, 2012. She arrived at work at 4:30 AM that day and began performing her regular duties. At about 8:00 AM, she began pulling a series of fourteen gelato bases out of the cooler. Each base weighed between 40 and 50 pounds. As she bent over in order to pull out the bottom base from a stack of three, she felt pain in her lower back and leg. She informed Lupe, her manager, of her injury. [Notice is not in dispute. Arb Exh 1.] Shortly after the accident, she took three Advils due to intense pain. She denied taking any other medication earlier that morning. At about 10:30 AM, she took one Tylenol with codeine. She testified that her supervisor, Susan, gave her this pill. Susan had injured her back the previous summer.

Petitioner testified she continued working after taking the Tylenol with codeine. She finished her shift at about 2:30 PM. She called her brother to ask for a ride since she was in a lot of pain. Her brother's girlfriend picked her up and started driving her home. At some point, she telephoned Respondent's chef but he did not answer her call. While she was still on the road, she received a call from Respondent. Three Respondent employees, including Lupe, Drew (the "front of the house" manager) and Effi (a male employee who worked in the pizza area) were on the line. They asked her when she reported the accident to Lupe and why no paperwork had been completed. She subsequently called Drew back. Drew instructed her to come back to work. She had her brother's girlfriend drive her back to the restaurant. When they pulled up, Drew met them outside, at which point she completed paperwork concerning the accident. At Respondent's direction, she then went to the Emergency Room at Northwestern Memorial Hospital.

An Emergency Room triage note bearing the time 5:28 PM sets forth the following history:

> "Pt comes in with lower back pain. Pt states she was lifting a box at work today. Pt complains of increased pain to lower back with radiating pain to upper back. Pt denies numbness or tingling to

legs. Pt denies loss of bowel or bladder function. Pt up with slow steady gait."

The triage nurse noted that Petitioner rated her pain level at 10/10. PX 2, p. 8. At about 6:09 PM, another nurse noted that Petitioner "suddenly threw her back out" while lifting a box at work that day. This nurse indicated that Petitioner complained of pain only in her lower back. PX 2, p. 7.

At about 6:17 PM, a resident evaluated Petitioner under the supervision of Dr. Lareau, an Emergency Room physician. The resident's history reflects that Petitioner denied any alcohol/drug use or medications and described her past medical history as negative. PX 2, p. 10. On lumbar spine examination, the resident noted mild paraspinal muscle spasm and no focal neurological deficit. He reached a differential diagnosis of back sprain/strain. At about 7:00 PM, Petitioner received an injection of Toradol, Dilaudid and Valium. At about 8:40 PM, the resident noted Petitioner was "still having some pain after IM Dilaudid, Toradol and Valium." He also noted: "given Acosta testing request at this time from patient. Nursing to notify Acosta. Will dose Dilaudid IV now." At about 9:00 PM, Petitioner was given another injection of Dilaudid. A clinical note bearing the time 9:24 PM (PX 2, p. 16) states: "Injured back at work. Needs drug and alcohol screening workmen comp. Patient has chain of custody form." A technician performed an "Acosta drug screen" at Petitioner's bedside at 9:28 PM. PX 2, p. 23. PX 1, p. 1. The drug screen was positive for codeine and morphine and otherwise negative. The drug screen report is dated April 6, 2012. PX 1, p. 1.

Petitioner was discharged from the Emergency Room with prescriptions for Ibuprofen, Valium and Norco and instructions to follow up with Corporate Health Services. PX 2, p. 5.

On March 15, 2012, Petitioner saw Dr. Joseph Mitton at Northwestern Memorial Corporate Health Services. The doctor's note reflects that Petitioner experienced an immediate onset of lower back pain at 8:00 AM the previous day while trying to lift a gelato base at work. The note also reflects that Petitioner underwent care at the Emergency Room, where she was given prescriptions.

Dr. Mitton noted that Petitioner had taken Ibuprofen for pain but had not yet taken the prescribed Norco or Valium. He also noted that Petitioner complained of lower back pain radiating "up the back." He indicated that Petitioner denied leg pain but described her legs as having felt weak the night before. He further indicated that Petitioner had experienced a similar lifting injury in December 2011 "but did not do a written report and did [sic] resolved completely."

On examination, Dr. Mitton noted tenderness in the paraspinals, left greater than right, negative straight leg raising and intact sensation bilaterally. He diagnosed a lumbar strain. He demonstrated various range of motion exercises to Petitioner and released her to work with no lifting over 10 pounds, no repetitive bending, twisting or leaning and the ability to change position as needed. PX 3, p. 8.

On March 16, 2012, Petitioner saw Dr. Jane Cullen at Corporate Health Services, with the doctor indicating that Petitioner was now experiencing pain "down left lateral thigh" as well as tingling in the medial area of both thighs. Dr. Cullen described Petitioner's gait as antalgic. She noted that seated straight leg raising produced pain only in the back.

Dr. Cullen recommended that Petitioner discontinue the Ibuprofen and start a Medrol Dosepak. She also indicated that Petitioner could take two Valiums three times daily, to be supplemented with one Norco as needed. She recommended some walking and gentle exercises. She noted that Petitioner only worked Tuesday through Thursday. She continued the previous work restrictions and instructed Petitioner to return the following Monday. PX 3, pp. 11-12.

Petitioner returned to Corporate Health Services on March 19, 2012 and again saw Dr. Cullen. The doctor's lengthy note of that date reflects that, when she first entered the examination room, Petitioner had her "eyes almost closed" and was "speaking very softly, complaining of pain in back and shakiness and nausea and some constipation," but, as the examination progressed, Petitioner began speaking normally and seemed alert and oriented. At some later point, however, Petitioner "started sobbing that she was stressed because work was going to make her come back and she still had pain." On further discussion, Petitioner "stated that she did feel better than when she first went to the ER."

On examination, Dr. Cullen noted tenderness in the left lumbar area, a limited but improved range of motion in all directions, intact heel and toe walking, intact sensory, negative seated straight leg raising and a positive Waddell's sign for overreaction.

Dr. Cullen directed Petitioner to finish the Medrol Dosepak, discontinue the Norco and take Valium and Ibuprofen as needed. She continued the previous restrictions and instructed Petitioner to return on Friday. She indicated that Petitioner called the office within ten minutes of leaving, indicating that work was going to have her come in. Dr. Cullen noted she called Ed Gilaty "and discussed restrictions which he said would be fully accommodated." The doctor noted she then called Petitioner, who was crying. She described Petitioner as complaining of nothing other than that she was "going to have to work." PX 3, pp. 13-14.

Petitioner returned to Corporate Health Services on March 21, 2012 and saw Dr. Mitton. The doctor noted that Petitioner reported improvement but complained of drowsiness secondary to the medication and "more pain when stuck in one position at a time." The doctor indicated that Petitioner complained of pain over the left lower back radiating into the left posterior thigh. He described seated straight leg raising as negative. He described Petitioner's strength as "decreased due to pain and meds." He increased Petitioner's lifting capacity to 15 pounds and otherwise continued the previous restrictions. He instructed Petitioner to return on April 3, 2012. PX 3, pp. 15, 20.

Petitioner testified she returned to work on March 21, 2012 and was fired due to the drug test results. The following day, Petitioner consulted Dr. Newman, an orthopedic surgeon affiliated with the Illinois Bone and Joint Institute.

Dr. Newman's initial history of March 22, 2012 reflects that Petitioner was pulling some containers of gelato out of a cabinet on March 14, 2012 when she felt a sudden onset of low back pain, worse on the left than the right. The history also reflects a prior episode of back pain in December 2011 which "got better without active intervention."

Dr. Newman noted that, per Corporate Health Services, Petitioner resumed restricted duty on March 21, 2012 but experienced pain while working and increased symptoms after work.

Dr. Newman described Petitioner as morbidly obese. He noted she did not limp and was able to heel and toe walk. On range of motion examination, he noted flexion to 45 degrees, extension to 10 degrees and lateral bending to 15 degrees to either side. He described Waddell signs as "negative x 3." He also described straight leg raising as negative. He concluded Petitioner was primarily suffering a soft tissue strain. He indicated Petitioner had some left leg symptoms but found these symptoms "not typical of a nerve root type pain." He prescribed two weeks of physical therapy and instructed Petitioner to remain off work for that period of time. He also prescribed anti-inflammatories. PX 4, pp. 87-89.

On March 26, 2012, Petitioner filed an Application for Adjustment of Claim alleging a low back injury of March 14, 2012. Arb Exh 2.

Petitioner testified she began a course of therapy at United Rehab on March 29, 2012. PX 5, pp. 4-10.

Petitioner returned to Dr. Newman on April 5, 2012. Dr. Newman noted that Petitioner was still having back pain but described her left leg pain as having resolved. The doctor examined Petitioner and described her back strain as "slowly resolving." He instructed Petitioner to remain off work, continue therapy and return to him in two weeks. PX 4, p. 78. Petitioner continued attending therapy thereafter. PX 5, pp. 14-18.

Petitioner returned to Dr. Newman as directed on April 19, 2012. The doctor described the previous leg symptoms as "much improved." He noted, however, that Petitioner "still gets up from a sitting position very slowly." He recommended that Petitioner stay off work, continue therapy and return to him in two weeks. PX 4, p. 75. Petitioner continued attending therapy thereafter. PX 5, pp. 19-21.

On May 3, 2012, Petitioner returned to Dr. Newman. The doctor's note of that date reflects that Petitioner "has very little in the way of symptoms at the present time" and "feels that she could resume her full work duties." On examination, the doctor noted a normal range of lumbar spine motion, with "no suggestion of radicular pain." He found Petitioner to be at

maximum medical improvement but recommended she attend two more therapy sessions that had already been scheduled. He released Petitioner to full duty and indicated he did not need to see her again. PX 4, pp. 69-70. Petitioner testified she began looking for work online as of May 3, 2012. On May 5, 2012, the therapist discharged Petitioner from care with a home exercise program. PX 5, p. 24.

Petitioner testified she was no longer experiencing any "shooting pain" as of May 3, 2012. She discontinued her medication the same day, only to have her symptoms return three days later.

Petitioner returned to Dr. Newman on May 22, 2012. The doctor recorded the following interval history:

> "[Petitioner] was discharged on her last visit but, when she stopped her medication, she found that her left low back pain returned. She was concerned. She was not given a home exercise program when she left physical therapy."

On examination, Dr. Newman noted a good range of motion with some complaint of left-sided low back pain with forward flexion. He recommended a "serious weight loss program" and one additional therapy visit "to learn a good home exercise program." He again released Petitioner to full duty. He released Petitioner from care on a "PRN" basis. PX 4, pp. 67, 68.

Petitioner testified that Dr. Newman prescribed a lumbar spine MRI on May 22, 2012 but there is no mention of such a prescription in the doctor's note of that date. Petitioner attended a therapy session that day.

Dr. Newman prescribed a lumbar spine MRI on May 24, 2012, noting that Petitioner's pain was "not relieved by NSAIDS or PT." PX 5, p. 65. The MRI, performed without contrast on June 5, 2012, demonstrated "mild lumbosacral degenerative disc disease," a "small central disc protrusion" at L3-L4 producing mild central canal stenosis and a "small right central disc protrusion" and annular fissure at L4-L5, with apparent mild central canal stenosis. PX 4, pp. 62-63. The MRI report states that the study was performed due to "low back pain radiating down to the left leg." PX 4, p. 62. PX 6-7.

Petitioner returned to Dr. Newman on June 7, 2012. The doctor indicated that Petitioner was still experiencing left-sided lower back pain and that "therapy feels they have nothing further to offer her." The doctor described Petitioner's pain as "suggestive of a radiculopathy." He again recommended weight loss. He targeted Petitioner's weight as "the primary reason that she has the degenerative changes in her lumbar spine." He referred Petitioner to a pain center for purposes of an epidural injection. He instructed Petitioner to return to him in six weeks, at which point he anticipated being able to release her to full duty. PX 4, pp. 59-61.

Petitioner saw Dr. Singh, a physiatrist, on June 18, 2012. The doctor's note of that date sets forth a consistent history of the March 14, 2012 work accident and subsequent care. The doctor indicated that Petitioner continued to complain of left-sided radicular pain despite doing home exercises. He also noted that Petitioner denied any new traumatic episodes or hospitalizations since her last visit to Dr. Newman. He indicated that Petitioner was hesitant about undergoing any type of injection.

Dr. Singh described Petitioner as obese. On examination, he noted minimal tenderness to palpation along the lumbosacral region paraspinal on the left, intact sensation and a normal gait. After reviewing the MRI, he referred Petitioner to his colleague, Dr. Alzoobi, for injections since Petitioner was "insisting on sedation." He prescribed Flexeril. PX 4, pp. 56-57.

On July 19, 2012, Petitioner returned to Dr. Newman. The doctor noted that Petitioner "is not getting better and in fact she has numbness down to her foot." He also noted that an injection had been scheduled for July 24th. He instructed Petitioner to remain off work and return to him in four weeks. PX 4, pp. 54-55.

Petitioner underwent additional epidural injections at St. Joseph Hospital on July 24 and August 23, 2012. PX 8, pp. 19-22. PX 9.

At Respondent's request, Petitioner saw Dr. Phillips for a Section 12 examination on August 28, 2012. Dr. Phillips is a spine surgeon affiliated with Midwest Orthopaedics at Rush. In his report (RX 1), he referenced the Emergency Room records, Dr. Newman's note of April 3, 2012, the MRI report and Dr. Singh's note of June 18, 2012.

Dr. Phillips' history reflects that Petitioner's back went out at work on March 14, 2012 while she was "carrying a gelato mixer." Dr. Phillips noted that Petitioner had undergone therapy and two epidural injections but was still complaining of 5-6/10 left-sided lower back pain radiating down her left leg with paresthesias in the left foot.

Dr. Phillips described Petitioner's posture and gait as normal. He noted no obvious Waddell's signs. He noted some mild left buttock tenderness to palpation, painful flexion and extension, intact sensation and negative straight leg raising.

Dr. Phillips described Petitioner as presenting "with back pain and possible radiculopathy." He lacked the MRI but opined that Petitioner "has at least a lumbar sprain/strain." He indicated that, if the MRI showed no consistent neural compression, he would recommend a formal rehabilitation program followed by a return to full duty. He found "no spinal contraindication to [Petitioner] currently working with a 30-pound lifting restriction." He asked that the MRI scan be sent to him. He did not criticize any of the care rendered to date. RX 1.

Dr. Phillips issued a second report the same day, after reviewing additional records authored by Dr. Newman. His review of these records did not prompt him to change any of his previously stated opinions. He again requested the MRI. RX 2.

On September 14, 2012, Petitioner saw Dr. Fisher, a spine surgeon affiliated with Illinois Bone and Joint Institute, at Dr. Newman's referral.

Dr. Fisher's report sets forth a consistent account of the work accident and subsequent care. Dr. Fisher noted that Petitioner rated her pain level at 6-8/10 and reported deriving some relief from the second injection.

Dr. Fisher described Petitioner's gait as normal. On examination, he noted tenderness to the paraspinous muscles from L3-S1, 5/5 lower extremity strength, intact sensation and a reported increase of pain with straight leg raising.

Dr. Fisher interpreted the MRI as showing a "left paracentral disc herniation at L3-L4." He indicated this abnormality could best be seen on sagittal T2 weighted images. He obtained lumbar spine X-rays, which revealed mild disc space narrowing at L5-S1 without osteophyte formation.

Dr. Fisher diagnosed lumbago, left sciatica and a left paracentral disc herniation at L3-L4. He recommended a third epidural injection and discussed the possibility of performing an L3-L4 discectomy in the future if Petitioner experienced only limited improvement. He instructed Petitioner to return to him following the third injection. PX 4, pp. 44-50. He completed a work status report indicating both that Petitioner was unable to work and that Petitioner could perform light duty with no lifting over 10 pounds and no repetitive bending, twisting or lifting. PX 4, p. 43.

On October 11, 2012, Petitioner underwent an EMG at Dr. Alzoobi's recommendation. PX 8, p. 15. Dr. Arayan performed the EMG. His report sets forth a consistent account of the work accident and subsequent care. He described the EMG results as normal, noting evidence of a left L5-S1 radiculopathy. PX 4, pp. 37-42. PX 11.

On October 13, 2012, Petitioner went to the Emergency Room at Lutheran General Hospital. Petitioner testified she went to the Emergency Room because she had fallen a couple of times due to bilateral leg weakness. The Emergency Room records reflect that Petitioner provided a history of her back injury and injections. The records also reflect that Petitioner had been experiencing headaches since the injections and questioned whether she could have contracted meningitis from the injected medication, referencing a recent outbreak reported in the news. She also reported having fallen secondary to dizziness the previous Monday, striking her knee and twisting her ankle. PX 12A, p. 29. The examining nurse described Petitioner's back as non-tender. She noted no evidence of meningitis. She contacted Dr. Alzoobi, who assured her that none of the medications he had injected into Petitioner had come from the pharmacy where the contamination occurred. Petitioner underwent X-rays of her right knee

and ankle. The X-rays were negative. Petitioner was diagnosed with headaches and was discharged with instructions to follow up with both Dr. Alzoobi and her family physician. PX 12A, p. 44.

On October 16, 2012, Respondent's examiner, Dr. Phillips, issued a third report, after reviewing the MRI. He indicated the MRI "confirmed some disc desiccation at L3-L4, L4-L5 and L5-S1. He described the overall disc height as "well maintained." He noted a diffuse disc bulge causing some mild effacement of the thecal sac at L3-L4, a diffuse disc bulge somewhat more prominent to the right at L4-L5 "not causing any frank compression," and a mild diffuse disc bulge at L5-S1 with no neurocompression. Based on the MRI, he again found it likely that Petitioner sustained a lumbar sprain/strain. He recommended a six-week course of therapy, to include work conditioning if necessary. He found no contraindication to Petitioner resuming full duty once she completed this therapy. He again found no contraindication to Petitioner currently working with a 30-pound lifting restriction. He did not criticize any of the care rendered to date. RX 3.

On October 18, 2012, Petitioner presented to Dr. Alzoobi and complained of worsening symptoms. The doctor noted that Petitioner had fallen three weeks earlier after becoming dizzy and had sought Emergency Room care for lower leg pain. He also noted that Petitioner complained of weakness in both legs and was awaiting a gynecological evaluation for excessive menorrhagia. On examination, he noted no radicular symptoms, negative straight leg raising, some bruising of the right leg and weakness with lateral eversion of the right leg. He ordered a coagulation profile and CBC to check for a bleeding disorder. PX 9, p. 67. He recommended that Petitioner stay off work and engage in work hardening, to be followed by a functional capacity evaluation. PX 8, pp. 8-9, 31.

Petitioner returned to Dr. Fisher on October 26, 2012. Petitioner complained of left-sided lower back pain and recurrent numbness in her left leg and all toes. Dr. Fisher's examination findings were essentially unchanged. He reviewed the EMG. On re-review of the MRI, he noted a broad-based herniation at L4-L5, slightly larger on the right, and a subtle left paracentral disc herniation at L5-S1, along with the previously noted L3-L4 left paracentral disc herniation. Dr. Fisher recommended a weight loss program, work conditioning and follow-up with pain management. He found Petitioner capable of light duty with no lifting over 10 pounds and no repetitive bending, twisting or lifting. PX 4, pp. 34-36.

Petitioner underwent a therapy evaluation at United Rehab Providers on October 23, 2012. Petitioner began a course of work conditioning thereafter. Petitioner testified she had difficulty walking fast and lifting certain amounts while undergoing work conditioning. On November 9, 2012, the therapist noted that Petitioner complained of "more than usual lower back pain and pain radiating to the lower extremities." He also noted that Petitioner had made no progress. PX 5.

On November 29, 2012, Petitioner returned to Dr. Alzoobi. The doctor noted that work conditioning had been discontinued because it was causing Petitioner's symptom to worsen.

On examination, he noted positive straight leg raising and moderate tenderness over the paravertebral muscle in the lumbar spine. He recommended that Petitioner pursue aggressive therapy for two more months. He increased Petitioner's Gabapentin dosage and prescribed Baclofen and Norco. PX 8, p. 7.

On December 7, 2012, Petitioner returned to Dr. Fisher and reported a significant increase in pain secondary to work conditioning. The doctor's examination findings were unchanged. He recommended a repeat lumbar spine MRI and continued the previous work restrictions. PX 4, pp. 30-33. Petitioner resumed work conditioning on December 11, 2012. PX 5, p. 86.

The repeat MRI, performed on December 19, 2012, demonstrated mild left foraminal stenosis at L5-S1, secondary to a "small left paracentral-left medial foraminal disc protrusion and facet arthrosis" and a small left paracentral disc extrusion at L3-L4 contacting the ventral cord surface but with no direct nerve root impingement or stenosis. PX 4, pp. 28-29.

On January 4, 2013, Dr. Fisher reviewed the repeat MRI results with Petitioner. Dr. Fisher did not find Petitioner to be a candidate for any form of surgery. He again discussed the importance of weight loss, noting that Petitioner's "morbid obesity is causing excessive forces on her lumbar spine and most likely aggravating her pain symptoms." He prescribed home exercises, to be continued indefinitely, and a functional capacity evaluation. He continued the previous work restrictions. PX 4, pp. 24-27.

Petitioner underwent the recommended functional capacity evaluation at United Rehab Providers on January 8, 2013. The evaluator found that Petitioner put forth full and consistent effort. He further found that Petitioner "demonstrated the ability to perform 30.2% of the physical demands of her job as a pastry cook." He noted poor lifting mechanics and 1/5 positive Waddell signs. Based on the Dictionary of Occupational Titles, he rated Petitioner's pastry cook position as a medium physical demand job. He found Petitioner able to perform within a light physical demand level. PX 4, pp. 13-23.

Petitioner continued undergoing work hardening thereafter. PX 5.

On January 24, 2013, Dr. Alzoobi noted that Petitioner was still attending therapy and had undergone a functional capacity evaluation. He recommended that Petitioner continue therapy. He did not recommend surgical intervention. He released Petitioner to light duty with no lifting over 20 pounds and no prolonged walking, sitting or standing. PX 8, pp. 6, 32.

On February 18, 2013, Dr. Fisher reviewed the functional capacity evaluation with Petitioner. He noted that Petitioner reported exercising three times weekly. He again recommended weight loss. He found Petitioner to be at maximum medical improvement and continued the previous work restrictions. PX 4, pp. 10-12.

On February 26, 2013, Petitioner's therapist conducted a re-evaluation, noting that work hardening had been put "on hold for a while for exaggeration of symptoms." PX 5, p. 167. At the hearing, Petitioner acknowledged that work hardening did not go well.

Petitioner returned to Dr. Alzoobi on April 11, 2013 and indicated she was still taking Gabapentin, Baclofen and Norco for radicular pain. On examination, the doctor noted moderate tenderness with pressure over the facet joint of the lumbar spine and positive straight leg raising on the left. He concluded that Petitioner had plateaued in therapy. He discharged Petitioner to a home exercise program and indicated she could resume her part-time job with no lifting over 20 pounds and no prolonged standing. PX 8, p. 33. He noted that Petitioner's pastry cook job requires lifting and prolonged standing. PX 8, p. 5.

Petitioner returned to Dr. Fisher on April 15, 2013. Petitioner rated her pain level as ranging from 2-8/10, depending on her activity level. The doctor's examination findings were unchanged. He diagnosed lumbar degenerative disc disease, lumbar disc herniation, morbid obesity and lumbago. He recommended continued weight loss and anti-inflammatories as needed. He found no need for injections or surgery, noting that Petitioner was continuing to undergo pain management. He continued the previous work restrictions. PX 4, pp. 7-9.

Petitioner continued attending work hardening through April 16, 2013. PX 5, p. 222.

Petitioner testified she has not undergone any additional treatment since mid-April 2013. She exercises on her own at United Rehab, where she uses a treadmill at no charge. She has been looking for work on her own but has not found a job. She identified PX 16 as a list of her job contacts. PX 16 consists of 6 ½ typed pages of job contacts. The listed contacts took place during the following intervals: June 12-19, 2013, July 10-17, 2013, August 11-12, 2013 and August 29-November 21, 2013. PX 16 reflects that nine of the contacts led to interviews, with Petitioner indicating that the owners or managers who interviewed her did not hire her due to her restrictions. Petitioner testified her medical and prescription bills are unpaid.

Petitioner testified she has difficulty sitting on a hard chair and standing for extended periods. Her left leg "goes numb" and she has to change positions. Her pain worsens in cold weather. She finds it difficult to carry bags of groceries. She used to love to travel but she would have to exceed her 10-pound lifting restriction in order to carry a suitcase. When friends ask her to go to a concert or movie, she has to inquire about the location and type of seating. She used to make specialty cakes for relatives and friends but no longer does this due to her lifting restriction and the difficulty of rolling fondant.

Under cross-examination, Petitioner testified she worked three days a week as of her claimed accident. Respondent had a set policy governing the reporting of work accidents. If an employee was injured, he was required to alert his manager and complete forms. Petitioner testified that Lupe, her manager, arrived at work at 8:00 AM on March 14, 2012. She reported her injury to Lupe but Lupe did not provide her with any forms. Lupe told her, "you took your Advil so keep working." The Advil relieved her pain for about half an hour. She told Lupe she

wanted to leave but Lupe told her to keep working. She continued working until about 10 or 10:30 AM, when she took the Tylenol with codeine. Susan gave her this pill. She does not know how Susan obtained this medication. She did not ask Susan if she could go to the hospital. She felt she had no choice but to keep working. She told the nurses and doctors at the Emergency Room she had taken Tylenol with codeine. After being released to light duty by Corporate Health, she received a call telling her she would be provided with a chair. She returned to work after she got this call but the chair was not initially provided. She did not continue working. She was released to full duty as of May 3, 2012. At this point, she had been terminated. She knew of Respondent's "zero tolerance" drug policy. She is aware of the cause of her termination. She returned to Dr. Newman on May 22, 2012 and indicated she began symptomatic again after discontinuing her medication. The first epidural injection caused her to experience headaches. This prompted her to go to an Emergency Room. Respondent's examiner, Dr. Phillips, recommended an MRI. She "barely got to see" Dr. Phillips. Dr. Fisher spoke about surgery as a possibility but did not actually recommend it. During the functional capacity evaluation, she told the evaluator she was in pain 100% of the time. All of the jobs listed on PX 16 were actual posted positions. She E-mailed her resume to some of the listed employers. Others told her "no" due to her restrictions. She has not returned to Kendall College to investigate their placement program. She worked as a bank teller for three or four years before attending Kendall. She did an internship while attending Kendall. After graduating, she worked for a little while at the same place where she did her internship. She then took time off due to family issues. She is 5 feet, 3 inches tall. She currently weighs about 260 pounds. As of March 14, 2012, she weighed about 270 pounds. When she went to the Emergency Room in October 2012, she complained of having fallen and injured her ankle secondary to dizziness. She also expressed concern about having been exposed to meningitis as a result of undergoing injections.

On redirect, Petitioner testified she obtained pain relief after taking the Tylenol with codeine on the morning of March 14, 2012. She was "fine" from about 10:30 AM until noon. She finished her shift that day because she was trained to not abandon a project. Susan was a supervisor. She has tried to lose weight. The internship she did was at Callahan Catering. She did this internship on and off until 2011. Her pain level varies from day to day. She spent only about five minutes with Dr. Phillips.

Under re-cross, Petitioner testified that Susan "works the line" in Respondent's "savory section." She and Susan worked in two different areas. Susan offered her the Tylenol with codeine.

Ronnie Rios, the interim deputy dean of students at the University of Chicago, testified on behalf of Petitioner. Rios testified she and Petitioner have been friends for 25 years. They are best friends. She has never known Petitioner to use drugs or abuse medication. She and Petitioner are in frequent communication.

Under cross-examination, Rios testified that Petitioner drinks alcohol socially but does not use illicit drugs. She is not always with Petitioner and thus has no direct knowledge as to Petitioner's medication intake.

In addition to the exhibits previous described, Petitioner offered into evidence an undated report from Neema Bayran, M.D., an interventional pain management physician, concerning Petitioner's urine toxicology examination. In this report, Dr. Bayran indicated he has practiced in the fields of anesthesiology and pain medicine for more than eleven years and has "vast experience in testing patients taking pain medication." Dr. Bayran addressed the urine toxicology results as follows:

> "It is absolutely normal and expected to see the urine test results positive for codeine and morphine in a patient taking Tylenol with codeine.
>
> I believe that [Petitioner's] story of injury in the morning and taking Tylenol with codeine about one or two hours later totally explains the presence of codeine and its metabolite morphine in her urine at 9:30 PM."

PX 1, p. 2.

No witnesses testified on behalf of Respondent on either November 22, 2013 or January 6, 2014.

Arbitrator's Credibility Assessment

The Arbitrator finds credible Petitioner's testimony that she injured her back at work on March 14, 2012 and was given Tylenol with codeine by a Respondent supervisor, Susan. Petitioner's description of the mechanism of injury finds support in the treatment records. Petitioner's testimony as to her interaction with Susan is plausible and uncontradicted. Petitioner provided Respondent's counsel with an affidavit concerning this interaction on December 18, 2012, long before the hearing. The affidavit identifies Susan Osowski and Lupe Tiscareno as the Respondent supervisors Petitioner interacted with on March 14, 2012. PX 1, p. 3. Respondent did not call either of these individuals at trial.

The Arbitrator also finds Petitioner generally credible with respect to her ongoing pain complaints. Dr. Cullen of Corporate Health Services questioned Petitioner's veracity but nevertheless recommended treatment and work restrictions. Respondent's examiner, Dr. Phillips, noted no obvious Waddell's signs. Neither Dr. Newman nor Dr. Fisher noted any exaggeration of symptoms. The functional capacity evaluator noted 1/5 positive Waddell's signs but described Petitioner as putting forth full effort.

Did Petitioner sustain an accident on March 14, 2012 arising out of and in the course of her employment?

Petitioner's testimony concerning her lifting-related back injury was detailed, credible and largely supported by her treatment records. Petitioner attributed her decision to continue working to her work ethic and her perception that she had no other alternative. Under cross-examination, Petitioner testified that, before she took the Tylenol with codeine, she told Lupe, her manager, she wanted to go home due to her pain, only to be told to continue working. She felt she had no choice but to take the medication that Susan offered and try to finish her shift. She completed accident-related paperwork at Respondent's direction before going to the Emergency Room.

In its proposed decision, Respondent maintains that the Arbitrator should deny benefits in accordance with Section 19(d) of the Act because Petitioner engaged in injurious practices by taking the Tylenol with codeine and continuing to work. Section 19(d) does not pertain to the issue of accident. Rather, it allows the Commission, in its discretion, to "reduce or suspend" compensation but only if an employee "**persist(s)** in insanitary or injurious practices which tend to either imperil or retard his recovery (emphasis added)" or "refuse[s] to submit to such . . . treatment as is reasonably essential to promote his recovery." Even if the Arbitrator viewed Section 19(d) as pertinent, she would be unable to conclude that Petitioner "persisted in insanitary or injurious practices" by taking one Tylenol with codeine pill offered to her by a Respondent supervisor and continuing to perform her duties thereafter. The Arbitrator is also unable to conclude that Petitioner refused to submit to treatment at any point.

The Arbitrator finds that Petitioner sustained an accident on March 14, 2012 arising out of and in the course of her employment.

Did Petitioner establish a causal connection between her work accident of March 14, 2012 and her current condition of ill-being?

Petitioner acknowledged having a prior episode of low back pain in December 2011 but testified this pain did not radiate and resolved on its own. Petitioner's testimony on this point is supported by the histories set forth in her treatment records.

Petitioner testified to an abrupt onset of low back pain after lifting a gelato base on the morning of March 14, 2012. Petitioner continued working thereafter, at her manager's direction and with the help of medication, but consistently described the lifting episode to Emergency Room personnel and subsequent treaters. Petitioner reported significant improvement to Dr. Newman on May 3, 2012, at which point the doctor discharged her to full duty, but credibly testified her symptoms came back several days later, after she discontinued her medication. It was after this recurrence that Dr. Newman prescribed an MRI. There is no indication that the recurrence stemmed from any intervening trauma.

Respondent's examiner, Dr. Phillips, found causation as to a lumbar sprain or strain. Petitioner's treating physicians attributed much of her persistent pain to her weight but did not rule out the accident as an aggravating factor.

The Arbitrator finds that the work accident of March 14, 2012 brought about a change in Petitioner's ability to perform her job and contributed to Petitioner's current lumbar spine condition of ill-being. That Petitioner's weight may be an additional contributing factor does not defeat recovery under Illinois law. Petitioner need only show that the work accident was a causative factor. She need not eliminate all other possible causes. Sisbro, Inc. v. Industrial Commission, 207 Ill.2d 193 (2003). Petitioner's weight did not prevent her from performing the physical tasks required of a pastry cook before the accident.

Is Petitioner entitled to medical expenses?

Petitioner seeks an award of multiple medical and prescription expenses in connection with her injury. These expenses total $66,590.19. PX 15. Respondent objected to many of these expenses on the basis of reasonableness and necessity.

The Arbitrator, having carefully reviewed the treatment records and corresponding itemized bills, declines to award the bills from Northwestern Memorial Hospital associated with Petitioner's Emergency Room visit of August 13, 2012. Records in PX 2 reflect that Petitioner sought Emergency Room care on August 13, 2012 because she had been experiencing abnormal menstrual bleeding for three weeks. Petitioner attributed this bleeding to an earlier epidural injection but there is no evidence indicating that either the Emergency Room physician or Dr. Alzoobi drew the same causative link. The Emergency Room physician indicated there was "no clear mechanism from epidural." PX 2, p. 31.

The Arbitrator also declines to award the bills from Advocate Lutheran General Hospital ($1,664.00) and Advocate Medical Group ($340.00) associated with Petitioner's Emergency Room visit of October 13, 2012. Petitioner mentioned her lower back condition at the Emergency Room but primarily sought care for headaches and lower extremity issues secondary to a fall that had occurred a week or so earlier. The Emergency Room bill includes charges for knee and ankle X-rays. Neither the Emergency Room records nor the subsequent records of Drs. Fisher and Alzoobi establish a clear connection between the work accident and the October 13, 2012 Emergency Room visit. Moreover, the Advocate Medical Group bill (PX 12B) reflects a $0 balance due to a charity payment.

The Arbitrator also declines to award the bill from St. Joseph Hospital relating to the blood work that Petitioner underwent on October 24, 2012. Dr. Alzoobi prescribed this blood work after Petitioner reported excessive menstrual bleeding to him. There is no evidence indicating that the doctor drew a link between that complaint and either the accident or the epidural steroid injections.

With respect to the claimed $29,162.03 bill from United Rehab Providers, which includes charges for the period March 29, 2012 through April 16, 2013, the Arbitrator awards only those charges for therapy and work hardening performed through November 27, 2012, six weeks after Dr. Phillips' last report of October 16, 2012. It was at that point that Dr. Phillips finally had an opportunity to review Petitioner's MRI. He again recommended a six-week course of rehabilitation. The Arbitrator views this as an appropriate period. The Arbitrator also notes that work hardening was put on hold for a period after October 16, 2012 due to exaggeration and/or compliance issues. While Dr. Phillips never reviewed the second MRI, performed on December 19, 2012, that MRI did not prompt Petitioner's treating physicians to embark on a new course of care.

With the exception of the bills addressed above, the Arbitrator awards the medical expenses claimed by Petitioner, subject to the fee schedule.

Is Petitioner entitled to temporary total disability?

Petitioner claims three intervals of temporary total disability benefits: March 15, 2012 through March 20, 2012, March 22, 2012 through May 3, 2012 and June 7, 2012 through April 15, 2013.

As indicated in the preceding section, the Arbitrator relies on Dr. Phillips insofar as treatment recommendations are concerned. When Dr. Phillips reviewed the first MRI on October 16, 2012, he again recommended six weeks of rehabilitation. The Arbitrator views this as a reasonable period. The Arbitrator awards temporary total disability benefits during the following intervals: March 15, 2012 through March 20, 2012, March 22, 2012 through May 3, 2012 (the date on which Dr. Newman released Petitioner to full duty) and June 7, 2012 through November 27, 2012, a total of 31 6/7 weeks. The Arbitrator declines to extend temporary total disability after November 27, 2012, as requested by Petitioner, noting that work conditioning was put on hold at one point, apparently due to lack of compliance. The Arbitrator also notes that, although Dr. Fisher found Petitioner to be at maximum medical improvement on January 4, 2013, Petitioner continued attending work hardening for several months thereafter. There is no evidence indicating that the additional work hardening was beneficial.

Is Petitioner entitled to maintenance?

Petitioner seeks maintenance benefits from April 16, 2013 through the initial hearing of November 22, 2013. The Arbitrator awards maintenance benefits during the four intervals of job search efforts chronicled in PX 16. Those intervals total 14 5/7 weeks. Petitioner offered no explanation as to why she did not begin looking for work until mid-June 2013. Nor did she explain the various interruptions in her job search.

What is the nature and extent of the injury?

Respondent's examiner, Dr. Phillips, characterized Petitioner's injury as a lumbar sprain or strain. He did not note any evidence of nerve root compression on review of Petitioner's initial MRI. He indicated Petitioner would be capable of resuming full duty once she completed six weeks of rehabilitation. He never commented on the functional capacity evaluation, which showed that Petitioner was not capable of resuming her former medium duty occupation as a pastry chef. Petitioner's treating physicians read both MRIs as showing herniations but did not find Petitioner to be a surgical candidate. They relied on the functional capacity evaluation in addressing Petitioner's work capacity.

With respect to the issue of permanency, the Arbitrator assigns greater weight to the opinions of the functional capacity evaluator and treating physicians than to those of Dr. Phillips. The Arbitrator finds it significant that Dr. Phillips never reviewed the functional capacity evaluation.

The Arbitrator considers the factors set forth in Section 8.1b of the Act, noting that neither party offered an AMA impairment rating into evidence.

Petitioner credibly testified to a significant pain condition that impacts many of her daily activities. Petitioner was only 30 years old as of the accident. She underwent training in a specialized occupation she can no longer perform per a valid functional capacity evaluation. She derived both income and pleasure from that occupation.

The Arbitrator, having considered the treatment records, Dr. Phillips' opinions, the functional capacity evaluation, Petitioner's chosen occupation and relatively young age and Petitioner's testimony, finds that Petitioner is permanently partially disabled to the extent of 22.5% loss of use of the person as a whole, equivalent to 112.5 weeks of compensation, under Section 8(d)2.

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

Refugio Marquez,

Petitioner,

vs.

No. 09WC02791

14IWCC0995

Plainfield Construction,

Respondent.

DECISION AND OPINION ON REMAND

This matter comes before the Commission on remand from the circuit court. The circuit court ordered the Commission to reconsider the issues of wage differential, medical expenses and vocational rehabilitation because there was "competent evidence" in the record. For the reasons discussed below, the Commission stands by its original decision.

On January 22, 2009, Petitioner filed an application for adjustment of claim alleging accidental injuries to his neck and back arising out of and in the course of his employment on November 26, 2008.

Following a hearing on all issues on November 30, 2010 and January 26, 2011, the Arbitrator filed a decision on April 1, 2011, finding that Petitioner reached maximum medical improvement on November 18, 2009. The Arbitrator awarded medical expenses, temporary total disability benefits from November 27, 2008, through November 18, 2009, and permanent partial disability benefits to the extent of 7.5 percent of the person as a whole. On May 7, 2012, the Commission modified the Arbitrator's decision, finding Petitioner reached maximum medical improvement on April 7, 2010. The Commission modified the awards of medical expenses and temporary total disability accordingly. Further, the Commission increased the award of permanent partial disability to 15 percent of the person as a whole.

On judicial review, the circuit court entered an order on December 4, 2012, which is handwritten and mostly illegible. The parties stipulate the circuit court directed the Commission to reconsider the issues of wage differential, medical expenses and vocational rehabilitation. Subsequently, on March 13, 2013, the circuit court issued an order stating it had confirmed the Commission's decision and, there being no further appeal, ordering the record returned to the Commission. Finally, on February 11, 2014, the circuit court vacated an order of December 10, 2013, dismissing the matter.[1] The matter having been reinstated *instanter*, the circuit court struck the order of March 13, 2013. The parties agree the matter is presently on remand pursuant to the circuit court's order of December 4, 2012.

In the meantime, Petitioner filed multiple petitions before the Commission in March through May of 2013 seeking medical expenses, prospective medical care, penalties and attorney fees. On April 17, 2013, Respondent filed a response disputing that its conduct had been vexatious and pointing out that there has been no final decision in the matter. In May of 2014, Petitioner renewed his petitions for medical expenses, prospective medical care, penalties and attorney fees.

On October 24, 2013, Petitioner filed his "Brief After Remand" seeking an award of wage differential or permanent disability benefits to the extent of 50 percent of the person as a whole. Further, Petitioner asks the Commission to award past and ongoing medical expenses, referencing his section 8(a) petitions. Petitioner does not seek vocational rehabilitation. Petitioner attached new evidence to his brief in the form of an affidavit, medical records and medical bills. On November 8, 2013, Respondent filed a response brief on remand. As a preliminary matter, Respondent asks the Commission to strike the exhibits attached to Petitioner's brief on remand and the references to new evidence in the brief,[2] asserting that section 19(e) prohibits the introduction of additional evidence at this point on remand. Turning to the issues on remand, Respondent asks the Commission to reaffirm and readopt its decision of May 7, 2012.

On November 25, 2013, Commissioner Brennan held a hearing to clarify the December 4, 2012, order of the circuit court and the procedural posture of the case. Commissioner Brennan found the handwritten order illegible and asked the parties to stipulate to the substance of the order. The parties stipulated the order states the following:

> "This cause coming to be heard, the Court having been fully advised, heard argument of counsel, it is hereby ordered, adjudged and decreed that there is competent evidence that there is a wage differential, and Dr. Chami's bill for consultation and anything from the time of his consultation to the close of evidence should be considered, and vocational rehabilitation should be considered, therefore this matter is remanded to the Commission to make its determination."

---

[1] The order of December 10, 2013, is not in the record.

[2] Respondent also filed a separate motion to strike.

14IWCC0995

The Commission finds the petitions for medical expenses, prospective medical care, penalties and attorney fees are separate and distinct from the circuit court's remand order and should be set for a separate hearing. Correspondingly, the Commission grants Respondent's motion to strike.

Turning to the circuit court's order, the circuit court did not identify any factual or legal errors in the Commission's decision of May 7, 2012, or find any part of the Commission's decision against the manifest weight of the evidence. Rather, the circuit court summarily ordered the Commission to reconsider the issues of wage differential, medical expenses and vocational rehabilitation because there was "competent evidence" in the record.

The Commission's decision and the parties' original briefs on review show the Commission had fully considered the issues of wage differential, medical expenses and vocational rehabilitation. Presently, Petitioner asserts his injuries preclude him from returning to his usual and customary occupation as a union construction laborer and asks the Commission to award wage differential benefits or permanent disability benefits to the extent of 50 percent of the person as a whole. Petitioner appears to variously argue that he had reached maximum medical improvement and that he requires ongoing medical care. Petitioner no longer seeks vocational rehabilitation.

Having carefully reviewed the entire record, the Commission notes evidence of symptom magnification and malingering. The Commission stands by its determination that Petitioner sustained a strain to his neck and lumbar spine and reached maximum medical improvement on April 7, 2010. Thereafter, Petitioner was able to return to work full duty and did not require further medical care. The Commission relies on the opinions of Dr. Malek, a neurosurgeon and Petitioner's treating physician, and Dr. Phillips, an orthopedic surgeon and Respondent's section 12 examiner. The Commission gives little weight to the FCEs performed October 15, 2009, and November 9, 2010, as they were determined to be invalid due to inconsistent effort and symptom magnification. The Commission also gives little weight to the opinions of Dr. Chami, a pain management specialist who did not review Petitioner's prior medical records. Dr. Chami began treating Petitioner after the date of maximum medical improvement and full duty release to return to work. Petitioner complained to Dr. Chami of severe, disabling symptoms. Dr. Chami was unaware of the opinions of Dr. Malek and Dr. Phillips. Likewise, Petitioner's vocational expert, Mr. Boyd, was completely unaware that Dr. Malek had agreed with the opinions of Dr. Phillips and released Petitioner to return to work full duty. The Commission gives little weight to Mr. Boyd's opinion, which was based on Petitioner's subjective complaints of severe disability and an assumption of a 40 pound lifting restriction.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Commission's decision and opinion on review issued May 7, 2012, is reaffirmed and readopted.

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

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

No bond is required for removal of this cause to the Circuit Court. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

NOV 2 0 2014

DATED:
SM/sk
o-10/23/2014
44

Stephen J. Mathis

Mario Basurto

David L. Gore

STATE OF ILLINOIS)
) SS.
COUNTY OF)
WINNEBAGO

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Robert J. Lash,

Petitioner,

14IWCC0996

vs.

NO: 09WC 25859

Championship Investments, LLC; Raptors Football Owners Club, LP; Lowe Entertainment, Inc; Robert Lowe, individually and d/b/a Rock River Raptors; and State Treasurer Dan Rutherford as ex-officio custodian of the Injured Workers Benefit Fund.,

Respondent,

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the respondent, herein and notice given to all parties, the Commission, after considering the issues of wages and coverage, 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.

14IWCC0996

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $16,994.00. 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: NOV 2 1 2014
MJB/bm
o-11/18/14
052

Michael J. Brennan

Kevin W. Lamborn

Thomas J. Tyrrell

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

LASH, ROBERT J
Employee/Petitioner

Case# 09WC025859

14IWCC0996

CHAMPIONSHIP INVESTMENTS LLC: RAPTORS FOOTBALL OWNERS CLUB, LP: LOWE ENTERTAINMENT INC: LOWE, ROBERT INDIVIDUALLY AND D/B/A ROCK RIVER RAPTORS: AND STATE TREASURER RUTHERFORD, DAN AS EX-OFFICIO CUSTODIAN OF THE INJURED WORKERS' BENEFIT FUND
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:

0529 GREG TUITE & ASSOC
GREGORY SZUL
119 N CHURCH ST SUITE 407
ROCKFORD, IL 61101

CHAMPIONSHIP INVESTMENTS LLC
C/O JORDAN J KOPAC SR
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HONEY CREEK, WI 53136

4623 LAW OFFICES OF ROBERT D LOWE
ROBERT MAY
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ROCKFORD, IL 61101

4987 ASSISTANT ATTORNEY GENERAL
LAURA HARTIN
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CHICAGO, IL 60601

14IWCC0996

STATE OF ILLINOIS)
)SS.
COUNTY OF WINNEBAGO)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Robert J. Lash
Employee/Petitioner

Case # **09** WC **25859**

v.

Championship Investments, LLC; Raptors Football Owners Club, LP; Lowe Entertainment, Inc; Robert Lowe, individually and d/b/a Rock River Raptors; and State Treasurer Dan Rutherford as ex-officio custodian of the Injured Workers Benefit Fund.
Employer/Respondent

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Anthony C. Erbacci**, Arbitrator of the Commission, in the city of **Rockford**, on **November 15, 2013**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **March 20, 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 **$32,066.84**; the average weekly wage was **$616.67**.

On the date of accident, Petitioner was **23** 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 **$500.00** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$0**.

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

ORDER

Respondent shall pay Petitioner temporary total disability benefits of **$411.11**/week for **20 4/7**th's weeks, commencing **March 21, 2009 through August 10, 2009**, as provided in Section 8(b) of the Act. Respondent shall be given a credit of $500.00 on the TTD owed.

Respondent shall pay reasonable and necessary medical services, pursuant to the medical fee schedule, of **$19,104.77** or the Fee Schedule amount, whichever is less, to the medical providers with outstanding bills as documented in Petitioner's Exhibit 10, as provided in Sections 8(a) and 8.2 of the Act.

Respondent shall pay Petitioner permanent partial disability benefits of **$370.00**/week for **50.1** weeks, because the injuries sustained caused the **30%** loss of the **right foot**, as provided in Section 8(e) of the Act.

The Illinois State Treasurer, ex-officio custodian of the Injured Workers' Benefit Fund, was named as a co-respondent in this matter. The Treasurer was represented by the Illinois Attorney General. This award is hereby entered against the Fund to the extent permitted and allowed under Section 4(d) of this Act. In the event the Respondent/Employer/Owner/Officer fails to pay the benefits, the Injured Workers' Benefit Fund has the right to recover the benefits paid due and owing the Petitioner pursuant to Section 5(b) and 4(d) of this Act. Respondent/Employer/Owner/Officer shall reimburse the Injured Workers' Benefit Fund for any compensation obligations of Respondent/Employer/Owner/Officer that are paid to the Petitioner from the Injured Workers' Benefit Fund.

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

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

December 11, 2013
Date

DEC 23 2013

14IWCC0996

FACTS:

This matter was heard on November 15, 2013 in Rockford, Illinois. The Petitioner was present and represented by counsel, and the Illinois Attorney General's office appeared on behalf of the Illinois State Treasurer, as *ex-officio* custodian of the Injured Workers' Benefit Fund, and participated in the arbitration proceedings. No one appeared on behalf of the other Respondents although it is noted that there was an attorney of Record on behalf of Respondent Robert Lowe. Respondent was not notified of the hearing by mail, certified or otherwise. However, the case was above the red-line. No attorney on the behalf of Respondent appeared at the call.

The Petitioner testified that on March 20, 2009, he was a football player for the Rock River Raptors. He testified that, at that time, the Raptors were owned by Championship Investments, LLC, the Raptors Football Owners Club, LP, and by Robert Lowe, who was understood to be the team owner. The Petitioner's employment contract was admitted into evidence as Petitioner's Exhibit 1. The Petitioner testified that, on that date, he was playing a professional football game at the Metro Center in Rockford, Illinois. The Petitioner testified that the Raptors played their home games at the Metro Center which was an indoor stadium, open to the general public, where alcohol was sold and consumed by patrons on the premises.

The Petitioner testified that his date of birth is February 27, 1986 and that on March 20, 2009, he was single, with no dependents.

The Petitioner testified that his employment contract specified that he was to be paid $100.00 per game and $50.00 per practice as a starter. The Petitioner testified that he was a starting running back and that he practiced 5 times per week. He testified that he played one game before the date of the accident and was injured during the second game. He also testified that he received a housing allowance where the team paid for an $800.00/month apartment that he shared with two other players.

The Petitioner testified that on March 20, 2009, while playing as a running back, he injured his right foot and ankle while being tackled. The game was stopped, the team trainer and coach came out onto the field, and he was taken by ambulance to St. Anthony Medical Center emergency room. The Petitioner testified that Robert Lowe was aware of the incident and the fact he was taken to the emergency room.

The ambulance record notes that on March 20, 2009, they responded to the Metro Center and examined the Petitioner. The Petitioner gave a history of being tackled and hearing his ankle "snap." He was taken to St. Anthony Medical Center where he was diagnosed with a fractured right fibula and referred to Dr. Mark Hastings. On March 26, 2009, Dr. Hastings performed an open reduction internal fixation of the right distal fibula.

The Petitioner testified that as he was from Ohio and could no longer play football, he moved back to Ohio. His treatment then continued with Dr. Bradley Youse. The Petitioner's

right foot at the location of the surgical site then became infected and, on May 4, 2009, the Petitioner received treatment at the Med Central emergency room and Med Central Hospital where he was an inpatient. The Petitioner also attended therapy at Med Central Hospital for his ankle condition. On July 1, 2009, the Petitioner was noted to have just started jogging in physical therapy. On October 2, 2009, he was released from Dr. Youse's care.

The Petitioner testified that Dr. Youse had him off work until his release from care and that he did not work until he found employment at Abraxas, a drug and alcohol rehab facility, and started working there on August 11, 2009. The Petitioner testified that he did not play football for the remainder of the 2009 season. The Petitioner further testified that he did receive approximately $500.00 in Temporary Total Disability benefits until he was informed that worker's compensation coverage for his injury was denied.

On September 25, 2013, the Petitioner was examined by Dr. Jeffrey Coe, a board certified occupational medicine physician. Dr. Coe's examination noted tenderness over palpable screw heads under the right ankle, atrophy in the right calf, decreased range of motion, swelling in the right ankle, and an antalgic gait. The Petitioner testified that he currently gets sharp pain in his right ankle frequently, still feels the 6 screws in the ankle, his ankle will buckle and roll, it is stiff and he lacks range of motion, and he takes Ibuprofen for it when needed.

CONCLUSIONS:

In Support of the Arbitrator's Decision relating to (A.), Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act, the Arbitrator finds and concludes as follows:

The Respondents were operating a football team playing its games at an indoor stadium which was open to the general public. Alcohol was sold and consumed at the stadium during the games. Accordingly, the provisions of the Illinois Worker's Compensation Act apply to Respondents under Section 3(12) of the Act.

In Support of the Arbitrator's Decision relating to (B.), Was there an employee-employer relationship, the Arbitrator finds and concludes as follows:

The Petitioner testified that he was employed by the Rock River Raptors. The Raptors were owned by Championship Investments, LLC, the Raptors Football Owners Club, LP, and Robert Lowe. Mr. Lowe was considered the team owner. Petitioner's employment Contract was entered into evidence and demonstrates and employment relationship between Petitioner and Respondents.

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 (D.), What was the date of the accident, the Arbitrator finds and concludes as follows:

The Petitioner testified that on March 20, 2009, he was playing for the Raptors during a football game when he was tackled and felt immediate pain in his right ankle. The Petitioner's treatment records corroborate this history of the accident. Accordingly, the Petitioner did have an accident that arose out of and in the course of his employment and the date of accident is found to be March 20, 2009.

In Support of the Arbitrator's Decision relating to (E.), Was timely notice of the accident given to Respondent, the Arbitrator finds and concludes as follows:

The Petitioner's injury was observed by his team trainer and coach as the game was stopped, and Petitioner was taken by the ambulance to the emergency room. The Petitioner testified that Mr. Lowe was aware of the injury that day or the next. Accordingly, the Respondents had timely notice of the accident.

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

The Petitioner testified that he felt immediate pain in his right ankle and was taken to the emergency room by ambulance. His treatment records corroborate the history of the accident and outline his medical treatment until later in 2009. Since that time, he has had no other accidents or injuries involving his right ankle. Prior to the injury, he has no right foot or ankle problem. Dr. Jeffrey Coe examined Petitioner on September 25, 2013 and opined that Petitioner's condition of ill-being with his right ankle is related to his accident of March 20, 2009. The Petitioner testified as to his symptoms in his right foot and ankle which have existed since the injury and to the present time. Accordingly, the Petitioner's condition of ill-being is causally related to the injury.

In Support of the Arbitrator's Decision relating to (G.), What were Petitioner's earnings, the Arbitrator finds and concludes as follows:

The Petitioner's testimony and his employment Contract indicate that he was paid $100.00/game and $50.00/practice. He was paid weekly, practiced 5 times per week, and played a game per week. Accordingly, his weekly wage from games and practices alone was $350.00. In addition, he received a monthly housing allowance of $800.00 although he shared his apartment with two other players. Therefore, he received the equivalent of another $266.67 in housing benefits. Accordingly, his average weekly wage is determined to be $616.67.

14IWCC0996

In Support of the Arbitrator's Decision relating to (H.), What was Petitioner's age at the time of the accident, and (I.), What was Petitioner's marital status at the time of the accident, the Arbitrator finds and concludes as follows:

The Petitioner testified that his date of birth is February 27, 1986. Therefore, the Petitioner was 23 years of age at the time of his injury. The Petitioner was single at that time with no dependents.

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:

Petitioner's Exhibits 2-9 document his medical care as a result of the accident all of which were reasonable and necessary. Petitioner testified that his surgery was paid for but all his other medical bills were not paid for and are outstanding. Petitioner's Exhibit 10 was offered and introduced into evidence documenting Petitioner's outstanding medical bills totaling $19,104.77. Accordingly, Respondent is liable to Petitioner in the amount of $19,104.77, or the Fee Schedule amount of the respective bill, if less.

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

The Petitioner was off work from March 21, 2009 through August 10, 2009 as he started another job on August 11, 2009. The Petitioner testified he did receive a "couple" of benefit checks following his injury, which he estimated to be $500.00, but then did not receive any further benefits. Accordingly, the Petitioner is entitled to Temporary Total Disability benefits from March 21, 2009 through August 10, 2009, a period of 20 4/7ths weeks, with the Respondent due a credit of $500.00.

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 suffered a fractured fibula requiring open reduction and internal fixation. He had 6 screws in his ankle. He testified that he gets sharp pain in his right ankle frequently, still feels the screws, has stiffness in the ankle, lacks range of motion, feels the ankle buckle and roll, and still takes over the counter medication. Dr. Jeffrey Coe's examination noted tenderness over palpable screw heads under the right ankle, atrophy in the right calf, decreased range of motion, swelling in the right ankle, and an antalgic gait. It is also noted that the Petitioner is a young individual, now 27 years of age. Based on the above, the Arbitrator finds that Petitioner is entitled to 30% loss of the right foot pursuant to Section 8(e) of the Act.

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Robert N. Falzone,

14IWCC0997

Petitioner,

vs.

NO: 13 WC 4210

Sangamon County Sheriff's Dept.,

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 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 April 17, 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.

14IWCC0997

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: NOV 21 2014
o11/5/14
RWW/rm
046

Ruth W. White

Charles J. DeVriendt

Daniel R. Donohoo

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

14IWCC0997

FALZONE, ROBERT N
Employee/Petitioner

Case# 13WC004210

SANGAMON COUNTY SHERIFF'S DEPT
Employer/Respondent

On 4/17/2014, 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:

2046 BERG & ROBESON PC
STEVE W BERG
1217 S 6TH ST PO BOX 2485
SPRINGFIELD, IL 62705

RUSIN MACIOROWSKI & FRIEDMAN LTD
JENNIFER MEJIA
2506 GALENA DR SUITE 108
CHAMPAIGN, IL 61821

14IWCC0997

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

ROBERT N. FALZONE
Employee/Petitioner
v.
SANGAMON COUNTY SHERIFF'S DEPT.
Employer/Respondent

Case # 13 WC 4210

An *Application for Adjustment 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 **December 11, 2013** and **February 17, 2014**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **April 3, 2012**, Respondent ***was*** operating under and subject to the provisions of the Act.

On this date, an employee-employer relationship ***did not*** exist between Petitioner and Respondent.

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

Timely notice of this accident ***was*** 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 **$910.00**; the average weekly wage was **$17.50**.

On the date of accident, Petitioner was **29** years of age, ***single*** with **2** dependent children.

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

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

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

ORDER

Petitioner is not entitled to any benefits under the Act because Petitioner was not an employee of 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

04/14/2014
Date

APR 17 2014

14IWCC0997

STATE OF ILLINOIS)
)SS
COUNTY OF SANGAMON)

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

ROBERT N. FALZONE
Employee/Petitioner

v. Case # 13 WC 4210

SANGAMON COUNTY SHERIFF'S DEPT.
Employer/Respondent

MEMORANDUM OF DECISION OF ARBITRATOR

FINDINGS OF FACT

Petitioner, Robert Falzone, testified he was an inmate at the Sangamon County Jail from approximately October 2011 to June 2012. He testified he requested to be a trustee, and he began working as a trustee at the jail on or after March 20, 2012. As a trustee, Petitioner testified he received $17.50 per week, and he performed trustee duties for approximately twelve hours per day, seven days per week. He was assigned to work in the kitchen, and his duties consisted of cooking, cleaning, and serving meals.

Petitioner testified he thought of himself as an employee of Respondent, but he admitted he did not fill out an employment application or an I-9 employment form. He did not need to show his Social Security card or a birth certificate prior to beginning his duties as a trustee. He testified he did not get to pick the hours he worked or receive a minimum wage.

Respondent's Superintendent, Terry Durr, testified Petitioner was not an employee of the Sangamon County Sheriff's Department. Rather, Petitioner volunteered to be a trustee. Superintendent Durr testified inmates could not volunteer as trustees unless they were serving time for a non-violent crime. Assuming an inmate met the basic criteria and had not had any past disciplinary problems, Superintendent Durr testified any willing inmate was eligible to become a trustee if a trustee position was available. Superintendent Durr testified that there were approximately 300 inmates at the jail at any given time, and only sixteen trustee spots were available at any given time. Superintendent Durr testified that if an inmate is willing, he may remain a trustee until he is released from jail, unless there is a disciplinary problem. Superintendent Durr testified that all employees at Sangamon County Jail complete a contract for hire and receive a contracted-for wage, whereas the money given to trustees for their services is considered a gratuity. Superintendent Durr testified that the $2.50 per day given to trustees was for their use at the jail commissary. Unlike an employee, Superintendent Durr testified Petitioner did not fill out an employment application or I-9 employment form. Further, Superintendent Durr testified that trustees were given more privileges and freedoms, such as more to eat and waiver of nurse fees. Superintendent Durr explained that waiver of nurse fees was not health insurance. He stated that the jail was statutorily required to pay for necessary health care of its inmates, and it charged a small fee when inmates saw the nurse in order to recoup some of the costs of health care. Petitioner consistently received the full weekly amount of $17.50 until he was released from jail on or about June 6, 2012. (See Petitioner's Exhibit (PX) 1).

Petitioner testified he was performing duties as an inmate trustee in the jail kitchen on April 3, 2012. Petitioner testified he cut his right index finger on a knife while he was washing dishes. Petitioner testified he reported the injury the next day, and Superintendent Durr's testimony confirmed that he received notice of the accident within 45 days after it occurred.

On April 4, 2012, Petitioner received medical treatment for his right index finger at St. John's Hospital. (PX 5). On December 4, 2012, Dr. Nada Berry performed surgery on Petitioner's right index finger. At the end of the surgery, Dr. Berry put a four inch splint on Petitioner's finger. (PX 7). Petitioner testified he did not have a splint on his finger after the surgery. Instead he had a wrap on his finger. He testified he wore his wrap regularly as directed by his doctor.

On January 3, 2013, Petitioner had a second surgery on his right index finger. According to the surgical report, surgery was indicated because Petitioner "was noncompliant, and the extensor tendon re-ruptured." Dr. Berry performed an extensor tendon repair with microscrew placement. As with the first surgery, Dr. Berry splinted Petitioner's finger once the surgical procedure was complete. (PX 7). After the second surgery, Petitioner testified he wore his splint regularly as directed by his doctor.

CONCLUSIONS OF LAW

Issue (B): Was there an employee-employer relationship?

By seeking benefits under the Illinois Workers' Compensation Act, 820 ILCS 305/1 *et seq*. (hereafter the "Act"), Petitioner is alleging that his position as an inmate trustee constituted employment by the jail. Petitioner testified he requested to be a trustee, and he was appointed as a trustee when a position became available.

Superintendant Durr testified that not all inmates are eligible to be trustees. In order to be a trustee, inmates had to be non-violent offenders. Absent the required criteria, trustee positions were awarded based on availability. Superintendent Durr testified that there are only sixteen trustee positions available at any given time out a total jail population of about 300. Superintendent Durr testified that many inmates desire to become trustees. He testified that all trustees are given a daily gratuity of $2.50 per day. They are also given privileges, such as more freedom and more food, than that of the other inmates. Superintendent Durr clarified that even though there are perks to being appointed as a trustee, a trustee position is not equivalent to that of an employee. He testified that trustees are not employees. Unlike a trustee, employees are contractually hired by the jail and receive a salary pursuant to contract.

Petitioner admitted he did not fill out an employment application, fill out an I-9 employment eligibility form, or provide verification of his fitness to work by providing his birth certificate or Social Security card. Superintendant Durr confirmed that there was not a contract for hire or any background check performed before Petitioner became a trustee.

Petitioner testified he did not receive minimum wage. In fact, Superintendent Durr testified that Petitioner did not receive any wages; instead, Petitioner received trustee gratuity for donating his time as a trustee. Superintendent Durr testified that the gratuity could be used to purchase items at the commissary.

The Illinois legislature has addressed whether an inmate is an employee. According to the Illinois Code of Corrections, "'Commitment' means a judicially determined placement in the custody of the Department of

Corrections on the basis of delinquency or conviction." 730 ILCS 5/3-1-2(b). Further, the Code states as follows:

> "Committed Person" is a person committed to the Department, however a committed person shall not be considered to be an employee of the Department of Corrections for any purpose, including eligibility for a pension, benefits, or any other compensation or rights or privileges which may be provided to employees of the Department.

730 ILCS 5/3-1-2(c).

As such, the Illinois legislature has determined that an inmate is not an employee. The General Assembly specifically excluded inmates from receiving benefits awarded to employees, which would include workers' compensation benefits.

Unlike the Illinois legislature, the Commission itself has not directly addressed whether an inmate is an employee. However, upon evaluation of the statute above, the Act, and relevant case law, an inmate is not an employee for the purposes of workers' compensation.

Though the Commission has not yet addressed whether an inmate is an employee, the Court of Claims of Illinois has long held that an inmate is not an employee under the Act. *See Kapella v. State of Illinois*, 4 Ill. Ct. Cl. 187 (1921); *Tiller v. State of Illinois*, 4 Ill. Ct. Cl. 243 (1922); *Heise v. State of Illinois*, 6 Ill. Ct. Cl. 267 (1929); *Hazelwood v. State of Illinois*, 6 Ill. Ct. Cl. 259 (1929); *Fitzmaurice v. State of Illinois*, 6 Ill. Ct. Cl. 247 (1929); *Collins v. State of Illinois*, 11 Ill. Ct. Cl. 445 (1941).

In *Tiller v. State of Illinois*, cited *supra*, inmate Joseph Tiller was injured while he was cleaning an ash pit. He filed a claim with the Court of Claims with the theory that he may recover pursuant to the Act. The court held that as an inmate, the claimant "forfeited his right of personal liberty, his right of social and business relations with the world, his citizenship, [and] his civil rights to contract or to be contracted with . . . as a part of penalty for his crime. There is no employment, express or implied, for hire between the State and its convicts." *Tiller*, 4 Ill. Ct. Cl. at 245. Further, the court held that the State "is not an industrial insurance company for its convicts," and it is against public policy to permit inmates to recover under the Act. *Id.* at 245-246.

In *Fitzmaurice v. State of Illinois*, cited *supra*, the Court of Claims held that the claimant was not an employee of the State at the time of the accident, but was an inmate of a State institution, and would further not come under the provisions of the Act. The court in *Fitzmaurice* also stated the following: "This court has repeatedly held that the State is not legally or equitably liable to an inmate who receives an injury while confined in one of its institutions." *Fitzmaurice*, 6 Ill. Ct. Cl. at 248.

Although the claimants in the foregoing cases were inmates in State institutions, the Arbitrator finds that Petitioner in this matter being a county inmate is immaterial, and finds sound guidance in the aforementioned Court of Claims holdings and reasoning. Further, the same reasoning and guidance in this regard is also found in the Code of Corrections definitions discussed above.

Based on the foregoing, the Arbitrator finds that Petitioner, as an inmate at the Sangamon County Jail, is not an employee entitled to benefits under the Act.

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

Issue (E): Was timely notice of the accident given to Respondent?;

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

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

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

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

Since Petitioner is not an employee under the Act, the issues of accident, notice, causal connection, liability for medical expenses, temporary total disability benefits, and the nature and extent of the injury are rendered moot. No benefits are awarded in this claim.

STATE OF ILLINOIS)
) SS.
COUNTY OF)
WILLIAMSON

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

LAURIE BARTON,

Petitioner,

14IWCC0998

vs. NO: 13 WC 6892

STATE OF ILLINOIS – HARRISBURG YOUTH 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, permanent partial disability, and medical expenses, and being advised of the facts and law, reverses the Decision of the Arbitrator and finds that Petitioner sustained her burden of proving a compensable accident and awards appropriate benefits.

Findings of Fact and Conclusions of Law

1. Petitioner testified she works for Respondent as a juvenile justice specialist. She drives to work and parks in the designated employee parking lot. She is required to park in that lot. She enters the facility through the main gate and there are about eight steps leading up to the gate. One could forego the steps and "walk around the sides of the hill." On December 30, 2012, it was very icy and snow was piled up; one had to use the stairs to gain access to the facility. There were "mounds of snow" on the hill next to the stairs.

2. At about 11:30 am she was leaving the facility on her break, which is allowed under the union contract. The mounds of snow were still covering the hill and the stairs were fairly icy. There was "a little bit of an attempt" to clear the ice from the stairs. There was salt on the steps but it had not "completely eliminated or diminished the ice in any way." On the path at the bottom of the stairs leading into the parking there "was a huge patch of ice you couldn't even step over."

3. Petitioner testified she slipped and fell injuring her left leg. There was no way to get to her car other than stepping on the ice. She never previously had injuries or treatment to her left leg or ankle. Petitioner eventually treated with Dr. Young who put a temporary cast on her leg. She progressed to a walking air cast and had physical therapy.

4. Petitioner also testified that currently she has 30% loss of range of motion in her left ankle and foot. She has swelling "after periods of walking, in an attempt to exercise." She elevates her foot when she gets swelling. She also has some stiffness in her ankle "usually after a couple of days of walking." She has quite of bit of pain with the cold weather. She estimated she is on her feet for four of the eight hours in her work day.

5. Petitioner testified she cannot bowl like she used to because she does not have the balance. She also used to enjoy kickboxing, which she is not longer able to do. She has gained 30 pounds after the accident because it is difficult for her to exercise due to stiffness, loss of range of motion, and balance issues.

6. On cross examination, Petitioner testified the patch of ice was at the bottom of the stairs. She agreed that there is an incline between the parking lot and the facility and the patch of ice was "even with the parking lot." Petitioner works from 8 am to 4 pm. She was taking her break around lunchtime. Petitioner agreed that the patch of ice was present when she first arrived at work; she actually slipped on it at that time as well. Petitioner did not have a designated space in the parking lot. Non-employees visit the facility and also park in that lot and use the same stairs to enter the facility; they have "their own little designated area." She attempted to kick box a couple of months previously but her leg swelled. She now bowls once a week while she used to bowl four times a week.

7. Kurt Sutton was sitting next to Respondent's lawyer and was called to testify by Petitioner. He testified he knew Petitioner and she was a good employee. He disagreed with her testimony that members of the public are limited to certain designated areas in the parking lot. They can park anywhere. The only designated spaces are for "people who are employee of the year, don't use sick time, State vehicles."

8. Mr. Sutton also testified that there are several ways into the building and they are very diligent in terms of salting the premises. In fact Petitioner's "husband was on grounds detail prior to that." Nevertheless, he was sure there was a slick spot. One could use the stairs or a sidewalk next to the stairs.

9. On cross examination, the witness testified members of the public also have access to the stairs to enter the facility.

10. Petitioner executed an accident report the same day. She reported slipping, falling and twisting her left ankle in the parking lot on ice that had not been cleared. The supervisor's report indicated she slipped on ice on the stairs while going to the parking lot on her break. A witness report of Mike Crank indicated he saw Petitioner slip and fall on ice in the parking lot on the only path to get to the vehicles. She tried to cross the ice slowly.

11. The medical records indicate that on December 31, 2012, Petitioner presented to Dr. Miller after injuring her left ankle after a fall on ice at work the previous day. Symptoms included ankle pain, swelling, bruising, instability, stiffness, decreased range of motion, and difficulty bearing weight. Dr. Miller referred Petitioner to Dr. Young.

12. On December 31, 2012, Petitioner presented to Dr. Young for evaluation upon referral from Dr. Miller. Petitioner slipped and fell in the parking lot of Respondent's facility injuring her left ankle. She reported 8/10 pain with associated swelling and bruising. X-rays showed a distal fibula fracture which appeared to be in good alignment. Dr. Young thought surgery was not indicated, applied a posterior splint, and restricted Petitioner to sedentary duty.

13. On April 1, 2013, Petitioner finished work hardening and "feels that she is doing very well." She still had slight edema. Dr. Young released her to full duty and from treatment.

In holding Petitioner did not prove a compensable accident the Arbitrator found Petitioner was not placed in greater risk for injury by her job duties because members of the public were exposed to the same risk associated with the ice. He noted that although the Application for Adjustment of Claim indicated the accident was in the parking lot, it clearly occurred at the base of the stairs leading from the building to the parking lot.

The Commission reverses the decision of the Arbitrator and finds Petitioner's accident did occur in the course of and arose out of her employment. There is a general rule that if a claimant injures oneself in a fall in a parking lot controlled by Respondent and in which the claimant is directed to park because of an accumulation of ice, the accident is compensable even if the general public also has access to the lot. *See, Hiram Walker & Sons, Inc., v. Industrial Commission*, 41 Ill 2d 429 (1969); *Mores-Harvey v. Industrial Commission*, 345 Ill. App. 3d 1034 (3rd Dist. 2004).

Here, the parties only really dispute whether the accident occurred in the parking lot or at the bottom of the stairs leading to the parking lot. While that may be a distinction, the Commission concludes that is a distinction without a difference. The record appears unclear on exactly where the accident occurred, with some accounts referring to the parking lot itself and other referring to the path to the parking lot. Obviously, if the accident occurred in the lot itself that fact would put the case more squarely within the realm of the cases cited above. However, that really should not affect the risk associated with the employment because Respondent controlled the path at the bottom of the stairs as well as the parking lot, there was a hazardous condition on the premises controlled by Respondent, and the public had equal access to the path leading to the parking lot as it did to the parking lot itself.

There is no indication that the treatment Petitioner received was in any way unrelated to the resulting injury, unnecessary, or unreasonable. Because it holds that Petitioner sustained a compensable accident, it awards the medical bills submitted by Petitioner subject to the appropriate medical fee schedule. Petitioner did not lose any time from work due to her injury.

14IWCC0998

Petitioner suffered a non-displaced fracture of her ankle. She testified that the injury has significantly affected her ability to engage in specific avocations and her ability to exercise in general. As a result she has gained 30 pounds. She testified to continuing reduced range of motion, swelling, pain, and stiffness in her foot and ankle, as well as problems with balance. In assessing the record as a whole, the Commission finds that an award of 20% loss of the use of the left foot is appropriate in this case.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $769.15 per week for a period of 33.4 weeks, as provided in §8(e) of the Act, for the reason that the injuries sustained caused 20% loss of the use of the left foot.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $7,510.50 for medical expenses under §8(a) of the Act pursuant to the applicable medical fee schedule under §8.2 of the Act.

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

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

DATED: NOV 2 1 2014

Ruth W. White

Daniel R. Donohoo

Charles J. DeVriendt

RWW/dw
O-11/5/14
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	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Brian Veath,

Petitioner,

14IWCC0999

vs.

NO: 12 WC 39067

SOI/Menard Correctional Center,

Respondent.

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed April 3, 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.

14IWCC0999

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: NOV 2 1 2014
o11/5/14
RWW/rm
046

Ruth W. White

Charles J. DeVriendt

Daniel R. Donohoo

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

14IWCC0999

VEATH, BRIAN
Employee/Petitioner

Case# **12WC039067**

SOI/MENARD CORRECTIONAL CENTER
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:

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

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

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

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

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

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

APR 3 2014

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

14IWCC0999

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)

BRIAN VEATH
Employee/Petitioner

v.

Case # 12 WC 039067

Consolidated cases: N/A

STATE OF ILLINOIS/MENARD 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 **Nancy Lindsay**, Arbitrator of the Commission, in the city of **Collinsville**, on **January 30, 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 _____

14IWCC0999

FINDINGS

On the date of accident, **October 6, 2012**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$$68,196.00**; the average weekly wage was **$1,311.46**.

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

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

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

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

ORDER

Respondent shall pay reasonable and necessary medical services of **$85,972.99**, as provided in Sections 8(a) and 8.2 of the Act and pursuant to the Medical Fee Schedule. Respondent shall be given a credit for any medical bills that have been paid, and Respondent shall hold Petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act.

Respondent is ordered to provide to Petitioner prospective medical treatment in the form of surgical intervention and corresponding course of treatment as prescribed by Dr. Gornet with regard to Petitioner's lumbar spine condition.

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

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

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

Harry Lindsay
Signature of Arbitrator

March 26, 2014
Date

ICArbDec19(b)

APR 3 - 2014

Findings of Fact and Conclusions of Law

The Arbitrator finds:

On October 6, 2012, Petitioner was a forty-eight (48) year old correctional sergeant for Respondent. He testified that he has been employed with the State of Illinois for twenty-two (22) years, and has been at the Menard Correctional Center for the past twenty-one (21) years. Petitioner testified that he hired in as a correctional officer at Menard, but was promoted to the position of sergeant after approximately fifteen (15) or sixteen (16) years of service.

The parties stipulated that on October 6, 2012, Petitioner sustained accidental injuries which arose out of and in the course of his employment. (AX1) According to the Notice of Injury form completed by Petitioner on October 6, 2012, Petitioner was restraining a combative inmate when he was hit in the face by the inmate and slipped on food lying on the floor pulling his right groin and twisting/ pulling his right knee. Dustin Salger was listed as a witness. Petitioner listed injuries to his head, right hand, and right groin. (RX 1) That same day an "Initial Workers' Compensation Medical Report" was completed by Nurse Walter. Petitioner's injuries were listed as: pain and slight swelling to the right hand with a small abrasion; a left hand abrasion; abrasion to the right cheek; and severe pain to the right groin (with pain upon walking but with no loss of range of motion noted). Petitioner was encouraged to visit the emergency room or convenient care for evaluation and given Ibuprofen. (PX 3; RX 1)

Petitioner completed an Incident Report on October 8, 2012. Petitioner's account of the accident included a notation that he and another individual had to take the inmate to the floor due to the inmate's combative nature and need to be restrained. (RX 1)

Petitioner reported to Red Bud Regional Hospital on October 9, 2012, where an x-ray was taken of his right knee. (PX1)

On October 10, 2012, Dustin Salger completed a Witness Report. He noted that Petitioner was struck in the head with a closed fist and also hit his head on one of the tables. (RX 1)

A Supervisor's Report was completed on October 11, 2012. In it, Lt. Cartwright noted that Petitioner had a knot on his head with facial scratches and swelling. It was further noted that Petitioner was also limping when he walked to the Health Care Unit. (RX 1)

Petitioner was examined by Dr. Choi on October 11, 2012 in regard to his presenting complaints of right groin and knee pain stemming from his October 6, 2012 accident. Dr. Choi took the following history from Petitioner:

> Mr. Veath is a 40-year-old white male employed as a correctional surgeon [sic] at Menard Facility for the past 19 years who presents for evaluation of right groin and knee pain. He states that he sustained an injury on 10/06/12. He reports he was in an altercation with an inmate in a dining room hall after a dispute. He attempted to place handcuffs on the inmate when an ensuing altercation occurred. He cannot recall exactly the mechanism of injury; however, he does recall that

> both of them were stuffing [sic] and wrestling on the floor. He states that he did fall on to his right knee and developed pain as well as ecchymosis along the anteromedial aspect. In addition, he had a significant groin pain as well.
>
> (PX3, Dr. Choi, 10/11/12 o/v)

Petitioner reported going to the emergency room on October 8, 2012 but he had no paperwork from the visit to show the doctor. By history, x-rays had been taken and read as negative, and Petitioner was told to return to work at a light activity level although no specific restrictions were provided. Petitioner also reported he had already contacted an attorney. (PX 3)

According to Dr. Choi's office note, Petitioner's primary complaint was groin pain although he also had some right knee and thigh complaints. Regarding his knee, he described a dull and shooting pain with occasional episodes of painful popping or catching. Petitioner also reported significant groin pain especially when twisting his thigh. Going up and down stairs, kneeling, and squatting were also painful. Examination of Petitioner's right thigh revealed diffuse tenderness along the groin due to adductor muscle groups. He was also noted to have diffuse pain throughout his hip flexor origin. Resisted adduction of his thigh caused significant sharp pain but there were no mechanical symptoms with full range of motion in terms of hip flexion, adduction, and extension. Petitioner's right knee was also examined and the right knee x-rays were obtained from the emergency room. Dr. Choi's impression was a right hip adductor strain and right knee pain of unknown etiology. He recommended an MRI of Petitioner's right knee, pelvis and thigh. Until the results were known Petitioner was advised to refrain from squatting, kneeling, running, and ladder climbing. (PX 3)

Petitioner signed his Application for Adjustment of Claim on November 1, 2012. In it, he claimed right knee/leg, left elbow/arm, and groin injuries. (RX 2)

Petitioner's care was subsequently transferred to Dr. Nathan Mall, one of Dr. Choi's partners within Regeneration Orthopedics. (PX3, Dr. Choi, 1/17/2013 o/v)
Petitioner first presented to Dr. Mall, an orthopedic surgeon, on March 6, 2013. At that time, Dr. Mall took a history of Petitioner's injury:

> Brian is a 49-year-old employee of the Illinois prison system. On 10/6/12 he was hit in the head by a prisoner with a food tray, causing him to get in a fight with a prisoner. He was tackled by a coworker, and slipped on a piece of chicken that had fell and hit the floor. This caused his leg to abduct, with severe pain in his groin, and then his head hit a table. He states that his pain is improving but still is fairly significant. It wakes him up at night. He feels a pulling sensation in his groin. He is [sic] difficulty lifting his leg. He has difficulty with stairs and steps. He has not had any physical therapy or anti-inflammatory medications thus far. He also has noted a right knee anterior pain. He states that it does swell on occasion, but this is minimal swelling. He states that he is

unable to fully bend his knee, because it hurts to keep his knee bent for prolonged periods of time.

(PX3, Dr. Nathan Mall, 3/6/2013 o/v)

Upon physical examination, Dr. Mall noted hip tenderness to palpation in the groin area along the adductor tendons, as well as pain in the groin, especially with hip flexion as well as flexion internal rotation. At that point, Dr. Mall's assessment was right hip groin strain, hip impingement, and patellofemoral pain. He recommended an MRI to further evaluate Petitioner's hip joint, and also recommended a cortisone injection be performed for diagnostic and therapeutic purposes, as well as physical therapy. Dr. Mall also indicated that assuming the history provided by Petitioner was factually correct, that since he was not suffering from any groin pain prior to the October 6, 2012 injury, he suffered a significant groin strain, which could also cause a labral tear. He believed that Petitioner's hip and knee pain were causally related to the October 6, 2012 injury. (PX 3)

Petitioner next followed up with Dr. Mall on March 8, 2013. Dr. Mall indicated that the MR arthrogram showed a clear anterosuperior labral tear with no evidence of cartilage damage of the hip. Dr. Mall continued to recommend conservative treatment in the form of physical therapy for Petitioner's groin as well as quadriceps muscle, and an anti-inflammatory medication. He also recommended a cortisone injection with regard to Petitioner's right knee, and prescribed work restrictions. (PX 3, 3/18/13 o/v)

After several weeks of physical therapy, Petitioner returned to see Dr. Mall on May 1, 2013 with radicular symptoms in his right leg. Petitioner reported some improvement in his knee with physical therapy but he was still experiencing symptoms in it along with right-sided back pain and numbness going down his right leg. On examination Dr. Mall noted tenderness to palpation over the right side of Petitioner's lumbar spine and a positive straight leg raise. Petitioner demonstrated no lumbar atrophy or instability. As he had received only thirty (30) percent relief from the cortisone injection into the hip which had been performed, Dr. Mall recommended that possible pathology in Petitioner's lumbar spine be explored with an MRI. (PX 3, 4/2/13 o/v)

Petitioner returned to Dr. Mall following the lumbar spine MRI on April 3, 2013. Dr. Mall noted the lumbar spine MRI demonstrated an annual tear and disc protrusion encroaching on the nerve root on the right. Dr. Mall went on to state:

> In terms of his back pain and symptoms, [sic] he does have some pathology here, which fits with his symptoms on the right. Therefore, I would like him to see Dr. Gornet to evaluate this MRI and the patient to see if treatment may be warranted for this. If he feels that injections are needed, this would help me differentiate how much of this is coming from his hip and how much his back. He got 30% relief from his hip injection and thus if l-spine injections are prescribed we can see what percentage of his pain is relieved by these. I will see him following his evaluation

by Dr. Gornet.

> In terms of causation, assuming the history provided by the patient is factually correct, the patient was not having any hip, groin, knee or back pain prior to this work-related injury on 10/6/12. Therefore, it is more likely than not, that he suffered a significant groin strain based on his mechanism of injury and description of his symptoms. This same mechanism of injury can also cause a labral tear. While labral tears can be present in patients with hip impingement pathology on x-ray, he was not having any prior symptoms of pain in the hip prior to this injury. Therefore, I believe his hip pain is also causally related to his injury. An injury like this can definitely cause significant forces through the knee and low back as well. The right knee does demonstrate a meniscus tear, however, I am sure that his symptoms are [sic] necessarily coming from this. I would like to continue therapy for this and his hip while the lumbar spine is being evaluated and continue to assess the knee to see if the pain localizes to the meniscus or focal cartilage defect.
>
> (PX3, Dr. Mall, 4/3/2013 o/v)

Petitioner again followed up with Dr. Mall on May 1, 2013It was noted that Petitioner had yet to see Dr. Gornet. As Petitioner was still suffering from significant knee symptoms, Dr. Mall recommended and performed an injection into the right knee. Dr. Mall further noted Petitioner was complaining of radicular symptoms with pain and numbness down into his foot, starting from the right side of his back. Petitioner's diagnoses included right hip impingement and a labral tear, right knee patellofemoral pain with a meniscus tear and cartilage defect, and low back and radicular pain with an annular tear and disk protrusion on the right. (PX 3, Dr. Mall, 5/1/13 o/v)

On May 9, 2013, Petitioner presented to Dr. Matthew Gornet, an orthopedic spine specialist. On that date, Dr. Gornet took the history of Petitioner's injury as follows:

> This is the first visit and spinal examination for Brian Veath. The patient is a 49-year-old [who] presents with a chief complaint of low back pain to both buttocks, right hip, right groin, right leg to his foot with numbness and tingling. He is referred by Dr. Mall. He states his current problem began on 10/6/12 while working for Menard Corrections. He was involved in an altercation with an inmate in which he was struck with a food tray to the head and then tackled. He had immediate pain. It was initially felt to be his knee and then potentially his hip. His knee workup by Dr. Choi was

> negative. He was referred by Dr. Mall who diagnosed him as having a labral tear, but felt there were other issues potentially with his back. He does not recall any previous problems of significance.
>
> (PX6, Dr. Gornet, 5/9/2013 o/v)

Dr. Gornet noted in his physical examination that Petitioner motioned his pain to low back, right buttock, right hip, low back to both sides, particularly right thigh, groin, alterolateral calf, and posterior calf to his foot. He also reviewed the MRI of Petitioner's lumbar spine, which he felt showed an "obvious central herniation, annular tear at L4-5, best seen on satittal views. He may have a subtle protrusion at L5-S1." Dr. Gornet indicated:

> I have discussed with the patient that the hip is not my area of expertise, but certainly his symptoms in his back, groin and right leg and occasionally the left leg are all consistent with a disc injury. I do believe his current symptoms are causally connected to his work related injury of 10/6/12.
>
> (PX 6, Dr. Gornet, 5/9/13 o/v)

Dr. Gornet also gave Petitioner work restrictions with regard to his lumbar spine.(PX 6, Dr. Gornet, 5/9/13 o/v)

On May 29, 2013 Petitioner again followed up with Dr. Mall, who noted that Petitioner continued to have complaints of pain in his right hip and right knee, and did not experience any significant relief from the right knee injection which had been performed. At that point, Dr. Mall continued to recommend conservative treatment with regard to Petitioner's right knee, and recommended a subsequent injection to his right hip in order to alleviate his symptoms. (PX3, Dr. Mall, 5/29/13 o/v) This injection was performed on June 6, 2013. (PX3, Dr. Mall, 6/6/13 o/v)

Petitioner again saw Dr. Gornet on June 27, 2013. At that time, Dr. Gornet noted:

> Brian returns. He had some relief with the second injection of his hip with Dr. Mall. We believe he has a lateral recess stenosis and a central annular tear at L4-5. He has had injections with Dr. Granberg and these gave him no significant relief. My recommendation would be a discogram at L4-5 and L5-S1. If L5-S1 is asymptomatic and L4-5 is symptomatic, I do not need to evaluate L3-4. We would consider L3-4 if L5-S1 is symptomatic. I believe he suffers from two problems, one in his back and one in his hip. Our recommendation would be to set him up for a CT discogram of his low back and then a follow-up with me. He is due to see Dr. Dave Robson for an IME and we will wait for his

> opinion also in this case, but our current belief is that his current symptoms are related to an annular tear at L4-5 and potentially a subtle problem at L5-S1. We believe that these are causally connected to his work injury of 10/6/12. His exam is unchanged. He is off his narcotics.
>
> (PX6, Dr. Gornet, 6/27/13 o/v)

Petitioner again followed up with Dr. Mall on July 2, 2013, reporting temporary improvement following the injection to his right hip. (PX3, Dr. Mall, 7/2/2013). Because Petitioner had experienced 80-90% relief of his pain following the second injection, Dr. Mall recommended a right hip arthroscopy, labral repair and osteochondroplasty. Dr. Mall also noted that while Petitioner's hip was feeling good and his level of activity had increased, Petitioner noticed a flare-up in his right knee and right side of his back.(PX3, Dr. Mall, 7/2/2013; 8/1/2013 o/v)

Prior to his right hip surgery, Petitioner underwent an examination with Dr. David Robson at the request of Respondent. This occurred on July 10, 2013. Petitioner provided Dr. Robson with a consistent history of his accident. His complaints included lower back pain that he described as aching, stabbing, and burning and radiating down the anterior and posterior aspects of his right leg. Petitioner denied any lower back pain prior to his work accident. Petitioner's physical examination revealed positive straight leg raising on the right at 90 degrees. Petitioner's quadriceps strength was noted to be weak. Dr. Robson reviewed Petitioner's medical records and the radiologist's reports from the lumbar spine MRI and x-ray. His assessment was degenerative disc disease at L4-5 and L5-S1 along with a right hip injury. He did not feel Petitioner needed any surgery and needed to "accept his condition." Dr. Robson did not believe the work injury was the aggravating factor in Petitioner's lower back pain and radicular complaints because Petitioner did not have any back complaints immediately after the accident. (RX 3)

Following his right hip surgery on August 1, 2013, Petitioner returned to Dr. Mall with improvement in his hip, but with continued complaints of numbness in his foot, "the same kind of numbness that he was having before the surgery, however, it has just worsened since surgery." (PX3, Dr. Mall, 8/20/2013 o/v) Dr. Mall also noted that Petitioner was suffering from increasing right knee pain which had worsened since his hip surgery for which he recommended reevaluation. (PX 3, 8/20/13 o/v)

On September 17, 2013, Petitioner again returned to Dr. Mall who noted improvement in Petitioner's hip pain, but indicated that "his low back pain and his right knee pain have worsened, however." "He also describes continued numbness of the foot and lateral leg." With regard to Petitioner's right knee, Dr. Mall reviewed the MRI, which revealed an anterior horn medial meniscus tear as well as a medial femoral condyle cartilage defect. As Petitioner had attempted and failed conservative treatment, he recommended a right knee arthroscopy and partial medial meniscectomy as well as a medial femoral condyle chondroplasty, as well as an additional cortisone injection, which was performed that day. (PX3, Dr. Mall, 9/17/2013 o/v)

Petitioner next saw Dr. Gornet on October 28, 2013, after undergoing surgery performed by Dr. Mall to repair the labral tear in his right hip. At that point, Dr. Gornet noted:

Brian returns today. Again, his main complaint is low back pain into his right hip, right groin and right leg with numbness and tingling. He is off his Percocet per our request. He has had a hip labral surgery by Dr. Mall, but has had mixed results. A portion of his pain is better, but he still has a significant portion of his pain and symptoms. He has not had any previous problems of significance with his back. Our current belief is that his right hip, right groin and right buttock pain is really a watershed area and while he may have a labral tear in his hip, our belief is that the hip area is a common referral region for a structural problem in his low back. He has an obvious objective finding of an annular [tear] at L4-5, which is known to refer pain into the buttock and hip area. He has been seen by Dr. David Robson, who felt his symptoms were not causally connected either as an aggravation of a preexisting condition or as an initial injury. It was Dr. Robson's reasoning that because he only reported hip and knee pain initially and not low back pain, that his lumbar spine problem is not causally connected. Certainly Dr. Robson would agree that patients often present with buttock and hip pain with minimal back problems. As this is so common of a referral pattern, it is obvious why an untrained evaluator or even a trained evaluator who is focusing on a certain area, would preclude another body part. As someone who deals with buttock and hip pain all the time, we tend not to evaluate people for labral tears. The fact that Mr. Veath has had mixed results from his labral surgery is further illustration and objective evidence that a structural problem in his back is probably the main source of his buttock, hip and groin pain. An altercation with an inmate such as that described by Mr. Veath clearly could at a minimum aggravate his condition, but given the fact that he has not had any significant issues with his back, buttocks or hips in the past, there is no other plausible explanation, but a causal connection between the event that he described and his current pain and symptoms

On reviewing Dr. Choi's notes, who saw him shortly after his injury, these clearly denote groin pain and again, this is consistent after the structural injury to his spine.

I have recommended a CT discogram. I continue to believe his symptoms affect all aspects of his life and

his quality of life. His exam is unchanged and our recommendation would be a CT discogram. We will test L4-5 and L5-S1, but my general suspicion is that only L4-5 is symptomatic, although there are some subtle structural changes that are present at the L5-S1 area including a central herniation present. We will test these discs and I will see him back after the results are available. He remains on light duty with a 10 lb limit, no repetitive bending or lifting, alternating between sitting and standing.

(PX6, Dr. Gornet, 10/28/13 o/v)

On October 29, 2013, Petitioner returned to Dr. Mall, who noted:

Brian returns today for followup after his right hip arthroscopy on August 1, 2013. He continues to suffer from right leg numbness and tingling as well as low back pain and right knee pain.

Mr. Veath has been complaining of his low back ever since I first met him. There is significant overlap between the hip and the lower back and some of his symptoms that he continues to complain of related to the hip also may be related to his back. I do think that some of the numbness and tingling that he feels also is related to his back. In terms of the knee, he clearly has pathology on his knee MRI. We attempted conservative treatment for this and despite getting his knee strong and his quadriceps strong he continued to have symptoms. Therefore, I think that he will do well with a knee arthroscopy and debridement of these defects. Clearly, the patient suffered an injury at the point in which he slipped and strained his lower back, his hip, and his knee. These were all complaints that were initially discussed and were not present prior to his work related injury. Therefore, I do believe that these symptoms that he is having related to his back, hip, and knee are all causally related to his work accident. I do believe that he would get benefit from a right knee arthroscopy. I do believe that a lot of his symptoms are related to his lower back and that these are preventing him from returning to work full duty. Therefore, I do believe that his back needs to be addressed as well. I likely would try to address the knee prior to the back

> as the knee recovery would be much faster than it would be from a back procedure.
>
> (PX3, Dr. Mall, 10/29/13 o/v)

On December 2, 2013, Petitioner again returned to Dr. Gornet following the discogram he had recommended. At that point, Dr. Gornet noted:

> His discogram reveals a severe concordant pain at L4-5, moderate to severe concordant pain at L5-S1, both with central annular tears. He is due to have knee surgery soon with Dr. Nathan Mall. He has hip pain. He can continue with light duty regarding his lumbar spine with no lifting greater than 10 pounds, no repetitive bending, alternating between sitting and standing positions, which are the same restrictions I had placed in the past. His exam today is unchanged. Our recommendation would be for spinal fusion at L5-S1, disc replacement at L4-5. He smokes approximately a pack per day and sometimes less. I think at this point his options are to move forward with surgery, if he can get his smoking down to a minimal amount. I would consider an anterior only L5-S1 fusion with a disc replacement at L4-5. If he continues to smoke, then he will require an AP fusion at L5-S1 and disc replacement at L4-5. We will wait for approval for treatment.
>
> (PX6, Dr. Gornet, 12/2/13 o/v)

On December 5, 2013, Petitioner underwent a right knee medial meniscus repair and lateral femoral condyle cartilage debridement, as well as a right knee two compartment synovectomy. Following surgery, Petitioner continued to make improvement with regard to his right knee. (PX3, Dr. Mall, 12/18/2013). However, it was noted on January 15, 2014 that Petitioner had not been receiving the physical therapy prescribed by Dr. Mall. (PX3, Dr. Mall, 1/15/2013).

Both Dr. Robson and Dr. Gornet were deposed.

Dr. Robson testified he took the history of Petitioner's complaints, and noted that Petitioner told him he felt a "pop" in his low back immediately after the altercation occurred. (RX4 , p.18). He testified that he reviewed the available medical records of Dr. Mall, but was only provided with Dr. Gornet's initial note of May 9, 2013. (RX 4, p. 19) He acknowledged that he was never provided with any of Dr. Gornet's supplemental records or Dr. Gornet's deposition, which was taken over two (2) months' prior to his own deposition. (RX 4, pp. 19-20)

Although Dr. Robson did not dispute Dr. Gornet's diagnosis of an obvious central herniation, annular tear at L4-5 and a subtle protrusion centrally at L5-S1, he testified that he did not believe his condition was in any way related to the October 6, 2012 altercation in which Petitioner was violently assaulted by an inmate. (RX 4, p. 15) Dr. Robson acknowledged that individuals with lumbar spine injuries often present with pain primarily in the hip or hip region, and specifically testified, "It occurs, yes. Generally it hurts in the back and radiates into the hip and groin would be the more classic presentation." (RX 4, p. 23) Dr. Robson also did not feel that Petitioner's lumbar spine condition was related to the October 6, 2012 injury despite the fact Petitioner reported no prior history of low back pain and his inability to find any evidence in the medical records demonstrating prior symptoms or treatment for low back, hip, or groin pain. (RX 4, pp. 22-23) When asked if there was any other explanation for Petitioner's lumbar spine condition, Dr. Robson testified, "Not that I can come up with and explain that I can satisfy myself with." (RX 4, p. 26)

With regard to Petitioner's medical care and treatment, Dr. Robson indicated that the injections performed by Dr. Gornet were reasonable and necessary, but in his opinion, Petitioner would not require surgery. (RX 4, pp.15-16)

Dr. Gornet testified that when Petitioner presented to him, his complaints were of pain in his right hip and groin, which moved into his right leg, and that based upon the history he took from the patients, the exam he performed, his review of lumbar spine MRI, as well as the prior treatment notes, he diagnosed Petitioner with a disc injury consistent with an annular tear and central herniation at L4-5 as well as a strong suggestion of an annular tear at L5-S1. (PX 13, pp. 7-8) He also noted that Petitioner specifically denied any prior low back injuries or any history of prior treatment. (PX 13, p. 8)

With regard to his opinion as to whether the October 6, 2012 injury caused, contributed to or aggravated Petitioner's lumbar spine condition, Dr. Gornet testified:

> I believe that we're dealing with, at least from a spine standpoint, a classic referral pattern. Everyone knows that, basically, pain back [sic] refers to the buttock and hip area. Anyone who's treated any of these patients I'm sure has seen patients who have buttock and hip pain that are associated with that. His complaints initially of buttock and hip pain only are not inconsistent at all in any way, shape, or form with a back injury. The fact that he was worked up by a specialist is [sic] a situation where the particular specialist may view it from their standpoint, but what we now know, based on the information we have and looking at this, is not only the hip specialist felt there was a potential spinal problem, but I felt there is. Second is—and I'm sure Dr. Robson would agree that he has treated people who have had only buttock and hip pain. If that is the case, then in this particular situation the fact that

this patient did not mention low back pain initially is irrelevant.

(PX 13, pp. 11-12)

The parties stipulated at trial that Respondent has accepted liability for Petitioner's injuries to his right knee and hip and all of the treatment received by Petitioner for same. (AX1)

At arbitration Petitioner briefly described the accident which occurred on October 6, 2012. Petitioner testified that there was dispute with an inmate over a cup or a tumbler and after Petitioner thought the dispute was over, he turned to walk away. While doing so the inmate blindsided him with a food tray over the top of Petitioner's head. Thereafter, Petitioner felt his knee starting to buckle and he lunged towards the inmate so he wouldn't fall. A struggle followed and Petitioner picked up the inmate and threw him to the ground. While this ensued, a fellow officer was heading their direction and Petitioner, knowing that the officer would try and tackle them to the ground, braced himself. Petitioner testified that his foot landed on a piece of chicken and they proceeded to fall. Petitioner testified he heard popping noises, hit his head on a table, hit his knee and elbow, and felt a burning sensation in his groin and hip area. Petitioner testified that he thought the popping sensation was in his lower back and/or hip region but he couldn't be sure.

Petitioner testified that prior to October 6, 2012 he had never experienced any symptoms of pain in his low back or right hip, and had never received any treatment to these areas of his body before. He similarly testified that since October 6, 2012, he has not sustained any new intervening traumas, slips, falls or other injuries.

Petitioner also testified that following the hip surgery performed by Dr. Mall, his condition has improved slightly, but he still experiences a burning sensation and pulling in his back and hip when attempting to lift or bend. He also testified that he frequently still experiences leg numbness. Petitioner also testified that the injections performed by Dr. Gornet have given him some temporary relief. Petitioner testified that he would like to receive the treatment recommended by Dr. Gornet with regard to his lumbar spine so he can return to work.

Petitioner also testified that he is still currently receiving treatment with Dr. Mall for his right knee and hip and has not been released from his care. (See also PX 3)

The Arbitrator concludes:

1. **Causal Connection (Issue "F").**

Petitioner's current condition of ill-being, including his lumbar spine condition, is causally connected to his October 6, 2012 accident. This conclusion is based upon the stipulation of the parties (as to Petitioner's knee and hip), and a chain of events and the causation opinions of Dr. Matthew Gornet and Dr. Nathan Mall, Petitioner's treating physicians, whose opinions are found to be more persuasive than that of Dr. Robson.

The Arbitrator notes that the medical records clearly demonstrate Petitioner's right knee and groin/hip area were the primary areas of concern following his accident, and were first addressed by Petitioner's treating physicians, Dr. Choi and Dr. Mall. Dr. Mall proceeded with conservative treatment in the form of physical therapy, injections, and medication in the hope that Petitioner's complaints with regard to his hip and groin areas would resolve. However, after several diagnostic injections had been performed on Petitioner's hip after which he had received only thirty (30) percent relief from those cortisone injections, Dr. Mall recommended that possible pathology in Petitioner's lumbar spine be explored with an MRI. Furthermore, Petitioner's low back pain complaints were initially noted after Petitioner had begun a course of physical therapy and Dr. Mall never questioned the credibility or etiology of Petitioner's low back pain. After pathology was discovered in Petitioner's lumbar spine, a referral to Dr. Matthew Gornet was made. (PX 3)

Dr. Gornet, an orthopedic spine surgeon, took a history of Petitioner's complaints, noting that Petitioner's history was lacking any prior history of low back, hip, or groin complaints or treatment prior to October 6, 2012. (PX6, Dr. Gornet, 5/9/13 o/v) He also noted that Petitioner had been under the care of Dr. Mall, who initially felt that Petitioner had a hip injury, but when his symptoms continued to persist and worsen, believed that Petitioner might be suffering from a lumbar spine condition which would also be causally connected to the October 6, 2012 altercation. (PX6, Dr. Gornet, 5/9/13 o/v)

While Petitioner failed to mention any specific injury to his back at the time of the accident or to his immediate medical providers, Petitioner, in this instance, credibly testified as to how he felt at the time of the accident and one witness reported Petitioner was limping when he left for medical. (RX 1) Furthermore, the mechanism of injury is consistent with the likelihood of a back injury and Petitioner's initial treatment was understandably focused on his right knee and hip/groin region. Even Petitioner's initial low back pain complaints were right-sided, consistent with the area of other injuries.

The Arbitrator finds it persuasive that Dr. Gornet indicated (in both his treatment notes and by way of deposition) that individuals with lumbar spine pathology often present with symptoms in their groin, hip or buttock region, and even described this phenomenon as a classic referral pattern. (PX12, Deposition of Dr. Gornet, pp. 11-12) The Arbitrator also notes that Petitioner testified as a credible witness on his own behalf indicating that he was unaware of exactly which parts of his body he initially injured in the altercation, only that he knew he hurt in the lower half of his body. The Arbitrator also finds it significant that there is no evidence in the record, either by way of medical evidence or testimony, that Petitioner had ever sustained an injury or received treatment for complaints related to his low back, groin, or hip prior to this undisputed accident.

Finally, with regard to causation, the Arbitrator also notes that Respondent's examining physician, Dr. Robson, acknowledged that patients with lumbar spine pathology often present with pain in the hip and groin region, which is entirely consistent with Petitioner's initial complaints. While he acknowledged such pain usually begins in the back he conceded that he had no other explanation for Petitioner's spine condition, especially in light of Petitioner's lack of pre-existing complaints or treatment. (RX4, Deposition of Dr. Robson, pp. 22-26)

2. Medical Expenses (Issue "J")/Prospective Medical Care (Issue "K")

An employee is entitled to medical care that is reasonably required to relieve the injured employee from the effects of the injury. 820 ILCS 305/8(a) (2011). This includes treatment that is obtained to diagnose, relieve, or cure the effects of claimant's injury. *F & B Mfg. Co. v. Indus. Comm'n*, 758 N.E.2d 18 (1st Dist. 2001).

As Petitioner has met his burden of proof on the issue of causation with regard to his lumbar spine condition, the Arbitrator concludes that Petitioner's medical care and treatment has been reasonable and necessary to date and reasonably required to cure or relieve the injured employee from the effects of the injury.

Respondent is liable for payment of the medical bills submitted in Petitioner's Exhibit 1 as provided in Section 8(a) and 8.2 of the Act subject to the fee schedule. As stipulated, Respondent shall receive a credit for any medical benefits that have been paid. However, if Petitioner's group health carrier requests reimbursement, Respondent shall indemnify and hold Petitioner's harmless.

The Arbitrator also awards Petitioner prospective medical care pursuant to Section 8(a) of the Act. Dr. Gornet has recommended that Petitioner undergo surgical intervention, since he has failed conservative treatment, and Petitioner testified that he desires to have the surgery performed so he can return to work. Respondent is therefore ordered to authorize and pay for the prospective treatment recommended by Dr. Gornet in the form of spinal surgery and all treatment related to Petitioner's recovery therefrom.

****

STATE OF ILLINOIS)
) SS.
COUNTY OF SANGAMON)

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

DEBRA ALDRIDGE,
Petitioner,

No. 06 WC 17132

v.

14IWCC1000

WALMART,
Respondent.

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

This matter comes before the Commission on Petitioner's Petition under §§19(h) and 8(a) of the Act. In the underlying cases, the Arbitrator issued a decision on March 31, 2009, in which he found Petitioner suffered a work-related accident on January 31, 2006 and awarded her 17&1/7 weeks temporary total disability benefits, incurred medical expenses, and 162.5 weeks of permanent partial disability benefits representing 32.5% loss of the person-as-a-whole.

Respondent sought review of the Decision of the Arbitrator. On review the Commission amended but affirmed the Decision of the Arbitrator. Petitioner filed the instant Petition on November 7, 2011, but a hearing was not held until June 26, 2014 before Commissioner Basurto in Springfield, and Petitioner did file her brief until August 1, 2014.

Finding of Fact and Conclusions of Law

1. Petitioner testified she continues to work for Respondent and has for 12½ years. Currently, she works as "overnight stocker of soft lines." In that job she hangs or folds clothing, sorts it, puts it away, and cleans the area.

2. On January 30, 2006, she was on a ladder pulling down a box. She twisted and injured her back. She went to her general practitioner, Dr. George Burns, who referred her to an orthopedic surgeon. She eventually had fusion surgery performed by Dr. Mack. After her case was arbitrated she continued to have soreness in her low back and "leg problems of mobility or whatever you want to call it." About eight months after the arbitration she returned to her general practitioner and she went to physical therapy from October 28, 2009 to December 8, 2009. She tried to get transferred out of her current job, but could not until they got a replacement. Her back was getting worse.

3. Petitioner's primary care doctor became Dr. Venigalla on March 7, 2011. She told her about her low back problems, including numbness going down her left leg.

4. Petitioner agreed that Dr. Venigalla's treatment note from December 2011 indicated that Petitioner said her back pain was so much better when she had surgery in 2006 but when she fell in Walmart in 2010 the symptoms started back again. Petitioner explained in October of 2010, she "slipped and slid" on a slick floor and twisted and almost fell. She already had back pain at that time; she's "always had low back pain." She filled an accident report at that time but did not seek medical attention right away.

5. Petitioner also testified she went to an emergency room on January 25, 2010 after a motor vehicle accident. She felt slight pain in her neck and left arm, so she went to have herself checked out. She wanted to make sure the accident did not affect her low back condition. She did not have any follow up treatment after the accident.

6. Dr. Venigalla referred Petitioner to Dr. Russell, a neurosurgeon, whom she saw on February 1, 2012, after an MRI was taken. He referred her for physical therapy which she had from March 6, 2012 to March 29, 2012. Dr. Russell preformed surgery on October 18, 2012. There was an issue about removal of a broken screw, but Petitioner did not to have additional surgery. Dr. Russell released her to work with restrictions on September 10, 2013, and she had not seen him since. She then stated she was "off of restrictions."

7. Petitioner testified that currently she has stabbing pain in her left hip and her legs down to the outside of her thighs and calves. Her right leg also "locks up." She did not have these symptoms at the time of her arbitration hearing. The pain initially went away after Dr. Russell's surgery but came back several months ago. She has not gone back to Dr. Russell because she really does not want additional surgery. Her pain is steady, but she has additional pain when lifting anything over 25 pounds. She takes Norco, nerve medication, and uses a pain patch. The Norco was prescribed by Dr. Burns, with whom she was currently treating rather than Dr. Venigalla.

8. On cross examination, Petitioner testified in the motor vehicle accident she remembered she was "hit on the edge of the driver's side door and fender." She did not remember telling the people at the emergency room that her low back hurt. They did take x-rays of her low back at that time.

9. Petitioner filed another Application for Adjustment of Claim after the 2010 slip. She slipped on baby food in an area accessible to the public. The 2010 claim had yet to be arbitrated.

10. Petitioner did not remember telling Dr. Venigalla that she did not think her pain returned after the 2006 surgery, she told her she's "always had low back pain." Petitioner then testified she last saw Dr. Russell on October 22, 2013. At that time he released to work full duty. Respondent was able to accommodate her previous restrictions from Dr. Russell.

11. On redirect examination, Petitioner testified her back pain got worse, which was the reason she has surgery with Dr. Russell. Her leg pain was also worse than it was at the time of arbitration. She did not have the "stabbing, sharp pains until recent." That was the reason why Dr. Venigalla referred her to Dr. Russell. The x-rays at the emergency room after the motor vehicle accident did not show any new injury.

12. The medical records indicate that on March 7, 2011, Petitioner presented to Dr. Venigalla to establish care. Included in her medical history was chronic back pain. Straight leg raises were negative.

13. On October 31, 2011, Petitioner presented to Dr. Venigalla complaining of having a lot of pain when she is done at work. By the end of the week she feels she has to go to the emergency room because of pain and stiffness throughout her body and pain and swelling in her fingers. She also complained of upper and lower back pain but did not believe the pain had returned after her 2006 surgery.

14. On December 15, 2011, Petitioner returned to Dr. Venigalla complaining of back and leg pain. She reported her pain got better after her surgery the symptoms started again after she fell at work in 2010. Dr. Venigalla ordered an MRI.

15. On February 1, 2012, Petitioner presented to Dr. Russell on referral from Dr. Venigalla. He noted she was injured in 2004 and had surgery in 2006. "She has had some rather constant back pain now, some left leg pain." Dr. Russell suspected that some of her leg symptoms may have been due to some foraminal stenosis at L4-5. He ordered physical therapy.

16. On October 18, 2012, Dr. Russell preformed posterolateral interbody fusion with pedicle screw and rods from L4 through the sacrum, lumbar discectomy, and interbody fusion at L4 with autograft and allograft bone, for a diagnosis of lumbar degenerative disc disease.

17. Dr. Russell testified by deposition on May 31, 2013. He testified that there is no consensus that fusion at one level makes disease at an adjacent level more likely. The witness himself goes back and forth on the issue.

18. He interpreted an MRI taken on January 17, 2012 as showing progressive degenerative changes had developed since 2006.

19. Petitioner reported to the witness that her symptoms had progressed in the past year. She complained of back pain with some left leg pain. He did not observe any abnormal findings in his examination. Her symptoms were consistent with the MRI findings.

20. Dr. Russell testified he really did not know whether the need for surgery was due to the stress caused by the previous surgery in conjunction of Petitioner's continued lifting/bending activities or simply a progression of the degenerative disease in conjunction with the activities. He thought "it's a little bit of both." There would be more stress on the adjacent level, but there is also the natural progression of the underlying arthritis.

21. Dr. Russell "absolutely" agreed that there was marked change in Petitioner's condition from 2006 to 2012. Petitioner progressed well after surgery. Initially, she still had a lot of back pain, but no leg pain, which was a good sign, and the rods and graft were in excellent position.

22. It may take another six months for her to at maximum medical improvement. He thought a permanent restriction of 25 pounds was probably reasonable considering she had two fusion surgeries.

23. On cross examination, Dr. Russell testified he thought Petitioner put his treatment through her regular insurance "because the assumption was that that was an old claim and wasn't sure about continuing a Work Comp status."

24. Petitioner never mentioned a fall at work in 2010 and he had no information about such a fall. She also did not mention any motor vehicle accident in 2010. He thought that those incidents would be important if Petitioner thought they were significant and such information could affect his opinions in this case.

25. Dr. Russell agreed that Petitioner had degenerative disc disease and that it is a natural process of aging. There are various risk factors in a person of Petitioner's age (Petitioner was 50 at the time of the accident) to develop degenerative disc disease and people with high BMI are more likely to be affected by degenerative disc disease. Petitioner had a BMI of 34.78, which would put her in the obese category. A patient's weight can also put more pressure on adjacent discs after fusion as can a person's smoking history (Petitioner was a smoker).

26. On redirect examination, Dr. Russell testified he believed there were several factors in Petitioner that led to the progression of degenerative disc disease at L4-5. She would be more susceptible to adjacent segment disease because of her age. He thought it was correct that "the fact that she had this fusion at L5-S1 [made] her more susceptible to the problems at L4-5, given these comorbid medical conditions."

27. Dr. VanFleet testified by deposition on August 22, 2012 that he is a board certified orthopedic surgeon. He performed an examination pursuant to Section 12 of the Act on Petitioner and reviewed her medical records.

28. Petitioner gave him a history of a 2006 work accident, but did not mention that she had a fall or motor vehicle accident in 2010. She did not report that her back pain was better after the surgery but "when she fell in 2006, [presumably 2010] her symptoms started back again."

29. Dr. VanFleet found no evidence of neurological abnormality in his examination. He diagnosed spondylolisthesis and degenerative disc disease. Dr. VanFleet did not believe that these conditions were related to her 2006 accident. He based that opinion on the lapse of time between the accident and the onset of current symptoms. Petitioner would have reached maximum medical improvement a year after the 2006 surgery.

30. Dr. VanFleet agreed that Petitioner had preexisting degenerative disc disease and that degenerative disc disease was a part of the natural process of getting older. Age is associated with degenerative disc disease because presentation of degenerative disc disease increases with age. Obesity is definitely a risk factor associated with degenerative disc disease, and smoking is also thought to be a contributing factor to the degeneration of disc space.

31. On cross examination, Dr. VanFleet testified Dr. Mack performed a fusion L5-S1, which the lowest level that can be fused. Dr. VanFleet explained that transition syndrome refers to increased stress in the spinal level above one that has been fused. He agreed that L4-5 is the level directly above L5-S1. He said that was a factor in Petitioner developing L4-5 pathology.

32. While he could not put a percentage of contribution of transition symptoms had in Petitioner's condition it would be relatively low because she had already shown a propensity for developing degenerative disc disease and the L4-5 is the level most likely to degenerate for all individuals irrespective of previous surgery. Lifting and twisting could also cause additional degeneration. His opinion that her current condition was not related to her 2006 injury was based on that specific single-event trauma.

33. On redirect examination, Dr. VanFleet testified weight can have negative effect in developing transition syndrome because increased weight puts greater stress on the adjacent discs. Smoking can also contribute to transition syndrome.

34. On re-cross examination, Dr. VanFleet testified that he believed smoking, obesity, age, transition syndrome, and her work activities all contributed to the degeneration at L4-5.

14IWCC1000

The Commission finds that Petitioner has not sustained her burden of proving her current condition of ill being is an enhancement of disability from her work-related accident in 2006. The alleged incident in October of 2010 would constitute an intervening accident breaking the causal connection between her 2006 accident and her current condition of ill being. In addition, the treatment notes of Dr. Venigalla indicate that Petitioner reported that her pain had improved after the 2006 surgery but recurred after her 2010 fall, further militating against her argument that her condition was constant since her 2006 accident. For these reasons the Commission denies Petitioner's petition for relief under §§19(h) and 8(a) of the Act.

IT IS THEREFORE ORDERED BY THE COMMISSION that Petitioner petition for relief under §§19(h) and 8(a) of the Act is hereby denied.

DATED: NOV 2 1 2014

Ruth W. White

Daniel R. Donohoo

Charles J. DeVriendt

RWW/dw
D-11/5/14
46

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Melvin Wright,

Petitioner,

vs. NO: 10 WC 586

Dollar Tree,

14IWCC1001

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 August 19, 2013, is hereby affirmed and adopted.

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

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

DATED: NOV 24 2014
TJT:yl
o 11/18/14
51

Thomas J. Tyrrell

Michael J. Brennan

Kevin W. Lamborn

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

WRIGHT, MELVIN
Employee/Petitioner

Case# **10WC000586**

THE DOLLAR TREE
Employer/Respondent

14IWCC1001

On 8/19/2013, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

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

1747 STEVEN J SEIDMAN LAW OFFICES
TWO FIRST NATIONAL PLAZA
20 S CLARK ST SUITE 700
CHICAGO, IL 60603

0208 GALLIANNI DOELL & COZZI LTD
ROBERT J COZZI
20 N CLARK ST SUITE 1600
CHICAGO, IL 60602

14IWCC1001

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

Melvin Wright
Employee/Petitioner

v.

The Dollar Tree
Employer/Respondent

Case # 10 WC 586

Consolidated cases: ---

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

DISPUTED ISSUES

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

FINDINGS

On **August 10, 2009**, Respondent *was* operating under and subject to the provisions of the Act. Arb Exh 1.

On this date, an employee-employer relationship *did* exist between Petitioner and Respondent. Arb Exh 1.

On this date, Petitioner *did not* sustain an accident that arose out of his employment by Respondent. The Arbitrator views the remaining disputed issues as moot and makes no findings as to those issues.

Timely notice of this accident *was* given to Respondent. Arb Exh 1.

In the year preceding the injury, Petitioner earned **$8,164.00;** the average weekly wage was **$157.00.** Arb Exh 1.

On the date of accident, Petitioner was **41** years of age, ***single*** with **3** dependent children. Arb Exh 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** . Arb Exh 1.

Respondent is entitled to a credit of $**0** under Section 8(j) of the Act. Arb Exh 1.

ORDER

- The Arbitrator finds that Petitioner failed to prove he sustained accidental injuries arising out of his employment. All benefits are denied. Based on the Arbitrator's ruling on the issue of accident, the remaining disputed issues of causal connection, medical bills, temporary total disability and permanency are rendered moot.

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

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

Molly C Mason
Signature of Arbitrator

8/18/13
Date

AUG 19 2013

Melvin Wright v. Dollar Tree
10 WC 586

14IWCC1001

Arbitrator's Findings of Fact

Petitioner testified he began working at Respondent about six months before his claimed accident of August 10, 2009. He worked part-time, performing stocking and maintenance. His duties consisted of cleaning various parts of Respondent's store and arranging merchandise. At no time prior to August 10, 2009 did Respondent ask him to perform security-related duties at his assigned store in Oak Park. T. 35.

Petitioner testified that, on August 10, 2009, he was working in an aisle of the Oak Park store when he heard his manager, Sharhonda Dumas, call out to him a couple of times. He responded to the calls and encountered Dumas in the rear of the store. Dumas "was in a dispute with" a male customer. Petitioner asked Dumas what was going on. Dumas told him the customer was "messing with" merchandise. Petitioner observed that the customer was "tossing" items around. Dumas also indicated she had asked the customer to leave. Dumas and the customer continued arguing, in Petitioner's presence, with the customer ultimately giving an indication he was willing to leave. At that point, Dumas asked Petitioner to "see [the customer] out of the store." T. 16.

Petitioner testified he followed Dumas' directive. He walked behind the customer as the customer headed toward the door. Other customers were in their general vicinity. Along the way, the male customer "moved a couple of things in the store," prompting Petitioner to instruct him to keep walking. At that point, the customer "started making, like, little threats at" Petitioner. Petitioner told him, "you and [Dumas] aren't seeing eye to eye right now. Just leave the store and come back another day." Petitioner testified that, after he said this to the customer, the customer became more agitated:

> "He started making threats to me, talking about, I'm not a security guard, forget about her [Dumas], you know, calling her – saying the 'b' word and stuff like that."

T. 19. Petitioner also testified that the customer started calling him names, saying, "who do you think you are?" and telling Petitioner what he planned to do to him. The customer went so far as to say he was going to kill Petitioner. T. 22. Petitioner testified that this exchange occurred while he and the customer were still inside the store, "maybe about halfway to the door." T. 21-22.

Petitioner testified that, at this point, he started "getting tired of the threats." Although the customer was continuing to walk toward the exit, he stopped a couple of times and "made a couple of flinches" at Petitioner. T. 22. Petitioner testified that, by the time he and the customer arrived at the exit, he was "mad and aggravated." When the customer pushed the door open, it appeared to Petitioner as if the customer was going to do something to him so

Petitioner "ended up swinging on" the customer. Petitioner recalling taking this swing "inside the doorway." T. 23. After he swung at the customer, the two began fighting "right at the doorway." Petitioner testified he "tried to swing on [the customer] again" but "failed." After the two "tried to connected again," Petitioner realized his left arm was bleeding and he "got out of the way." T. 23. It was at this point that Petitioner saw a knife in the customer's hand and concluded the customer had stabbed him. T. 23-24. Petitioner "tried to get back to the store and tried to stop the bleeding."

Petitioner testified that, after the incident, a co-worker drove him to the Emergency Room at West Suburban Hospital. At the Emergency Room, Petitioner reported having been stabbed. Emergency Room personnel noted a large laceration on Petitioner's left forearm. Left forearm X-rays demonstrated a "small fracture fragment adjacent to the anteromedial aspect of the olecranon in the left elbow with mild surrounding subcutaneous emphysema" and no evidence of a foreign body. PX 1. Petitioner was given a tetanus shot and was transferred by ambulance to Mt. Sinai Hospital. The Mt. Sinai records contain the following history: "Pt reports that at 2 PM he was involved in an altercation at the store he works in and was stabbed in left arm with unknown object." Petitioner complained of left forearm pain and tingling of the distal left arm. Hospital personnel noted a 3 centimeter laceration to the left forearm. A resident sutured the wound. Petitioner was discharged from the hospital with instructions to call Dr. Kaymakcalan at the hand clinic the following morning. PX 2.

Petitioner returned to the Emergency Room at Mt. Sinai Hospital on August 13, 2009. Petitioner complained of left elbow pain. Emergency Room personnel noted partial separation of the previously sutured wound but no evidence of infection. Personnel redressed the wound and provided Norco for pain. They instructed Petitioner to follow up at the hand clinic on August 19, 2009. PX 2.

On August 19, 2009, Petitioner saw Dr. Hassed at Mt. Sinai Hospital and complained of numbness along the left ulnar nerve distribution. The doctor recommended surgical exploration of the wound. PX 2.

On August 21, 2009, Dr. Kaymakcalan operated on Petitioner's left forearm at Mt. Sinai Hospital. The surgery consisted of a wound exploration, cubital tunnel release with anterior submuscular transposition and microscopic repair of a partial ulnar nerve laceration. In his operative report, Dr. Kaymakcalan noted that the medial antebrachial cutaneous nerve was "completely divided" and irreparable. PX 2.

On August 25, 2009, Dr. Kaymakcalan issued a note indicating that Petitioner would be unable to work for approximately twelve weeks. PX 3, p. 33.

On August 26, 2009, Petitioner met with Ursula Villatoro, a social services representative at Mt. Sinai Hospital. Villatoro recorded the following note:

"Received pt from financial counselors. Pt is a victim of a stab wound to the

right [sic] arm. Pt stated he was on the job when a male offender came into the store and started to pick on the women employees. Pt stated, 'since there is no security, I had to tell him to leave. He got upset.'"

PX 2.

Postoperatively, Petitioner underwent occupational therapy at Mt. Sinai Hospital from September 2, 2009 through November 25, 2009. PX 2.

On October 13, 2009, Petitioner returned to Dr. Kaymakcalan and reported improvement. The doctor prescribed Neurontin and Elavil. He released Petitioner to one-handed work and recommended additional therapy. PX 3, p. 8.

On December 3, 2009, Dr. Kaymakcalan noted that Petitioner reported tingling but was able to make a fist. He prescribed Neurontin and Elavil and released Petitioner to light duty with no work around dangerous machinery. He instructed Petitioner to return to him in four weeks. PX 3, p. 27. Petitioner failed the next appointment on December 30, 2009. PX 3, p. 4.

Petitioner testified he never resumed working for Respondent. For the last two years, he has worked as a machine operator at Deluxe Stitcher. T. 11-12. Petitioner testified he continues to experience numbness in some parts of his left forearm. He has difficulty using two of his fingers to grip an object. He has some difficulty opening cans. At work, he tends to use his dominant right hand to perform most functions. He uses his left hand as a guide. T. 30.

Petitioner testified that police were called to Respondent's store on August 10, 2009. The police did not charge him. The customer who stabbed him was also not charged, at least at that time. T. 31.

Under cross-examination, Petitioner acknowledged he and the customer did not have any physical contact with one another before they reached the exit. Petitioner was initially unsure whether he held the door open for the customer. He then acknowledged he "maybe" did this. The following exchange then occurred:

"Q: Is it also possible that he [the customer] walked out of the store, turned his back on you and then you chased after him and lunged at him, falling to the ground, and then getting into a fight with him?

A: That's possible, too.

Q: And did this lunge take place in the parking lot area to the store?

A: I'm thinking it did but I think the first part started inside of the doorway.

Q: Okay.

A: That's the first time that I know that I was to the point and mad with him for threatening me that I tried to swing on him.

Q: So you believe you took a swing at him in the doorway as he was walking out?

A: I think so.

Q: Okay. But then – well, did you hit him?

A: I don't know. I think I nicked him or I tried to hit him. I'm not sure if I connected with him or not.

Q: But then he kept walking out into the parking lot and turned his back on you, correct?

A: Maybe. All I know is at that time I was mad because he was threatening my life.

Q: And when you got cut, you were in the parking lot, were you not?

A: Yes. I was right outside of the store."

T. 33-34. Petitioner acknowledged that Respondent terminated him following the incident. He is able to perform his current job by predominantly using his right hand. T. 34.

On redirect, Petitioner testified that no security guard was on duty in Respondent's store at the time of his claimed accident. He had no security-related training. T. 35.

Respondent called Lorenzo Williams pursuant to subpoena. T. 38. RX 1. Williams testified he worked as a stocker at Respondent's store as of August 2009. His duties included unloading trucks and putting merchandise on the sales floor. T. 39. Petitioner also worked at Respondent's store as of August 2009.

Williams testified he worked at Respondent's store on August 10, 2009. On that date, he observed an altercation between Petitioner and an "unruly customer." The customer was "making a lot of commotion" in the store. He and Petitioner were asked to escort the customer to the door. Petitioner opened the door for the customer. The customer exited the store and was on a little walkway "right outside the door" when Petitioner lunged at the customer. The customer had his back turned to Petitioner and was walking away from the store when Petitioner lunged at him. The front door of Respondent's store is equipped with a video camera. After the incident, the police came to the store and viewed the videotape. Williams

testified he viewed the videotape the morning of the hearing, at the office of Respondent's counsel. The video accurately depicts the altercation. T. 42.

Respondent's counsel played the video (RX 2) during the hearing. The video appears to have been taken at an elevated level inside the store. It shows the front door of the store from some distance. Petitioner stipulated he appears in the video. Early on, he can be seen opening the front door of the store for a male customer, who sets down a suitcase or bag before exiting the store. Shortly after the customer leaves, Petitioner can be seen exiting the door and lunging to his right toward the customer.

Under cross-examination, Williams testified he was one or two feet behind Petitioner as Petitioner escorted the customer toward the door. T. 46. He was on the right side of the door when Petitioner opened the door. T. 47.

Williams acknowledged that the store manager, Sharhonda Dumas, called for help before the incident. Both he and Petitioner came to Dumas's aid. Dumas asked him and Petitioner to get the customer out of the store. Petitioner escorted the customer to the door. Williams testified that Petitioner and the customer were yelling and swearing at one another as they made their way toward the front door. The customer acted unruly toward Petitioner.

Williams testified that neither he nor Petitioner laid a hand on the customer while the customer was inside the store. The customer "didn't leave right away" but eventually exited on his own. T. 49-50. After exiting, the customer continued threatening Petitioner, saying, "motherf****, I'll kill you." It was then that Petitioner lunged at the customer. Williams testified he saw the customer take a knife and cut Petitioner. Williams did not know why the customer was carrying a suitcase as he walked toward the front of the store. The following exchange occurred:

"Q: You were a stock person, is that correct?

A: Yes.

Q: And [Petitioner] was maintenance and stock, is that right?

A: Yes.

Q: Neither of you were trained by Dollar Tree of what to do in a situation like this?

A: Correct.

Q: And you did the best you could at that time, didn't you?

A: Correct."

T. 51-52.

On rebuttal, Petitioner testified he lunged at the customer because the customer threatened his life. Even though the customer had left the store, he was "still talking about killing" Petitioner. The customer was a number of feet away at that point but Petitioner's anger remained heightened by what had occurred earlier, inside the store. T. 55. His emotions carried over.

Under cross-examination, Petitioner acknowledged the customer's back was to him when he lunged at the customer. T. 55-56.

In addition to the treatment records previously discussed, Petitioner offered into evidence bills from both hospitals and Dr. Kaymakcalan. PX 1-3.

Respondent offered into evidence the subpoena served on Lorenzo Williams (RX 1) and the video (RX 2).

Arbitrator's Conclusions of Law

Did Petitioner sustain a compensable work accident on August 10, 2009?

The threshold issue is whether Petitioner's injury arose out of his employment. An injury arising out of employment is one which has its origin in some risk so connected with, or incidental to, the employment as to create a causal connection between the employment and the injury. Orsini v. Industrial Commission, 117 Ill.2d 38, 44 (1987).

Respondent maintains Petitioner is not entitled to benefits under the Act because he was the "aggressor" in a work altercation, citing Franklin v. Industrial Commission, 211 Ill.2d 272 (2004). Petitioner relies on a different analysis and asserts he is entitled to benefits because he was injured while attempting to complete a "special" task outside of his normal work duties.

The Arbitrator agrees with Petitioner that Franklin is inapplicable. The altercation at issue did not take place between co-workers. The Arbitrator also agrees that an injury can be compensable if it occurs while an employee is performing a special errand or mission outside of his usual occupation. In the instant case, it is undisputed that Respondent, acting through its store manager, directed Petitioner to assume a new and unfamiliar role as a security guard. Prior to the incident, Petitioner's job consisted of stocking and performing maintenance. Respondent's subpoenaed witness acknowledged that Respondent never trained Petitioner how to handle security-related issues.

Regardless, the Arbitrator denies this claim because Petitioner was injured 1) after he successfully completed the "special" assignment; and 2) while reacting, unreasonably, to what

was by then a purely personal threat. The store manager tasked Petitioner with getting an unruly customer out of the store. Petitioner completed this task. The video clearly shows that the customer was well outside the entryway, with his back to Petitioner, when Petitioner lunged at him. Petitioner testified the customer remained abusive after leaving the store but conceded that, at that point, the abuse was purely verbal and directed only toward him. There is no evidence suggesting that Petitioner lunged at the customer because the customer expressed an intent to re-enter the store or harm anyone therein.

The Arbitrator, having found that Petitioner failed to prove a compensable work accident, views the remaining disputed issues as moot. Compensation 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

Stormy Monday,

Petitioner,

vs.

NO: 12 WC 24136

14IWCC1002

Caterpillar, Inc.,

Respondent.

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed January 30, 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.

14IWCC1002

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: NOV 24 2014
CJD:yl
o 11/5/14
49

Charles J. DeVriendt

Ruth W. White

Daniel R. Donohoo

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

MONDAY, STORMY
Employee/Petitioner

Case# **12WC024136**

CATERPILLAR INC
Employer/Respondent

14IWCC1002

On 1/30/2014, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

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

0252 HARVEY & STUCKEL
DAVID STUCKEL
101 S W ADAMS ST SUITE 600
PEORIA, IL 61602

0477 CATERPILLAR INC
HENRY VICARY III
100 N E ADAMS ST
PEORIA, IL 61629-4425

STATE OF ILLINOIS)
)SS
COUNTY OF PEORIA)

14IWCC1002

☐ Injured 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

STORMY MONDAY,
Employee/Petitioner

v.

CATERPILLAR, INC.,
Employer/Respondent

Case # 12 WC 24136

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: _____

14IWCC1002

FINDINGS

On **June 9, 2012**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$35,215.34**; the average weekly wage was **$677.22**.

On the date of accident, Petitioner was **58** 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 **$ 8,642.62** for TTD, **$ 0.00** for TPD, **$ 0.00** for maintenance, and **$ 0.00** for other benefits, for a total credit of **$ 8,642.62**.

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

ORDER

Respondent shall pay Petitioner temporary total disability benefits of **$451.48**/week **44-5/7** weeks, commencing **June 10, 2012** through **April 18, 2013**, as provided in Section 8(b) of the Act.

Respondent shall pay Petitioner permanent partial disability benefits of **$406.33**/week for **75** weeks, because the injuries sustained caused the **15%** loss to his **person as a whole,** as provided in Section 8(d)2 of the Act.

Respondent shall pay to Petitioner reasonable and necessary medical services of **$63,791.32**, pursuant to Section 8(a) of the Act, subject to the medical fee schedule as created by Section 8.2 of the Act. Respondent shall receive credit for all amounts paid to date.

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

STATEMENT OF INTEREST RATE If the Commission reviews this award, interest at the rate set forth on the *Notice of Decision of Arbitrator* shall accrue from the date listed below to the day before the 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 22, 2014
Date

JAN 30 2014

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

Petitioner testified that on Saturday, June 9, 2012, he slipped on oil in the floor near the end of his work shift. Petitioner testified he did not fall to the ground but twisted very hard and suddenly to keep from falling. At that time he experienced a pop in his back, followed by immediate pain in his lower back and his legs.

Petitioner testified he did not report the accident at that time, but did report at the start of his next shift on Monday, June 11, 2012. At that time he filled out an accident report that corroborated his testimony in this matter. (Rx2)

After reporting the accident, Petitioner later that day sought emergency room treatment at OSF St. Francis Medical Center. A history of injury was recorded that corroborated his testimony in this matter. Petitioner during examination was found to have a positive straight leg raising test to the left. Petitioner was prescribed pain medication and advised to see Respondent's first aid department the next day.

Petitioner then visited the first aid department and complained of pain to his right buttock and left leg with numbness down the right leg. Petitioner was prescribed pain medication and instructed to return the next day. Petitioner testified his left leg pain subsided after a few weeks, and he later received treatment only for his right sided symptoms. During his return visit to first aid, Petitioner was found to be favoring his right leg and moving slowly with a limp. There was limited range of motion with tenderness noted at L3-L4. Petitioner reported being unable to lift more than 2 pounds away from his body and was found to not meet the requirements to return to work. Petitioner was advised to follow up with his primary care physician, and that the injury was work related. (Rx2)

Petitioner then saw Dr. Hoffman on June 15, 2012. Dr. Hoffman noted L3-S1 tenderness with limited extension and rotation. Dr. Hoffman diagnosed a lumbosacral strain, prescribed an MRI and pain medication, and no work. Following the MRI, Dr. Hoffman diagnosed a herniated disc and referred Petitioner to see Dr. Mulconrey.

Petitioner first saw Dr. Mulconrey, an orthopedic surgeon, on August 22, 2012. Petitioner arrived in a wheelchair and was noted to not be able to walk normally. Dr. Mulconrey reviewed the MRI and noted significant foraminal stenosis at L4-L5 on the right. Dr. Mulconrey prescribed surgery.

Respondent introduced a video into evidence claiming it showed Petitioner leaving the plant on the date of accident without any apparent difficulty. Petitioner denied during his testimony he was the individual in the video. The video dos not show the face of the individual filmed.

Mr. Scott Kelso testified on behalf of Respondent that he manages security in emergency services in the area where Petitioner worked. He testified that someone from safety requested he retrieve the video from the date of accident at the gate where Petitioner would leave the facility. Mr. Kelso testified he retrieved the video that shows a time stamp. Mr. Kelso testified the video time may not be accurate since the recording system was maintained by an outside contractor who would only check the time when someone noticed it was incorrect. Mr. Kelso testified he reviewed the gate video 15 minutes before and after Petitioner checked out, and the person filmed was the only one who left through that gate during that time frame. Mr. Kelso testified he checked the video from around 6:35 pm to 7:05 pm. The video time stamp indicates a recording at 18:40, or 6:40 pm, and shows a person with a baseball cap, long hair, short sleeved shirt, and shorts walking out of the gate. Mr. Kelso again admitted the video time stamp did not show the true time when it was recorded. Mr. Kelso was also unable to explain how he knew the time he was looking for corresponded with Petitioner's departure at the gate. Mr. Kelso testified the video was also accessible by several people before he retrieved it, and the time on the video could be off by 5-30 minutes.

Ms. Holly Kampas, Petitioner's supervisor on the date of accident, testified that at least one other person left within 10 minutes of Petitioner that day. She testified she saw him at least three times during the shift on the date of accident. Ms. Kampas was not his regular supervisor and was filling in on that date. Petitioner testified he only saw her once that day, shortly before he finished working and had his injury. Ms. Kampas testified that she recognized Petitioner in the video and that he regularly wore shorts to work. Her last contact with him was after 6:00 pm, when she told him he could leave when he finished his work assignment. He never reported an injury to her on that date. She then left the work area but testified she was at the next line over and could see Petitioner walk out. He appeared normal at that time.

Petitioner testified he did not report the accident to Ms. Kampas when it occurred, because she was normally located so far away from his work area he was not sure he could get there and he was not sure she would be at her desk. Ms. Kampas testified her desk was two football fields away from where Petitioner worked. Ms. Kampas testified she identified Petitioner in the video based on the ponytail shown on the person depicted. Petitioner testified several other workers who may not have been employees were in the area and they had ponytails.

Ms. Kampas testified no other employee saw Petitioner get hurt or voice complaints about his condition. Petitioner testified in rebuttal there were no other employees in the area when he slipped and fell and he did not report the incident to any co-employee.

Mr. Ronald Anderson testified he was Petitioner's regular supervisor. Mr. Anderson testified he was not working on the accident date of June 9, 2012. Mr. Anderson testified there were other individuals working who had hair similar to the individual depicted in the video. Mr. Anderson did work the following Monday and was the person to whom Petitioner reported that he had been injured on Saturday. Mr. Anderson testified he could identify Petitioner in the video by his hair, clothes and walk, but did not see the face of the person depicted in the video. Mr. Anderson testified he sent Petitioner to the company medical department on Monday, and that was the last time he saw him.

Mr. Anderson testified he never saw oil spots on the floor in the area where Petitioner claimed he fell, but admitted it was possible that something was on the floor. Again, Mr. Anderson did not work on the date of the slip and fall. Mr. Anderson testified there are holes in the transmissions where there are connections when installed in a machine and there can be liquid dripping out.

Petitioner testified he never wore shorts to work.

Based upon the above, the Arbitrator finds that on June 9, 2012, Petitioner sustained an accidental injury at work that arose out of and in the course of the employment by Respondent. The Arbitrator finds it unclear that Petitioner is depicted in the video, and the witnesses were unclear at times as to their testimony as to how they managed to identify the individual in the video as being the Petitioner. Petitioner's testimony that he never wore shorts at work is relevant. The pony tail identification in this matter is insufficient. There is also no explanation as to how Mr. Anderson could identify the clothing on the date of accident when he did not work on that day. The Arbitrator declines to base an identification based on a ponytails. In addition, there is no medical testimony that would confirm the individual depicted in the video was injured or not injured, and although the lay testimony on this subject is admissible, the lay witnesses conclusions that the unidentified individual in the video was walking normally do not necessarily prove it was the Petitioner so depicted in that video.

The Arbitrator further bases the finding on accident based on the consistent histories of injury given to the medical providers along with the examinations that corroborated that an injury occurred.

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

See findings of this Arbitrator in "C" above.

Petitioner sought treatment with his personal physician, Dr. Hoffman, on June 15, 2012. Dr. Hoffman diagnosed a lumbosacral strain, prescribed pain medication, no work, and an MRI. Dr. Hoffman later interpreted the MRI as revealing a herniated disc and referred Petitioner Dr. Mulconrey, an orthopedic surgeon.

Dr. Mulconrey first saw Petitioner on August 22, 2012, who reviewed the MRI and prescribed surgery. Dr. Mulconrey testified by evidence deposition that he diagnosed spinal stenosis, right lower extremity radiculopathy and degenerative disc disease. Dr. Mulconrey felt the stenosis was caused in part by a bulging disc and enlarged facet at the same level. He noted absent patellar reflex on the right. Based on the x-rays and MRI he reviewed, Dr. Mulconrey noted significant foraminal stenosis at L4-L5. Respondent refused to authorize the surgery.

Dr. Mulconrey felt the slipping incident at work was consistent with the development of immediate pain and the need for surgery.

Petitioner was examined by Dr. Weiss on October 12, 2012. This examination was at the request of Respondent. Dr. Weiss felt the history of accident was consistent, and felt he suffered an aggravation of a degenerative back condition, which he felt resolved after a short period of time. Dr. Weiss did not indicate where he received information that the condition resolved itself and when. Dr. Weiss felt surgery was not warranted and related to this accident, and diagnosed pre-existing degenerative disc disease, symptom magnification, and prior back problems in 2010. Dr. Weiss did admit the 2010 injury resulted in a short period of treatment, and there was no evidence of ongoing symptoms prior to June 9, 2012. Dr. Weiss based his symptom magnification opinion on a negative straight leg raising test.

The Arbitrator notes with interest that Petitioner was hired 6 months before this accident following a pre-employment physical examination that indicated no back symptoms or problems.

Petitioner eventually underwent surgery on January 31, 2013 with Dr. Mulconrey in the form of a right hemilaminectomy, partial facetomy and foraminotomy at L4-L5 and L5-S1. Post surgery, Petitioner underwent physical therapy and was released to return to work on April 18, 2013.

Dr. Mulconrey testified Petitioner had a good recovery after surgery with significant relief of his back and right leg pain. Petitioner testified he was substantially better after surgery but still experiences low back pain and right leg numbness 20% of the time. Petitioner did not return to work for Respondent as he was terminated while off work.

Dr. Weiss reexamined Petitioner post surgery and felt the surgery was not causally related to this accident.

Based upon the above, the Arbitrator adopts the findings and opinions of Dr. Mulconrey as being more credible of those of Dr. Weiss, and finds the conditions of ill-being as diagnosed by Dr. Mulconrey as being causally related to this accidental injury.

14IWCC1002

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

Petitioner introduced into evidence medical charges for treatment that were incurred after this accidental injury:

OSF St. Francis Medical Center	$ 3,296.85
Dr. Daniel Hoffman	$ 750.00
Peoria Imaging Center	$ 1,525.00
Central Illinois Radiological Associates	$ 156.00
Midwest Orthopaedic Center	$11,383.80
Illinois Regional Pain Institute	$ 1,500.08
Prescription Partners, LLC	$ 441.65
Methodist Medical Center of Illinois	$41,134.64
Methodist Anesthesia Services	$ 3,242.00
Comp. Emergency Solutions	$ 290.00
Peoria Tazewell Pathology Group	$ 71.30

These charges total $63,791.32.

See findings of this Arbitrator in "C" and "F" above.

The parties are unclear as to which of the above medical charges may have been paid by Respondent or Respondent's group health insurance carrier. The evidence before this Arbitrator on this issue is also unclear. Respondent shall be entitled to receive a credit as against this award and it will be the responsibility of the parties to assure the awarded medical charges are either paid or will be paid.

Based upon the above, the Arbitrator finds the above charges to represent reasonable and necessary medical care and treatment that was causally related to this accidental injury, and finds Respondent to be liable for same, subject to the medical fee schedule as created by the Act.

Based further upon said findings, Respondent is to hold Petitioner safe and harmless from all attempts at collection or reimbursements of amounts that may have been paid by Respondent's group health insurance carrier, in accordance with Section 8(j) of the Act.

K. What temporary benefits are in dispute?

See findings of this Arbitrator in "C" and "F" above.

Petitioner was taken off work commencing June 10, 2012 until release by Dr. Mulconrey on April 18, 2013 to return to work.

Based upon the above, the Arbitrator finds that Petitioner is entitled to receive from Respondent temporary total disability benefits commencing June 10, 2012 through April 18, 2013.

14IWCC1002

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

See findings of this Arbitrator in "C" and "F" above.

In order to assess permanent partial disability for accidents subsequent to September 1, 2011, the Arbitrator has considered the criteria in accordance with Section 8.1(b) of the Act.

1. **The level of impairment pursuant to the AMA Guidelines.** Dr. Stephen Weiss examined Petitioner on behalf of Respondent on October 18, 2012 and July 1, 2013. On July 1, 2013, Dr. Weiss issued an impairment rating of 6% of the whole person. Dr. Weiss testified he rated Petitioner on spinal stenosis with a resolved radiculopathy that he did not think was work related. The Arbitrator found Dr. Weiss' opinions to be suspect as noted in "F" above.

2. **Petitioner's occupation.** Petitioner was employed by Respondent as a painter. His job entailed painting transmissions and drive train.

3. **Petitioner's Age.** Petitioner was 58 years of age at the time of the injury.

4. **The Employee's Future Earning Capacity.** Petitioner testified he had significant relief of his pain symptoms subsequent to his back surgery, however he still experiences pain in his lower back. Petitioner testified he is 80% better than before surgery. Petitioner was deemed a supplemental employee at the time of the injury by Respondent and was terminated while awaiting medical treatment.

5. **Evidence of Disability.** Petitioner's treating orthopedic surgeon, Dr. Mulconrey, testified he performed a foraminotomy, partial fasciatomy, and a hemilaminotomy at L4-L5 and L5-S1. Dr. Mulconrey testified Petitioner's incident at work was consistent with the symptoms he experienced in his lower back and right lower extremity. Dr. Mulconrey released Petitioner to perform full duty work on April 17, 2013.

The Arbitrator has taken all of the factors listed above in consideration and finds Petitioner is entitled to receive an award from Respondent of 15% disability to his man or person as a whole under Section 8(d)2 of the Act.

Based further upon the above, the Arbitrator finds the above conditions of ill-being to now be permanent in nature.

N. Is Respondent due any credit?

See findings of this Arbitrator in "C," "J," and "F" above.

The parties are unclear as to which of the above medical charges may have been paid by Respondent or Respondent's group health insurance carrier. The evidence before this Arbitrator on this issue is also unclear. Respondent shall be entitled to receive a credit as against this award and it will be the responsibility of the parties to assure the awarded medical charges are either paid or will be paid.

Based upon the above, the Arbitrator finds the above charges to represent reasonable and necessary medical care and treatment that was causally related to this accidental injury, and finds Respondent to be liable for same, subject to the medical fee schedule as created by the Act.

14IWCC1002

Based further upon said findings, Respondent is to hold Petitioner safe and harmless from all attempts at collection or reimbursements of amounts that may have been paid by Respondent's group health insurance carrier, in accordance with Section 8(j) of the Act.

STATE OF ILLINOIS)
) SS.
COUNTY OF LA SALLE)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

LaWayne Lee,

Petitioner,

vs.

NO: 14 WC 1119

14IWCC1003

Premier Transportation,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b-1) having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of accident, notice, causal connection, temporary total disability, and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof. The Commission further remands this case to the Arbitrator for further proceedings for a determination of a further amount of temporary total compensation or of compensation for permanent disability, if any, pursuant to Thomas v. Industrial Commission, 78 Ill.2d 327, 399 N.E.2d 1322, 35 Ill.Dec. 794 (1980).

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed July 22, 2014, is hereby affirmed and adopted.

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

14IWCC1003

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 $42,000.00. 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: NOV 24 2014
CJD:yl
o 11/12/14
49

Charles J. DeVriendt

Ruth W. White

Daniel R. Donohoo

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF 19(b-1) DECISION OF ARBITRATOR

LEE, LaWAYNE
Employee/Petitioner

Case# **14WC001119**

PREMIER TRANSPORTATION
Employer/Respondent

14IWCC1003

On 7/22/2014, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

Unless a party does the following, this decision shall be entered as the decision of the Commission:

1) Files a Petition for Review within 30 days after receipt of this decision; and

2) Certifies that he or she has paid the court reporter $ 327.75 for the final cost of the arbitration transcript and attaches a copy of the check to the Petition; and
3) Perfects a review in accordance with the Act and Rules.

If the Commission reviews this award, interest of 0.05% 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:

5314 CARAS & ASSOCIATES
DEAN J CARAS
320 W ILLINOIS ST SUITE 2216
CHICAGO, IL 60654

2965 KEEFE CAMPBELL BIERY & ASSOC LLC
MATTHEW IGNOFFO
118 N CLINTON ST SUITE 300
CHICAGO, IL 60661

14IWCC1003

STATE OF ILLINOIS)
)SS.
COUNTY OF Will)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b-1)

LaWayne Lee,
Employee/Petitioner
v.
Premier Transportation,
Employer/Respondent

Case # **14** WC **1119**

Consolidated cases: **none**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. Petitioner filed a *Petition for an Immediate Hearing Under Section 19(b-1) of the Act* on **5/1/14**. Respondent filed a *Response* on **5/13/14**. The Honorable **Peter M. O'Malley**, Arbitrator of the Commission, held a pretrial conference on **6/23/14**, and a trial on **6/27/14**, in the city of **Ottawa**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

14IWCC1003

FINDINGS

On the date of accident, **8/30/13**, 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 **$56,310.80**; the average weekly wage was **$1,082.90**.

On the date of accident, Petitioner was **44** years of age, ***married*** with **2** dependent children.

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

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

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

ORDER

Respondent shall pay Petitioner temporary total disability benefits of $721.93 per week for 19-4/7 weeks, commencing 2/11/14 through 6/27/14, as provided in Section 8(b) of the Act.

Respondent shall pay Petitioner the temporary total disability benefits that have accrued from 8/31/13 through 6/27/14, and shall pay the remainder of the award, if any, in weekly payments.

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.

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

RULES REGARDING APPEALS Unless a party 1) files a *Petition for Review* within 30 days after receipt of this decision; and 2) certifies that he or she has paid the court reporter **$327.75** or the ***final*** cost of the arbitration transcript and attaches a copy of the check to the *Petition*; and 3) perfects a review in accordance with the Act and Rules, then this decision shall be entered as the decision of the Commission.

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

Peter A Foley
Signature of Arbitrator

7/10/14
Date

ICArbDec19(b-1) p. 2

JUL 22 2014

STATEMENT OF FACTS:

The Arbitrator notes that this case was assigned to New Lenox. Upon Petitioner's filing of the present Petition for Immediate Hearing pursuant to §19(b-1) on May 1, 2014, the matter was assigned a pre-trial date by the Commission of June 23, 2014 in Ottawa, the assigned arbitrator's next call. The matter subsequently proceeded to trial in Ottawa on June 27, 2014 and proofs were closed on that date.

Petitioner, a 44 year old truck driver, testified that he had worked for Respondent for a year prior to the alleged date of accident and that he had suffered no prior injuries to his right shoulder leading up to that date. Petitioner testified that on August 30, 2013, he was hooking up to an empty trailer by attempting to pull a frozen release pin when he felt a sharp pain in his right shoulder. He noted that he had never felt that kind of pain in his shoulder before. Petitioner noted that he did not tell anyone about his injury at that time.

Petitioner testified on that on September 4, 2013, he contacted his supervisor, Tori Lengel, by telephone and told her that he was going to see a doctor. When asked why he waited until that date to report the incident, Petitioner stated that he had used cold pack and Icy Hots up until that point, but that they did not work, and that he had set up an appointment for September 11, 2013. He also stated that at the time of this phone conversation he told Ms. Lengel the same history of injury as he related at arbitration. Petitioner noted that Ms. Lengel instructed him to call her back after he saw the doctor and to contact human resources. Petitioner testified that he contacted human resources that same day and spoke to Kelsey Austin. He indicated that he gave the same history of injury to Ms. Austin and was told that they would get back to him. Petitioner noted that that same day a Ms. Swanson called from Crum & Forrester, the workers' compensation administrator. He testified that he advised Ms. Swanson that he was injured on August 30, 2013 and that a claim was started, specifically claim MCL 906800.

Petitioner testified that on September 11, 2013 he visited his primary care physician, Dr. Irshad. He indicated that he informed Dr. Irshad that he had injured his right shoulder at work and how he was pulling a frozen release pin at the time. Dr. Irshad's notes from that visit show that Petitioner was complaining of "... pain in r[igh]t shoulder since he pulled off handle at work. [P]t says pain bothers him more at night time ... [and] is unable to reach above head." (PX1). Dr. Irshad's diagnosis was "rotator cuff (capsule) sprain" and unspecified essential hypertension. (PX1). Petitioner was prescribed pain pills as well as an MRI at that time. (PX1).

An MRI of the right shoulder performed on September 28, 2013 was interpreted as evidencing a full thickness tear of the rotator cuff tendon near its insertion in the greater tuberosity as well as moderately advance degenerative disease of the acromioclavicular joint and a moderate amount of fluid in the subacromial/subdeltoid bursa. (PX2).

Petitioner testified that on October 10, 2013 he contacted Ms. Lengel and explained to her that he felt a sharp pain in his shoulder again. He indicated that she told him to put it in writing because she had to send something to the corporate office in Georgia. In this type-written document, dated October 10, 2013 and signed by Petitioner on October 14, 2013, Petitioner noted that he "... injured [his] right shoulder by pulling the level to release the pins of the tandems approximately seven weeks ago. [He] went to the doctor in the month of September of 2013 for the pain in [his] right shoulder and a MRI was done. As of October 10, 2013 while [he] was working the pain in [his] right shoulder became severe." (RX2).

Driver manager Tori Lengel testified that Petitioner first told her about the injury on October 10, 2013. Ms. Lengel denied that Petitioner called her on September 4, 2013 and reported the accident. However, Ms. Lengel later agreed that she was aware of Petitioner's shoulder problem prior to October 10, 2013, and that Petitioner had informed her prior to that date that he would send her records.

Ms. Lengel also testified on October 10, 2013 she prepared an "Employee's Report of Injury" form, the original of which was admitted at RX3. This form reflects a handwritten date of injury of "10/10/13." (RX3). The Arbitrator notes that this date was clearly written over white-out. When questioned on this point, Ms. Lengel admitted that she had placed the wrong date of accident on the form and had to correct it. However, she could not recall what the original entry had been. On this form, in describing the details of the injury, Ms. Lengel noted "1st injured about 1 month ago pulling tandem pin. Reinjured 10/10/13 unloading freight." (RX3). Ms. Lengel also acknowledged that she received a copy of Petitioner's MRI report within 45 days of August 30, 2013 as well as his blood test results from September 11, 2013 from Med Star.

On October 18, 2013, Petitioner returned to Dr. Irshad, who noted the MRI results of a full thickness tear of the rotator cuff and was referred him to an orthopaedic physician. (PX1).

Petitioner subsequently visited Dr. Chadwick Prodromos on November 20, 2013. On that date, Dr. Prodromos recorded a history of "[w]hile at work he pulled a release lever in the rear of truck to release pins injuring right shoulder. MRI has shown full-thickness rotator cuff tear." (PX3). Following his examination, Dr. Prodromos recommended surgery in the form of a right rotator cuff repair. (PX3).

On February 11, 2013, Dr. Prodromos performed right shoulder arthroscopic rotator cuff repair and arthroscopic distal clavicectomy and acromioplasty surgery at Resurrection Medical Center. (PX4). Petitioner had continued to work his regular duties up to the date of surgery. Dr. Prodromos has had Petitioner off of work from February 11, 2014 through the date of arbitration, June 27, 2014. (PX3).

Petitioner testified that he has not received any payments for temporary total disability from his employer for the 20 weeks that he has been off of work. Petitioner has requested TTD be paid and has also undergone a course of physical therapy from April 29, 2014 through June 26, 2014, and anticipates that he will continue to go to physical therapy. Petitioner also has a scheduled appointment with Dr. Prodromos on July 2, 2014.

WITH RESPECT TO ISSUES (C), DID AN ACCIDENT OCCUR THAT AROSE OUT OF AND IN THE COURSE OF THE PETITIONER'S EMPLOYMENT BY THE RESPONDENT, AND (D), WHAT WAS THE DATE OF THE ACCIDENT, THE ARBITRATOR FINDS AS FOLLOWS:

Petitioner testified that on August 30, 2013 he was attempting to remove a frozen release pin to hook up an empty trailer when he felt a sharp pain in his right shoulder. Petitioner noted that he had worked for Respondent for a year prior to the incident and had not suffered any injury to his right shoulder prior to that time. He also noted that he had never experienced this kind of pain in his right shoulder before. Petitioner testified that he used cold packs and Icy Hots to relieve his pain, to no avail, and that he finally set up an appointment to see his primary care physician.

Petitioner claims he called his supervisor, Tori Lengel, on September 4, 2013, and reported the injury. For her part, Ms. Lengel denies that Petitioner contacted her that day. Petitioner also claims that he was told to report the incident to human resources, which he did, as was later contacted by a workers' compensation claims administrator and given a claim number. None of these individuals were called to testify and no documentary evidence from either Respondent's human resource department or the claims administrator were introduced into evidence.

On September 11, 2013, Petitioner visited his primary care physician, Dr. Irshad who recorded that that Mr. Lee presented at that time with complaints of "... pain in r[igh]t shoulder since he pulled off handle at work..." (PX1).

An MRI of the right shoulder performed on September 28, 2013 was interpreted as evidencing a full thickness tear of the rotator cuff. (PX2).

Petitioner testified that on October 10, 2013 he contacted Ms. Lengel and explained to her that he felt a sharp pain in his shoulder again. He indicated that she told him to put it in writing because she had to send something to the corporate office in Georgia. In this type-written document, dated October 10, 2013 and signed by Petitioner on October 14, 2013, Petitioner noted that he "... injured [his] right shoulder by pulling the level to release the pins of the tandems approximately seven weeks ago. [He] went to the doctor in the month of September of 2013 for the pain in [his] right shoulder and a MRI was done. As of October 10, 2013 while [he] was working the pain in [his] right shoulder became severe." (RX2).

Ms. Lengel testified that Petitioner first told her about the injury on October 10, 2013. Ms. Lengel denied that Petitioner called her on September 4, 2013 and reported the accident at that time. However, Ms. Lengel later agreed that she was aware of Petitioner's shoulder problem prior to October 10, 2013, and that Petitioner had informed her prior to that date that he would send her records. Ms. Lengel also testified she prepared an "Employee's Report of Injury" form on October 10, 2013 that notes a handwritten date of injury of "10/10/13" over white-out. (RX3). When questioned on this point, Ms. Lengel admitted that she had placed the wrong date of accident on the form and had to correct it. However, she could not recall what the original entry had been. This form also contains the following description of the injury: "1st injured about 1 month ago pulling tandem pin. Reinjured 10/10/13 unloading freight." (RX3).

Petitioner eventually visited Dr. Prodromos on November 20, 2013 at which time he recorded a history of "[w]hile at work [Petitioner] pulled a release lever in the rear of truck to release pins injuring right shoulder..." (PX3).

While the Arbitrator is inclined to believe that Petitioner did not specifically report a work related accident, at least in so many words, during the course of a phone conversation with Ms. Lengel on September 4, 2013, the evidence strongly suggests that Ms. Lengel was well aware of Petitioner's shoulder complaints prior to October 10, 2013. Furthermore, the medical histories and Petitioner's written statement all point to an incident at work approximately a month or so before wherein Mr. Lee was attempting to pull a pin or lever and felt pain in his right shoulder. Petitioner credibly testified that he had no prior history of right shoulder problems, and there is absolutely no evidence to suggest that he sought treatment for any such complaints prior to the incident in question.

Therefore, based on the above, and the record taken as a whole, the Arbitrator finds that Petitioner proved by a preponderance of the credible evidence that he sustained accidental injuries arising out of and in the course of his employment on August 30, 2013.

WITH RESPECT TO ISSUE (E), WAS TIMELY NOTICE OF THE ACCIDENT GIVEN TO THE RESPONDENT, THE ARBITRATOR FINDS AS FOLLOWS:

During the course of the hearing, there was much debate as to whether or not Petitioner reported a work related injury to Ms. Lengel at the time of an alleged phone conversation on September 4, 2013.

What is not disputed is the fact that Ms. Lengel acknowledged, at the very least, that Petitioner informed her on October 10, 2013 that he had injured his right shoulder at work "... about 1 month ago pulling tandem pin" and that he had "[r]einjured [himself on] 10/10/13 unloading freight." (RX3).

Since October 10, 2013 is less than 45 days from the date of injury, Respondent clearly had effective notice of a claimed work related injury within the time requirements set forth in the statute. Furthermore, Respondent failed to show that it was somehow prejudiced by any possible defect in said notice.

Therefore, based on the above, and the record taken as a whole, the Arbitrator finds that Petitioner provided Respondent with proper and adequate notice pursuant to §6(c) of the Act.

WITH RESPECT TO ISSUE (F), IS THE PETITIONER'S PRESENT CONDITION OF ILL-BEING CAUSALLY RELATED TO THE INJURY, THE ARBITRATOR FINDS AS FOLLOWS:

No medical opinion was offered on the question of causation. However, the medical record reflects, and Petitioner credibly testified, that he had not suffered any prior injuries to his right shoulder or received any treatment for same during the period leading up to the date of the accident.

Therefore, based on the above, and the record taken as a whole, as well as the Arbitrator's determination as to accident (issues "C" and "D", supra), the Arbitrator finds that Petitioner proved by a preponderance of the credible evidence that his current condition of ill-being with respect to his right shoulder is causally related to the accident on August 30, 2013.

WITH RESPECT TO ISSUE (L), WHAT AMOUNT OF COMPENSATION IS DUE FOR TEMPORARY TOTAL DISABILITY, TEMPORARY PARTIAL DISABILITY AND/OR MAINTENANCE, THE ARBITRATOR FINDS AS FOLLOWS:

Petitioner continued to work his regular duties up through the date of surgery on February 11, 2014 at which point he was taken off work by Dr. Prodromos. No physician, including Dr. Prodromos, has yet to release Petitioner to return to work in capacity as of the date of arbitration.

Accordingly, based on the above, and the record taken as a whole, as well as the Arbitrator's determination as to accident and causation (issues "C", "D" and "F", supra), the Arbitrator finds that Petitioner was temporarily totally disabled from February 11, 2014 through June 27, 2014, the date of hearing at arbitration, for a period of 19-4/7 weeks.

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 Causal connection Future Medical	☐ Second Injury Fund (§8(e)18)
☐ Modify	☐ PTD/Fatal denied
	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Bobby Whitledge,

Petitioner,

vs.

NO: 11 WC 42146

14IWCC1004

Heartland Regional Medical 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 causal connection, medicaal expenses both incurred and prospective and temporary total disability and being advised of the facts and law, reverses 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 finding that Petitioner is entitled to temporary total disability payments from October 19, 2013, through December 30, 2013.

The Commission further finds that Petitioner is not entitled to any medical expenses after January 4, 2012 and that his left knee complaints subsequent to that date are not causally connected to the accident.

The Commission also finds that Petitioner is not entitled to any medical care to the right knee after Petitioner completed his physical therapy in October 2013.

The Commission finds that Petitioner's testimony was not credible with respect to his left knee complaints. The Petitioner told Dr. Bonutti, his treating physician, that he could not walk on his left knee. (Petitioner Exhibit 15 Pg. 281) This was three weeks prior to surveillance films which revealed Petitioner walking up and down a gravel hill in flip flop sandals without the use of an assistive device. Petitioner did not walk with a limp and was walking briskly throughout the surveillance video. Petitioner was carrying several items to his pontoon boat without difficulty. These items included a bag of ice, gasoline cans and several bags. Petitioner was also seen in the video lifting and carrying a large cooler onto his boat. Petitioner climbs from boat to boat without any apparent distress. (Respondent Exhibit 3)

The Petitioner saw Dr. Rende on July 15, 2013. This was one week after the surveillance video was taken. In that exam, Petitioner had considerable difficulty performing tasks such as standing up from a chair without assistance. He even held onto the walls to assist him in walking. (Respondent Exhibit 1 Pgs. 26-32)

Petitioner tried to explain away this video footage, but the Commission finds his explanations unconvincing. Petitioner claimed that he was able to perform the activities shown in the video footage because of the effects of the pain medications and alcohol. (Transcript Pgs. 22-25)The Commission finds it inexplicable that the Petitioner could perform the activities that he performed in the video and a week later is unable to walk or stand without holding onto furniture for support. When questioned about the Petitioner's explanation regarding his medications and alcohol and his ability to undertake those activities, Dr. Bonutti did not buy that explanation. He indicated that even if Petitioner's pain was mitigated by pain medications, such a presentation would mean that Petitioner's knees were probably functioning better than reported. Dr. Bonutti testified that he would be surprised to see petitioner walking without a limp, moving from boat to boat or carrying bags without a limp. (Petitioner Exhibit 19 Pgs. 43-45)

It is clear that Dr. Bonutti did not see the actual video surveilliance. Dr. Rende the Respondent's IME doctor did. He also had the opportunity to physically examine the Petitioner and review the relevant medical records and diagnostic imaging. He agreed with Dr. Bonutti that there was no evidence of hardware loosening in the left knee. (Respondent Exhibit 1 Pg. 8 and Pgs. 38-39)Unlike Dr. Bonutti, he also had the opportunity to review the video surveilliance. He noted the video showed Petitioner performing several activities involving the left knee without difficulty. He testified that given the inconsistencies between Petitioner's presentation on the date of his evaluation and his presentation on the videotape, he expressed concern with the veracity of the Petitioner's subjective complaints. (Respondent Exhibit 1 Pgs. 27-29)

14IWCC1004

Dr. Bonutti testified that the objective diagnostic studies did not necessarily support a left knee replacement at that time. In reviewing the x-rays he admitted that the two areas which were separated by one millimeter and the other by two millimeters was not a significant gap to warrant a diagnosis of hardware loosening. In light of that and the negative CT scan he admitted that it is not conclusive the Petitioner does in fact have hardware loosening. (Petitioner Exhibit Pgs.31-33) Dr. Bonutti further testified that he relies on statements from his patients in diagnosing and treating their conditions, especially in an incident such as this where the Petitioner subjective complaints of pain are allegedly due to a loss of function of his left knee. Dr. Bonutti acknowledged that if Petitioner's presentation was different than what was reported to him, it could change his opinion. (Petitioner Exhibit 19 Pg. 42)

The Commission therefore finds the opinions of Dr. Rende more persuasive than those of Dr. Bonutti. Dr. Rende was of the opinion that Petitioner had reached maximum medical improvement of his left knee based on the x-rays, excellent range of motion and a normal physical examination. He was of the opinion that there were no objective findings that Petitioner required any further treatment with respect to his left knee after January 4, 2012. He further opined that Petitioner should be at medical maximum improvement in October of 2013 after completing physical therapy on the right knee. (Respondent Exhibit 1 Pgs. 40-42)

In regards to the Arbitrator's award of temporary total disability, the Commission reverses. Dr. Rende found that Petitioner was at maximum medical improvement on October 13, 2013. He also found that Petitioner was at maximum medical improvement regarding his left knee on January 4, 2012. Petitioner testified that he was not aware of any restrictions placed on him by Dr. Bonutti. (Transcript Pg. 26)

IT IS THEREFORE ORDERED BY THE COMMISSION that Arbitrator's award as it pertains to causal connection of the left knee, temporary total disability and prospective medical is reversed.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the medical expenses under §8(a) of the Act and 8-2. Respondent shall pay for only the medical expenses pertaining to the left knee up until January 4, 2012 and only the medical expenses regarding the right knee up until October 13, 2013.

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.

14IWCC1004

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: NOV 24 2014

Charles J. DeVriendt

Daniel R. Donohoo

Ruth W. White

HSF
O: 9/23/14
049

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

WHITLEDGE, BOBBY
Employee/Petitioner

Case# **11WC042146**

HEARTLAND REGIONAL MEDICAL CENTER
Employer/Respondent

14IWCC1004

On 1/30/2014, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

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

0355 WINTERS BREWSTER CROSBY ET AL
LINDA CANTRELL
111 W MAIN ST
MARION, IL 62959

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

14IWCC1004

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)

Bobby Whitledge
Employee/Petitioner

v.

Heartland Regional Medical Center
Employer/Respondent

Case # **11 WC 42146**

Consolidated cases:

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

DISPUTED ISSUES

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

B. ☐ Was there an employee-employer relationship?

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

D. ☐ What was the date of the accident?

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

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

G. ☐ What were Petitioner's earnings?

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

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

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

K. ☒ **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** Section 8(a) benefits and TTD.

FINDINGS

On **10/21/2010**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$61,620.00**; the average weekly wage was **$1,185.00**.

On the date of accident, Petitioner was **59** years of age, ***married*** with **1** dependent children.

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

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

Respondent shall be given a credit of **$81,484.10** for TTD, **$0** for TPD, $0 for maintenance, and **$0** for other benefits, for a total credit of **$81,484.10**.

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

ORDER

Respondent shall pay Petitioner the temporary total disability benefits that have accrued from 10/19/2013 through 12/30/2013.

Respondent shall pay reasonable and necessary medical services of $250,775.64, as provided in Section 8(a) of the Act.

Respondent shall be given a credit of **$81,484.10** for TTD.

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

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

11/27/14
Date

JAN 30 2014

THE ARBITRATOR RENDERS THE FOLLOWING FACTS RELEVANT TO ALL ISSUES IN DISPUTE.

It is undisputed that Petitioner injured both knees when he fell approximately 8 to 10 feet off a chiller on October 21, 2010 while employed by Heartland Regional Medical Center as the Director of Facilities. Petitioner subsequently underwent six (6) surgeries on his bilateral knees. On November 30, 2010, Dr. John T. Davis performed a left and right partial lateral meniscectomy and synovectomy. [PX 534-537]. Dr. Davis released Petitioner on April 11, 2011, at which time he discussed possible knee replacements in the future. [PX 495].

On May 23, 2011, Petitioner was examined by Dr. Dethmers, an orthopedic surgeon at Bonutti Orthopedic Services, for stiffness, swelling and pain in his left knee. [PX 199]. Dr. Dethmers performed a left total knee replacement on September 8, 2011. [PX 205]. On January 4, 2012, Dr. Dethmers examined Petitioner's right knee for catching, popping, locking and giving way. [PX 219]. Dr. Dethmers performed a right total knee replacement on February 2, 2012. [PX 225]. Petitioner continued to experience pain and crepitus in his right knee and Dr. Bonutti ordered an arthroscopic procedure to remove loose cement and a tricompartmental synovectomy with chondroplasty. [PX 238-241].

Petitioner testified that his treatment was transferred to Dr. Bonutti due to Dr. Dethmers leaving his practice at Bonutti Orthopedic Services, where he moved up north and has since lost his license to practice medicine. On August 28, 2012, Dr. Bonutti noted arthroscopic surgery did not improve Petitioner's right knee pain and recommended a revision total knee replacement. [PX 248]. On October 23, 2012, Dr. Bonutti performed a right revision total knee replacement of all components of the knee system. [PX 250]. Despite the right revision, Petitioner's knee continued to swell and was very painful, resulting in the use of a walker. [PX- 255]. On February 19, 2013, Dr. Bonutti recommended a right knee manipulation to help improve Petitioner's range of motion. [PX 260]. On February 19, 2013, Dr. Bonutti stated the worker's compensation insurer had not approved the manipulation and he was concerned that a delay in manipulation would decrease the efficacy of same. [PX 260]. The right knee manipulation was not performed until March 11, 2013. [PX 269].

On April 9, 2013, Dr. Bonutti noted Petitioner was taking three Percocets a day due to left knee pain. [PX 269]. Dr. Bonutti opined he was concerned about possible femoral component loosening which was the case in Petitioner's right knee resulting in a revision. [PX 271]. On April 30, 2013, Dr. Bonutti noted "significant palpable and audible crepitus" in Petitioner's left knee, which buckles and gives way. [PX 275]. Dr. Bonutti recommended a revision of the left total knee replacement due to Petitioner's significant symptoms, including crunching, grinding, and grating. [PX 281]. Dr. Bonutti

also noted Petitioner was dependent on his right leg for support and his right knee was swelling, painful and in jeopardy of injury, while his left knee was losing range of motion the longer he waited a revision. [PX 281-283, 285-286]. Dr. Bonutti has ordered Petitioner to remain off work until he undergoes a left revision total knee replacement. [PX 293]. Dr. Bonutti also noted a possible quad tear and strained LCL of the right knee for which he referred Petitioner to therapy and to remain off work. [PX 293-294].

Petitioner testified he wants to proceed with a left total knee revision due to the pain he experiences and the success of his right knee revision. He testified he takes pain medication daily and his physician is recommending a morphine patch due to his dependency over a three year period. Petitioner testified he is able to perform daily activities and does not have to use a cane if he is medicated. He stated that if he is not taking pain medication he suffers tremendous pain and uses a cane to walk. Petitioner also uses a device coined and prescribed by Dr. Bonutti to ice his knees on a daily basis and he rests when the pain medication wears off before taking the next dose. His limp is less pronounced when taking pain medication.

Dr. Peter Bonutti - Evidence Deposition on 11/19/2013 [PX-19]

Dr. Bonutti is an orthopedic surgeon who has specialized in hip, knee and shoulder arthroscopy and arthroplasty for 24 years. Dr. Bonutti took over treatment of Petitioner when Dr. Dethmers left his clinic in 2012. Dr. Bonutti testified that after Petitioner underwent a right total knee replacement in February, 2012, his recovery was eventful, including major pain and unusual swelling. A duplex scan was ordered to eliminate blood clots, he was bleeding into the knee, multiple aspirations were performed, grating and grinding resulted in arthroscopic surgery to remove infection and scarring and to correct a tilted patella. [Deposition p. 9-13]. Petitioner's symptoms did not improve with arthroscopic surgery and Dr. Bonutti testified he was suspicious of a loose femoral component causing decreased range of motion and pain in Petitioner's right knee. [Dep. p. 13-14].

Dr. Bonutti testified that it is very unusual for an implant to loosen at an early stage like Petitioner's [5 months following replacement] and if the implant is not grossly loose it is not obvious on a CT study. [Dep. p. 14]. Dr. Bonutti testified he had seen other of Dr. Dethmers' patients with the same problem and based on Petitioner's loss of range of motion, stiffness and his pattern of discomfort, a revision was appropriate. [Dep. p. 15]. Dr. Bonutti performed the right knee revision in October, 2012 and he stated the implant was so grossly loosened that he could pull on the implant with his fingers and the implant and cement would separate from the bone. [Dep. p. 15]. Petitioner's right knee pain greatly improved after the revision, but his range of motion had to be corrected by a manual manipulation approximately five months later.

Dr. Bonutti re-evaluated Petition for left knee pain in April, 2013. Petitioner was experiencing the same symptoms in his left knee that he did in his right following the initial knee replacement. [Dep. p. 16]. Dr. Bonutti testified as follows:

"Again, we told him because of his right leg femur component was loose, could the same thing be occurring on the left side. The x-rays did not show anything on the loosening on the inner aspect of the femur, but based on his history, and based on the experience with this time line of Dr. Dethmers' patients, it was a suspicion that may be, so we did perform a CT, and the CT arthrogram came back negative for *gross* loosening. The x-rays again where showing lucency in Zone 1." [Dep. p. 16].

Note, Dr. Bonutti testified that CT scans do not always show loosening unless it is grossly defined.

Independent Medical Examiner - Dr. Richard Rende [RX - 1]

Dr. Rende examined Petitioner on July 15, 2013 pursuant to Section 12 of the Act. Dr. Rende states in his report that Petitioner was leaning heavily on a cane, limped severely, and used objects for support when maneuvering around his office. [Pages 3-4 of Dr. Rende's IME report - Exhibit 3 to RX-1].

Petitioner testified at arbitration that he drove himself six (6) hours round trip to Dr. Rende's office and was in tremendous pain when he arrived. He was not able to take any pain medication that morning because he had to drive three hours one way and after sitting for three straight hours he was very stiff and sore. Petitioner testified that if he is not taking pain medication, he is "worthless" and his limp is extremely pronounced and he is forced to use his cane. Petitioner testified that Dr. Rende did not ask him if he was taking any medication that morning, which Dr. Rende admits in his deposition. (see below).

It is Dr. Rende's opinion that Petitioner does not require a left revision total knee replacement because the x-rays he took in his office do not show loosening or infection. [Page 4 of Rende's IME report - RX-1]. That he would never operate on a patient unless there was objective diagnostic findings, regardless of the amount of pain or symptoms the patient was experiencing. [Dep. p. 60]. Although Dr. Rende performed an x-ray of Petitioner's knee that did not show loosening, Dr. Rende testified that a patient would typically experience pain, giving way, and swelling if loosening occurred. [Dep. p. 64]. Dr. Bonutti has noted repeatedly that Petitioner is experiencing these exact symptoms in his left knee and that loosening can occur that is not detected on x-ray, particularly when there is no gross loosening.

Dr. Rende also states in his report that he reviewed 30 minutes of video footage of Petitioner taken on July 6, 2013. [RX-3]. Dr. Rende summarized Petitioner's activities on the video in his report as follows:

(a) " the patient is working on his boat, carrying a gas can"

Dr. Rende testified in his deposition that Petitioner was not doing mechanical work on the boat, but rather moving things around. Dr. Rende testified he did not know how much the gas can weighed or whether it was full or empty when Petitioner was seen carrying the gas can on the video. [Dep. p. 69-70].

Petitioner testified that he moved things around on the boat, he was not performing any mechanical work or extraneous activities, and the gas can held 2.5 gallons of gas which he lifted and poured into the tank. Petitioner also testified he is not under any physical restrictions and never claimed he could not perform such activities. More importantly, Petitioner testified he was capable of performing daily activity as long as he was taking pain medication. Petitioner testified he was heavily medicated on July 6, 2013 in order to participate in their annual Fourth of July lake celebration.

(b) "he is walking in his yard. He is not using any assistive devices. His is not limping"

Dr. Rende clarified in his deposition that Petitioner was walking swiftly and was not holding onto cabinets or a cane or anything when he was walking. [Dep. p. 70]. Dr. Rende testified he does not know whether Petitioner regularly uses a cane, but that he only saw Petitioner one time, on July 15, 2013, and he was using a cane. Dr. Rende infers that because the Petitioner was using a cane on July 15, 2013, he should have been using a cane on July 6, 2013. [Dep. p. 71].

Petitioner testified that he is not cane dependent when taking pain medication. Despite being heavily medicated, Petitioner is seen on the video walking with an antalgic gait and appears to walk cautiously in every scene of the video.

(c) "he is carrying two heavy objects. One appears to be a heavy beach bag, the other a large bag of ice"

Dr. Rende testified he did not know what was in the beach bag or how much it weighed. [Dep. p. 69].

Petitioner testified the beach bag contained three beach towels to the best of his recollection and the bag of ice was not too heavy for him to carry. Petitioner was not under any lifting restrictions on July 6, 2013.

(d) "later he is swimming"

Dr. Rende testified he did not see Petitioner "swimming" in the video as he reported, but rather Petitioner was holding onto something, he was not doing laps. [Dep. p. 68].

Petitioner testified that he floated on a flotation device and did not tread or swim in the water, which is reflected on the video. The scene that the Respondent and/or videographer redacted from the video is Petitioner attempting to use the boat ladder to get in and out of the water. Petitioner testified he has a lot of trouble using ladders and steps and if the video shown him using the boat ladder "it would not have helped Respondent's position".

Petitioner testified he was aware he was being surveillanced on July 6, 2013. He testified he did not do anything that he ever claimed he was unable to do and he was not under any physical restrictions. He testified he was heavily medicated that particular day in order to enjoy their traditional Fourth of July lake celebration and consumed alcohol that significantly helps manage his pain. He testified that Dr. Rende never discussed the video footage with him, which was in Dr. Rende's possession when Petitioner was in his office on July 15, 2013. Petitioner testified that Dr. Rende never asked him if he was capable of performing such activities. Dr. Rende testified he did not know if Petitioner was taking any medication the day Petitioner was in his office, or if he was taking pain medication the day he was surveillanced. [Dep. p. 67-68]. Dr. Rende also testified that alcohol can help mask pain and that Petitioner was observed drinking alcohol on the videotape. [Dep. p. 68].

Petitioner stated he was heavily medicated the day of arbitration because his wife drove him to the hearing site and the 2 ½ hour car ride made his symptoms worse. Petitioner stated he did not need to use his cane the day of arbitration because he was taking pain medication.

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

Based upon the evidence that was presented at Arbitration by both the Petitioner and the Respondent, the Arbitrator finds that a causal relationship exists between the Petitioner's present condition of ill-being and his accidental injuries. It is undisputed that Petitioner's first six surgeries were a result of the accident that occurred on October 21, 2010.

Dr. Bonutti testified he had seen other of Dr. Dethmers' patients with the same problem and based on Petitioner's loss of range of motion, stiffness and his pattern of discomfort, a revision was appropriate. [Dep. p. 15]. Dr. Bonutti performed the right knee revision in October, 2012 and he stated the implant was so grossly loosened that he could pull on the implant with his fingers and the implant and cement would separate from the bone. [Dep. p. 15]. Petitioner's pain greatly improved after the revision, but his range of motion had to be corrected by a manual manipulation.

Dr. Bonutti's testimony is credible and opines that Petitioner is experiencing the same symptoms in his left knee that he did in his right following the initial knee replacement. Dr. Bonutti had suspicions of loosening in Petitioner's right knee that were

accurate, resulting in a right revision total knee replacement. Dr. Bonutti opined that it is his suspicion that loosening has also occurred in Petitioner's left knee based on the Petitioner's history and on his experience with the time line of Dr. Dethmers' patients. Dr. Bonutti testified that x-rays where showing lucency in Zone 1 and that CT scans do not always show loosening unless it is grossly defined.

K. TTD

Dr. Bonutti has consistently ordered Petitioner to remain off work pending the left revision total knee replacement surgery, the last off work slip being October 8, 2013. [PX-15, bate-stamp 293]. Respondent terminated TTD benefits beginning October 18, 2013. [RX 4, page 1]. Consistent with the Arbitrator's finding of causal connection, Respondent shall pay TTD benefits from October 19, 2013 through the present.

L. Medical expenses

Respondent failed to produce any evidence that Petitioner's medical services were unreasonable or unnecessary. Petitioner produced thirteen bills into evidence. Respondent shall pay all appropriate charges related to Petitioner's Exhibits 1 and 3 through 13 for a total of $250,775.64. The Arbitrator does not award PX 2 as it was not an itemized statement and has no date of service listed.

END OF ATTACHMENT

STATE OF ILLINOIS)
) SS.
COUNTY OF ADAMS)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

RICHARD GEIST,

Petitioner,

14IWCC1005

vs.

NO: 12 WC 42327

INDUSTRIAL WORKFORCE, LTD.,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of causal connection, temporary total disability, permanent partial disability, 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.

Findings of Fact and Conclusions of Law

1. Petitioner testified in December of 2010 he worked for Respondent and had since October of that year. Respondent places people in various jobs. He was placed to work full time at Titan Wheel, which manufactures wheels. He "was placed at the end of the line where you change hooks that hold the wheels to go through heat coat and powder coat." He would change the hooks on the rack based on the particular part coming on the conveyor line. The line was constantly moving and was not supposed to stop. The hooks weigh between 10 and 40 lbs and there are 110 hooks on each rack. He would have to take the racks off, and put racks on, the racks. Once the racks were refitted and full he would send them down the line.

2. On December 21, 2010, one of the racks got stuck in a crack. Petitioner was not able to get in back of the rack so he moved his left foot back and tried to rock the rack to get it rolling. He heard something pop and thought he had "stuck it in a fan or something." He then realized he pulled something, his left foot hurt, and he started to limp. After a few minutes he "realized how bad it was getting" and he notified his supervisor.

3. Petitioner continued to work despite his foot worsening. He filled out an accident form on December 24, 2010 at Respondent's facility and not Titan's. He thought he was at Respondent's facility to pick up his paycheck because December 24th was in the middle of the Christmas shut-down and he would not have been working. He was off work for the shut-down for 11 or 12 days.

4. Petitioner further testified that during the time off he tried to stay off his foot as much as possible because it hurt to walk. It got a little better, the pain subsided somewhat, and it was a bit easier to walk. He thought he could handle the situation even though he did not know what was wrong with his foot. He did not seek medical attention at that time. After the shut-down, Petitioner returned to his previous job with Titan. It still hurt to stand or walk, but it was worse after a prolonged period of sitting, at which time he could hardly walk until his foot was stretched out. He did not have health insurance, Respondent did not send him to a doctor, and he did not go to a doctor because he has been hurt a lot of times and just got better.

5. Petitioner began working for Titan directly, rather than through Respondent, around early October of 2011. Prior to that hire he had a physical examination. During the exam, he told the administrator about his accident because it affected the exercises he was directed to perform. She examined his left foot and noted the "tendon back there or whatever" was "inflamed and puffed up." She provided him heel lifts.

6. Titan provided Petitioner health insurance and informed him he had to have a doctor of record. Petitioner never had a general practitioner previously. His fiancé worked for Hannibal Clinic and he asked her to refer him to a doctor. He first saw Dr. Evans on March 15, 2012. At the end of the examination, Petitioner informed him about his left foot. Dr. Evans examined his left foot and said "yeah, it's really inflamed" and referred him to Dr. Friedersdorf, whom he saw on April 11, 2012.

7. Dr. Friedersdorf asked Petitioner what his problem was and Petitioner reported his work accident. He prescribed a CAM boot, but Petitioner was not permitted to work with it. He wore the boot and was off work from May 7, 2012 through June 15, 3012, at which time he was released back to work. His foot improved during that period and did not hurt as much.

8. Petitioner further testified his foot and ankle got worse after he returned to work and it got as bad as it was previously. He returned to Dr. Friedersdorf who then ordered an MRI. After the MRI, Dr. Friedersdorf recommended surgery, which was performed on August 22, 2012.

9. Petitioner's condition improved by about 50% after the surgery; there was still some pain, but it was not nearly as bad. Petitioner had physical therapy through November 6, 2012. Physical therapy did not help that much and if he were paying for it he would not have gone. He was doing the same exercises at home. Petitioner was released to full work on November 12, 2012.

10. Petitioner also testified that currently, his condition is similar to what it was immediately after the surgery. He is always conscious of it and it is stiff, but it is not as debilitating as it was before. He had not injured his foot, ankle, or Achilles tendon prior or subsequent to, his accident. He still works for Titan.

11. He wakes at about 5:30 for his 7:00 shift and stretches out his foot for a while and then "can move around pretty good." He drives about 45 minutes to his job and his foot is stiff and he has to stretch it out again. After work, his foot gets tired and sore. Sometimes there is numbness and tingling. He takes over-the-counter pain reliever every day. He did not take anything daily prior to his accident.

12. On cross examination, Petitioner testified Respondent did not send him to a doctor, but Petitioner did not ask to be sent to one either. It was probably correct that after the accident report he did not inform Respondent about any pain until May 7, 2012. After he began working for Titan, he had no reason to go back to Respondent. He was not aware that he was supposed to report any continued pain symptoms to Respondent. He was then shown an exhibit which he acknowledged signing indicating that employees of Respondent were required to report accidents and "follow up concerns."

13. Petitioner also testified he worked full duty for Respondent after the Christmas shut-down for about nine months. Thereafter, he did not report the condition again for another seven months. He passed the physical exam he was give before being hired by Titan. He was not exactly sure when he became eligible for health insurance from Titan, but he thought he may not have been eligible for 16 months after hire. Petitioner has hobbies of hunting, fishing, and boating. He has been able to engage in those hobbies.

14. On redirect examination, the first time he actually presented to a doctor for treatment of his left foot was with Dr. Friedersdorf. At that time he did mention the accident 15 months earlier and that it never completely healed after that accident. He had to work for Respondent for 16 months before he would be eligible for benefits.

15. Allison Hollenstine was called to testify by Respondent. She testified she is a personnel manager with Respondent. Respondent is a staffing agency, which recruits and hires for their client which is Titan Wheel. When Petitioner picked up his paycheck on December 24, 2011, he reported having pulled a muscle on the 21st. Petitioner would come in every two weeks to pick up his paycheck. They had some conversations at those times, but Petitioner never mentioned anything about his foot.

16. The medical records indicate that on March 15, 2012, Petitioner presented to Dr. Evans to address lipoma, arthritis, prostrate screen, left Achilles tendonitis and left soleus contracture, tobacco dependence, and health maintenance. Dr. Evans noted the Achilles tendonitis and resulting contracture had been bothering him for quite some time and he had a history of partial avulsion in the past. He would set him up with podiatry for consultation.

17. On April 11, 2012, Petitioner presented to Dr. Friedersdorf on referral from Dr. Evans for evaluation of painful left Achilles tendon. Petitioner reported that about 15 months previously he was pushing a heavy object at work and felt a pop in the posterior aspect of his Achilles tendon. "It really never has completely healed. He has had this chronic intermittent pain in this area ever since." After examination, Dr. Friedersdorf diagnosed Achilles tendonitis with history of likely partial rupture with mild residual equinus left leg, and planter fasciitis in the right foot. He provided Petitioner heel lifts and prescribed medication.

18. On August 22, 2012, after conservative treatment had failed, Dr. Friedersdorf performed debridement and secondary repair of left Achilles tendon for Achilles tendonosis with old partial Achilles tendon rupture.

19. Petitioner ruptured to Dr. Friedersdorf on September 5, 2012 and reported pain for a few days after surgery, but it really was not bothering him. He had been mostly non-weightbearing. He had hobbled around for the last couple of days on his posterior splint but had not other problems. Dr. Friedersdorf removed the sutures provided Petitioner a CAM boot but indicated he was to be completely non-weightbearing for another two weeks.

20. On October 17, 2012, Petitioner reported he really had no pain whatsoever and eagerly wanted to get out of the boot. Dr. Friedersdorf's treatment note indicated that he and Petitioner "again discussed that it is highly likely that this chronic Achilles tendonitis that he has is secondary to an old injury that he had at work where he did not receive treatment initially and put up with the discomfort for a period of 15 months." "This chronic degeneration is common finding with this type of injury and it is very probable that this is all secondary to this remote injury."

21. On November 7, 2012 Petitioner was in physical therapy and had improvement in range of motion and strength. He had a little tenderness but overall doing very well. Dr. Friedersdorf indicated he would release him to full duty as of Monday November 12th.

22. On September 12, 2013, Petitioner presented to Dr. Coe for a medical examination pursuant to section 12 of the Act on referral by his lawyer. After the examination, Dr. Coe opined that Petitioner suffered a partial left Achilles tendon rupture while pushing a heavy rack at work on December 21, 2010 resulting in scarring in the distal calf and ankle, loss of range of motion, as well as ankle swelling and weakness. Petitioner's current impairment was the result of his work accident.

23. On November 19, 2013, Dr. Krause performed a records review on referral by Respondent. He opined that Petitioner had preexisting Achilles tendonitis that was only mildly aggravated by the work accident. He based that opinion on the fact that Petitioner did not seek treatment for 15 months. On December 3, 2013, Dr. Krause included an addendum opining that the aggravation to which he previously referred was only a temporary aggravation that resolved in two weeks without treatment. The subsequent worsening was because of the preexisting Achilles tendonosis and not the aggravation.

In finding Petitioner proved causal connection, the Arbitrator specifically found Petitioner eminently credible and that his testimony was supported by the medical records. He found the causal opinions of Dr. Friedersdorf and Dr. Coe more persuasive that that of Dr. Krause and noted there was no evidence of any preexisting Achilles pathology. He also stressed that Petitioner suffered only a partial tear in the Achilles tendon and fully understood that he could have continued to work despite the pain hoping the condition would improve.

In assessing the testimony at arbitration and the medical records, the Commission agrees with the conclusions of the Arbitrator regarding causal connection, temporary total disability and the award of medical expenses. There is no reason for the Commission to dispute the Arbitrator's assessment of the credibility of Petitioner and he is correct that there was no medical record or any indication whatsoever supporting Dr. Krause's opinion that he had preexisting Achilles tendonosis.

The Arbitrator awarded Petitioner permanent partial disability benefits representing 25% loss of the use of the left foot. The Arbitrator noted that Petitioner's occupation of laborer involves being on his feet all day and therefore his injury would affect his work more than an average employee. He testified credibly that his Achilles tendon injury affects him on a daily basis, he had pain at the end of the work day, and had some reduction in range of motion, weakness in heel walking, and decreased sensation over the surgical scar.

The Commission notes that Petitioner was able to work and did not seek medical treatment for his Achilles tendonosis and partial rupture tear for about a year and a half after his accident. While that does not necessarily militate against a causal connection between the accident and his condition, it does indicate that the condition was not extremely debilitating. Despite his injury, he was able to return to his previous employment which involves being on his feet for an extended period of time before he ever received treatment for his condition. According to Dr. Friedersdorf's treatment notes, on September 5, 2012, only about two weeks after surgery, Petitioner reported only a little bit of pain that was not really bothering him and by October 17, 2012, only about 8 weeks after surgery, Petitioner reported he really had no pain whatsoever. Petitioner has not shown any loss of earning potential. In assessing the record as a whole, the Commission finds that an award of 15% loss of the use of the left foot is appropriate in this case and modifies the award of the Arbitrator accordingly.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $311.43 per week for a period of 17&2/7 weeks, that being the period of temporary total incapacity for work under §8(b) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $280.29 per week for a period of 25.05 weeks, as provided in §8(e) of the Act, for the reason that the injuries sustained caused 15% loss of the use of the left foot.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $16,875.00 for medical expenses under §8(a) of the Act pursuant to the applicable medical fee schedule under §8.2 of the Act.

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

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

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $30,000.00. The party commencing the proceeding for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in the Circuit Court.

DATED: NOV 24 2014

Ruth W. White

Daniel R. Donohoo

Charles J. DeVriendt

RWW/dw
O-11/5/14
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ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

GEIST, RICHARD
Employee/Petitioner

Case# **12WC042327**

INDUSTRIAL WORKFORCE LTD
Employer/Respondent

14IWCC1005

On 3/25/2014, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

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

0293 KATZ FRIEDMAN EAGLE ET AL
JASON P CARROLL
77 W WASHINGTON ST 20TH FL
CHICAGO, IL 60602

2674 BRADY CONNOLLY & MASUDA PC
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14IWCC1005

STATE OF ILLINOIS)
)SS.
COUNTY OF ADAMS)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

RICHARD GEIST
Employee/Petitioner

v.

INDUSTRIAL WORKFORCE, LTD.
Employer/Respondent

Case # 12 WC 42327

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

FINDINGS

On **December 21, 2010**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$6,339.83 for a period of 13 4/7 weeks**; the average weekly wage was **$467.15**.

On the date of accident, Petitioner was **55** 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

Respondent shall pay Petitioner temporary total disability benefits of $311.43/week for 17 2/7 weeks, commencing May 7, 2012 through June 14, 2012, and from August 22, 2012 through November 11, 2012 as provided in Section 8(b) of the Act.

Respondent shall pay reasonable and necessary medical services, pursuant to the medical fee schedule, of $10,375.00 to Hannibal Clinic, $4,094.00 to Northeast Missouri Ambulatory Surgery Center, $1,626.00 to Advance Physical Therapy, and $780.00 to Hannibal Anesthesia Associates, as provided in Sections 8(a) and 8.2 of the Act.

Respondent shall pay Petitioner permanent partial disability benefits of $280.29/week for 41.75 weeks, because the injuries sustained caused the 25% loss of the left foot, as provided in Section 8(e) of the Act.

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

March 22, 2014
Date

MAR 25 2014

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

RICHARD GEIST,	)	
	)	
Petitioner,	)	
	)	
v.	)	**12 WC 42327**
	)	
INDUSTRIAL WORKFORCE, LTD.,	)	
	)	
Respondent.	)	
	)	

FINDINGS OF FACT AND CONCLUSIONS OF LAW

I. FINDINGS OF FACT

The Parties stipulated that Petitioner, Richard Geist, sustained an accidental injury to his left foot that arose out of and in the course of his employment by Respondent, Industrial Workforce. (Arb.Ex.1). The Parties further stipulated that Petitioner provided notice of his accident to Respondent within the time limits stated in the Act. (Id.). The parties also stipulated to the 17 2/7 weeks TTD period from May 7, 2012 through June 14, 2012 and from August 22, 2012 through November 11, 2012, however, Respondent disputed liability for this entire period. The additional disputed issues in this claim are causal connection, medical bills, and the nature and extent of Petitioner's injury.

Petitioner testified that he began working for Respondent in September of 2010. He testified that Respondent is a company who employs workers that they then place into temporary employment at Titan Wheel, which is a manufacturer in Quincy, Illinois. He testified he was still employed for Respondent in December of 2010 and that he was still working at the Titan Wheel facility. He explained that his job duties included loading racks with hooks weighing between ten and forty pounds and then rolling the full racks to another location.

Petitioner testified he was working for Respondent on December 21, 2010 when he sustained an injury to his left foot. He testified that he was attempting to move one of the racks full of hooks when one of the wheels became stuck in a crack in the cement floor. He testified he put his left foot back in order to gain more leverage to dislodge the wheel. As he pushed forward, he testified he heard an audible pop from his lower left leg and felt immediate pain. Immediately after his accident, Petitioner notified his supervisor at Titan Wheel, Justin, of his injury. He did not elect to seek medical attention that day.

Three days later on Friday, December 24, 2010, Petitioner went to Respondent's offices in order to pick up his paycheck. While there, he requested and completed a written accident report, which was admitted without objection as Petitioner's Exhibit Number 1.

In this report, Petitioner indicated he was injured on December 21, 2010 while he, "Was trying to move a rack of hooks, the weels (sic) were in a crack in the cement, when I put my left foot back to try to get more leverage to push I heard a pop and my left calf mussel (sic) was hurting and I couldn't walk without pain." (PX1).

Allison Hollinstein testified on behalf of Respondent. She testified she is the personnel manager at the Respondent and was the assistant personnel manager in December of 2010. She testified she has worked for Respondent since August of 2010. She indicated she was familiar with Petitioner from working with him at Respondent. She testified she was present on December 24, 2010 when Petitioner completed his written accident report at Respondent's offices. On cross examination, Ms. Hollinstein testified she had no reason to believe that Petitioner was not being completely truthful regarding the manner in which he was injured and as to what he testified to at trial. Ms. Hollinstein testified that she saw the Petitioner every couple of weeks after his accident until he left the Respondent's employ in October 2011. She said they had general conversations, and that the Petitioner never mentioned or complained about his left foot. She also testified that the Petitioner was given a policy form identified, as Respondent's Exhibit 3, when he was hired. The form states the procedures for reporting accidents, and also requires the worker to report follow up concerns. Ms. Hollinstein interpreted that phrase to mean that workers should report the need for any follow up treatment.

After he reported his accident to Respondent on December 24, 2010, Petitioner testified he had the next eleven or twelve days off from work due to the holidays. He testified that these days off allowed him to rest his injured left foot and that his pain decreased. He testified it became easier to walk as well.

After this time off for the holidays, Petitioner testified he returned to work for Respondent. He testified that the he still had pain and stiffness following his injury. He testified that every morning, he had to stretch his left foot and lower leg for several minutes before he could truly walk on it. He testified he still did not seek medical attention at that time because he was "old school" and had always just healed.

Petitioner testified he eventually was hired directly by Titan Wheel in October of 2011. Prior to beginning working directly for Titan Wheel, he underwent a physical. He testified that this physical occurred in approximately October of 2011 and that this was the first medical visit of any type he had had since his accident of December 21, 2010.

Petitioner's first medical treatment since his accident occurred on March 15, 2012. He treated with Dr. Jeffry Evans at the Hannibal Clinic. Petitioner explained that he was required to obtain a primary care physician by Titan Wheel, which was the purpose of this initial visit. At this visit, Dr. Evans noted Petitioner was there that day to address lipoma, arthritis, prostrate screen, left Achilles tendinitis and left soleus contracture, tobacco dependence, and health maintenance. (PX2). Dr. Evans noted Petitioner strained his left Achilles tendon and got a contracture. (Id.). He noted it had been bothering him for quite some time. (Id.).

Dr. Evans referred Petitioner to Dr. Scott Friedersdorf, a podiatrist, who also practiced at the Hannibal Clinic. (PX2). At his first visit on April 11, 2012, Dr. Friedersdorf noted that Petitioner injured his left Acchilles tendon about fifteen months prior to that visit. (Id.). Dr. Friedersdorf noted Petitioner "...was pushing a large heavy object at work, felt a pop in the posterior aspect of his Achilles tendon on the left lower extremity." (Id.). He indicated Petitioner found it difficult to walk and that he limped and had a lot of pain for about two weeks. (Id.). He further noted the injury got somewhat better but never completely healed. (Id.).

Dr. Friedersdorf noted that Petitioner complained of chronic intermittent pain ever since the accident and that it is most painful after Petitioner has been working or on his feet for long hours and then sits and rests and gets up. (PX2). He indicated Petitioner has difficulty weight bearing and limps significantly for twenty to thirty minutes before his Achilles feels somewhat better, but the pain never goes completely away. (Id.). Dr. Friedersdorf also noted Petitioner had recently developed some pain in his right heel over the past couple months before this visit. (Id.).

Dr. Friedersdorf provided Petitioner with a physical examination at this first visit as well. (PX2). He noted Petitioner's left Achilles tendon was "very tight" compared to the right. (Id.). He indicated Petitioner had pain with palpation to his left Achilles tendon from approximately three to four centimeters proximal to the insertion for about five to six centimeters more proximal to that. (Id.). Dr. Friedersdorf's assessment of Petitioner was, "Achilles tendonitis with history of likely partial rupture with mild residual equinus left lower extremity" and "Plantar Fascititis right foot."

Dr. Friedersdorf advised Petitioner to begin an aggressive home stretching exercise for both his left Achilles tendon and his right plantar fascia. (PX2). He also provided Petitioner with heel lifts and advised him to avoid barefoot walking or wearing of unsupportive shoe gear. (Id.).

After his initial visit with Dr. Friedersdorf, Petitioner followed up on May 2, 2012 and was provided with a CAM walker boot for his left foot. (PX2). Petitioner testified he returned to Dr. Friedersdorf the following day, May 3, 2012, because he had concerns about wearing the CAM boot at work. After this visit, Petitioner began wearing the boot and was not able to return to work for Titan Wheel. The parties stipulated that he was off work from May 7, 2012 through June 14, 2012. (Arb.Ex.1).

Petitioner continued to follow up with Dr. Friedersdorf on May 31 and June 14, 2012. (PX2). At his June 14, 2012 visit, Petitioner reported significant pain reduction as a result of wearing the CAM boot and wished to return to work. (Id.). Dr. Friedersdorf allowed Petitioner to return to work without the boot but advised him to wear a stiff soled supportive shoe with a heel lift instead. (Id.). However, he noted that if the left Achilles tendon pain returned, they would likely need to do debridement repair. (Id.).

Petitioner testified he returned to work for Respondent following his June 14, 2012 visit with Dr. Friedersdorf. At his August 2, 2012 follow up, Dr. Friedersdorf noted Petitioner complained that his pain in his left Achilles tendon had returned now that he had been out of the CAM boot. (PX2). He noted Petitioner's pain had gotten progressively worse over the past couple weeks and that he was starting to limp significantly. (Id.). Dr. Friedersdorf recommended a left ankle MRI with attention focused on the Achilles tendon. (Id.). The MRI was completed on August 10, 2012. (Id.).

Following this MRI, Petitioner treated with Dr. Friedersdorf again on August 13, 2012. (PX2). After reviewing the MRI, Dr. Friedersdorf recommended he proceed with surgery of the left Achilles tendon to include a "...debridement of the diseased portion of the Achilles tendon with a repair and grafting to strengthen the area." (Id.).

Surgery was scheduled and completed on August 22, 2012 by Dr. Friedersdorf at the Northeast Missouri Ambulatory Surgery Center. (PX3). The parties stipulated that Petitioner was temporarily totally disabled as of his surgery date through November 11, 2012, although, Respondent disputes liability for this period. (Arb.Ex.1).

The operative note indicates that a portion of the petitioner's Achilles tendon was degenerative, hypertrophic and discolored. The injured area represented about half of the full thickness of the tendon. Dr. Friedersdorf performed the procedure as planned. He commented that the remaining portion of the tendon was "good, healthy and healthy appearing." (PX 3)

After his surgery, Petitioner continued to follow up with Dr. Friedersdorf on September 5, 19, and October 17, 2012. (PX2). Petitioner testified that following his surgery and as he continued to follow up with Dr. Friedersdorf, he noticed his left Achilles tendon had improved but was not fully healed. He testified he had approximately fifty-percent improvement at that time.

At his October 17 follow up, Dr. Friedersdorf advised Petitioner to begin a course of physical therapy. (PX2). At that same visit, Dr. Friedersdorf noted:

> *We again discussed that it is highly likely that this chronic Achilles tendinosis that he has had is secondary to an old injury that he had at work where he did not receive treatment initially and put up with the discomfort for period of approximately 15 months. Discussed with him that this chronic degeneration is common finding with this type of injury and it is very probable that this is all secondary to this remote injury. (Id.).*

Petitioner's first therapy visit occurred on October 18, 2012 at Advance Physical Therapy. (PX4). He continued in therapy through November 6, 2012. (Id.). On November 7, 2012, Petitioner had his final visit with Dr. Friedersdorf and was allowed to return to work full duty as of November 12, 2012. (Id.).

At the request of Respondent, Dr. John Krause reviewed medical records pertaining to Petitioner and drafted an initial report dated November 19, 2013 and a brief addendum dated December 3, 2013. (RX1). Petitioner confirmed that he was not personally examined by Dr. Krause nor has he ever spoken with him. Dr. Krause concluded that Petitioner had a preexisting left Achilles tendinosis and that his work accident of December 21, 2010 "...likely aggravated that preexisting Achilles tendinosis." (Id.). He concluded that the aggravation at work was "...very mild given that the patient did not seek medical treatment for 15 months." (Id.). Dr. Krause attempted to clarify his opinion with his December 3, 2013 addendum noting, "The aggravation of the Achilles tendonosis was a temporary aggravation that was resolved within the first 2 weeks without any treatment." (Id.).

On September 12, 2013, Petitioner was personally examined by Dr. Jeffrey Coe at the request of his attorneys' office. (PX6). Dr. Coe obtained a history directly from Petitioner and noted:

> *Mr. Geist states that on December 21, 2010, he was attempting to move a large, heavy wheeled rack. Mr. Geist states that one of the wheels of the rack became caught in a crack on the shop floor. Mr. Geist states that he pushed the rack forcefully (pushing off with his left leg). As Mr. Geist pushed, he states he felt a "pop" in the back of his left calf.*

Dr. Coe further reviewed and summarized Petitioner's related medical records and provided him with a physical examination. (PX6). He opined that Petitioner suffered a partial left Achilles tendon rupture while pushing the heavy rack at Titan Wheel on December 21, 2010. (Id.). He explained that this injury caused chronic left nodular Achilles tendinitis with scarring in the area of the partial rupture. (Id.). He concluded that there is a causal relationship between the injury suffered by Petitioner on December 21, 2010 and his current state of impairment as it pertained to his left lower extremity. (Id.).

Petitioner testified that prior to December 21, 2010, he had never injured his left foot or Achilles tendon. He testified that since his accident, he has not had any other accidents or injuries involving his left foot or Achilles tendon. As a result of this injury, Petitioner testified he continues to have ongoing symptoms.

He continues to work for Titan Wheel and typically wakes up for work at approximately 5:30 a.m. He testified that upon waking up, he needs to stretch his left Achilles tendon in order to get it feeling fully functional. He testified his drive to work each day is approximately thirty minutes long. After this drive, he testified he must also briefly stretch out his left Achilles. After a full work day on his feet, he stated he just wants to get off his feet because his left Achilles is always very tired. He testified that he takes naproxen sodium, an over the counter painkiller, every day to help reduce his ongoing left Achilles pain and stiffness.

Petitioner further explained that his non work days also involve pain and stiffness in his left Achilles tendon. However, he testified his complaints are dependent on how much he is required to be on his feet. On the day of hearing, he testified his Achilles was stiff and sore after the drive from his home. During the hearing, he indicated he was having some numbness as well.

II. CONCLUSIONS OF LAW

F. WHETHER PETITIONER'S PRESENT CONDITION OF ILL BEING IS CAUSALLY RELATED TO THE ACCIDENT?

The Arbitrator finds that Petitioner's present condition of ill-being as it relates to his left foot is causally related to his work accident of December 21, 2010.

This decision is based very much upon the Petitioner's credibility. The Arbitrator believes Mr. Geist's testimony and finds that his testimony is fully supported by the medical records and other evidence.

There was no testimony or evidence offered to show any pre-existing problem with the Petitioner's left foot. Also, there was no evidence of any intervening accident involving the Petitioner's left foot during the months following the accident and the onset of treatment.

During the hearing, Petitioner testified very openly and honestly regarding his accident and ongoing symptoms over the next fifteen months before he sought treatment. His testimony was fully supported and corroborated by the written accident report he completed only three days after his injury. Further, Respondent's own witness, Ms. Hollinstein, affirmed her belief that Petitioner was being open and honest regarding his injury at the time he drafted his accident report and while testifying. The Petitioner testified that he had ongoing symptoms but wanted to work through them, hoping they would subside. Accordingly, there would have been no reason for him to report any concerns, as the accident policy dictates, during the time he worked for the Respondent after the accident.

In addition to his testimony, his medical records are fully consistent with his history of accident and ongoing symptoms. Dr. Friedersdorf's records are consistent with Petitioner's own in court testimony and written accident report. This same consistency was evident in Dr. Coe's report as well.

Although Respondent obtained a records review and report from Dr. Krause, his opinions are not as credible as those of Petitioner or Drs. Friedersdorf and Coe. He assumed that Petitioner must have had a left Achilles tendon injury prior to his accident but this is simply not supported by the evidence presented at trial. He said that the Petitioner would have treated sooner following the accident if he had ruptured his Achilles tendon. He did not, however, explain the reasoning behind that opinion. The operative note shows that the tendon was not completely ruptured. Half of it remained intact. Under the

circumstances, the Arbitrator certainly can understand how the Petitioner could work with ongoing symptoms, hoping for improvement.

When viewed as a whole, the timeline of events, medical evidence, and testimony prove by a preponderance of the evidence that Petitioner's left Achilles tendon injury is causally related to his work-related accident of December 21, 2010.

J. WERE THE MEDICAL SERVICES THAT WERE PROVIDED TO PETITIONER REASONABLE AND NECESSARY? HAS RESPONDENT PAID ALL APPROPRIATE CHARGES FOR ALL REASONABLE AND NECESSARY MEDICAL SERVICES?

The Arbitrator finds that medical services provided to Petitioner have been reasonable and necessary. Respondent has not paid all appropriate charges.

The doctors that examined Petitioner or reviewed his related medical records in regards to his left foot injury, including Drs. Friedersdorf, Coe, and Krause, all agreed that Petitioner was in need of surgery to repair his Achilles tendon. Because Petitioner's December 21, 2010 accident arose out of and in the course of his employment by Respondent and because his current condition of ill being is causally related to this accident, the Arbitrator awards the total amount of bills as outlined on the Request for Hearing form.

For these reasons, Respondent shall pay reasonable and necessary medical services, pursuant to the medical fee schedule, of $10,375.00 to Hannibal Clinic, $4,094.00 to Northeast Missouri Ambulatory Surgery Center, $1,626.00 to Advance Physical Therapy, and $780.00 to Hannibal Anesthesia Associates, as provided in Sections 8(a) and 8.2 of the Act.

K. WHETHER PETITIONER IS DUE COMPENSATION FOR TEMPORARY TOTAL DISABILITY?

The Arbitrator awards TTD benefits from May 7, 2012 through June 14, 2012 and from August 22, 2012 through November 11, 2012. The Arbitrator notes that the parties stipulated to this TTD period on the Request for Hearing form but Respondent disputed liability for this time period.

Because the Arbitrator has already found that Petitioner's condition and need for medical treatment was causally related to his accident of December 21, 2010, he further finds that Petitioner's period of disability was also causally related.

For these reasons, the Arbitrator finds that Respondent shall pay Petitioner temporary total disability benefits of $311.43/week for 17 2/7 weeks, commencing May 7, 2012 through June 14, 2012, and from August 22, 2012 through November 11, 2012 as provided in Section 8(b) of the Act.

L. WHAT IS THE NATURE AND EXTENT OF PETITIONER'S INJURY?

The Arbitrator finds that Respondent shall pay Petitioner permanent partial disability benefits of $280.29/week for 41.75 weeks, because the injuries sustained caused the 25% loss of the left foot, as provided in Section 8(e) of the Act.

Petitioner sustained an injury to his left Achilles tendon ultimately requiring surgical repair occurring on August 22, 2012. Because Petitioner's occupation is that of a laborer and his job involves being on his feet all day, his injury will affect his work greater than the average injured employee. He testified clearly and convincingly that his left Achilles tendon injury affects him on a daily basis – especially those days in which he works and is on his feet all day.

After surgery, the Petitioner had six weeks of physical therapy. The therapist's final note on November 27, 2012 indicates the Petitioner still has pain at the end of the day and a slight reduction of the normal range of motion. One year later, Dr. Coe made similar findings with respect to motion, and noted weakness on heel walking and decreased sensation over the surgical scar.

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 Down	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

DAVID SHARPE,

Petitioner,

14IWCC1006

vs.

NO: 12 WC 42493

LAKE LAND COLLEGE,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of the nature and extent of Petitioner's permanent partial disability, and the "interpretation of section 8.1b," 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.

Petitioner worked for Respondent teaching construction/carpentry skills to inmates at Taylorville Correctional Center. On October 12, 2011, he sustained an injury to his left elbow in the course of, and arising out of, those work activities. On November 22, 2011, Dr. Maender performed left distal biceps repair for biceps rupture. On February 8, 2012, Dr. Maender noted Petitioner was doing "wonderful." He released Petitioner to full duty and would see him in three months to ensure complete healing. On May 9, 2012, Dr. Maender noted Petitioner was doing "excellent," declared him at maximum medical improvement, continued full work status, and released him from care. Finally, Dr. Maender indicated both he and Petitioner were "very happy with the results."

Petitioner testified that currently, his left arm is definitely weaker than it was prior to the surgery. He has to lift things primarily with his right arm (Petitioner is right-hand dominant). If he lifts a gallon of milk with the left arm he feels tension on the tendon right on the inner elbow. Even though Dr. Maender indicated he could lift plywood, "there's no way in the world" he was "going to lift that." He was currently semi-retired. He left Respondent's employment on August 30, 2013 to tend to his ailing mother.

14IWCC1006

On cross examination, Petitioner testified he was "delighted" with the overall outcome of the surgery. He did not have any treatment for his elbow since May 9, 2012, when he was discharged by Dr. Maender. He worked his normal job for about 15 months, except he did not lift anything heavy. He taught inmates to use all sorts of tools including saws, hammers, drills, and sanders. There were over 800 tools, and he used all of them. He worked in a union shop and he believed he got a raise on July 1, pursuant to the union contract.

On redirect examination, Petitioner testified he was no longer in a union. He estimated that 85-90% of a construction job involves heavy lifting. After his injury, he had the inmates lift things that needed to be lifted. Prospective employers in construction would probably hesitate to hire him because he cannot lift anything heavy.

On re-cross examination, Petitioner testified he did not really have the intention of looking for employment other than his self-employment; he and his wife were considering buying and flipping property.

Dr. Petkovich performed a medical examination pursuant to section 12 of the Act and reviewed his medical records. He also prepared an impairment rating determining Petitioner's residual impairment from his injury using the AMA guides. He noted that the treatment Petitioner had received was appropriate and he recovered quite well. Dr. Petkovich concluded Petitioner had a residual impairment of 5% of his left arm.

The Arbitrator awarded Petitioner 22½% loss of the use of the left arm. In determining Petitioner's permanent partial disability, the Arbitrator noted that the AMA rating of 5% impairment was valid, Petitioner's vocation of carpenter requires the active use of both arms, he was 51 years old and would have to live with the disability for the rest of his life, there was no evidence of any loss of earning potential, the injury required surgery including the use of a surgical screw, and both Dr. Maender and Petkovich found reduced range of motion and Dr. Petkovich found a loss of muscle mass.

The Commission notes that Dr. Maender released Petitioner to full duty construction-type work within about 2½ months of surgery and Petitioner was able to return to his previous job activities for 15 months. He did not show any loss of earning potential, eventually left employment voluntarily, and is not seeking future employment. Everybody, including Petitioner, all agreed that he had an excellent outcome from his surgery. In assessing the record as a whole, the Commission finds that an award of 17.5% loss of the use of the left arm is appropriate in this case and modifies the award of the Arbitrator accordingly. Finally, the Commission notes that Respondent has already paid all reasonable and necessary medical expenses and temporary total disability benefits.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $482.99 per week for a period of 44.275 weeks, as provided in §8(e) of the Act, for the reason that the injuries sustained caused the loss of 17.5% of the use of the left arm.

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

14IWCC1006

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 $22,000.00. The party commencing the proceeding for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in the Circuit Court.

DATED: NOV 24 2014

Ruth W. White

Daniel R. Donohoo

Charles J. DeVriendt

RWW/dw
O-11/5/14
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ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

SHARPE, DAVID
Employee/Petitioner

Case# **12WC042493**

14IWCC1006

LAKE LAND COLLEGE
Employer/Respondent

On 3/11/2014, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

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

2934 BOSHARDY LAW OFFICE PC
JOHN V BOSHARDY
1610 S 6TH ST
SPRINGFIELD, IL 62703

RUSIN MACIOROWSKI & FRIEDMAN LTD
MARK COSIMINI
2506 GALEN DR SUITE 108
CHAMPAIGN, IL 61821

14IWCC1006

STATE OF ILLINOIS)
)SS.
COUNTY OF SANGAMON)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
NATURE AND EXTENT ONLY

David Sharpe
Employee/Petitioner

v.

Lake Land College
Employer/Respondent

Case # 12 WC 42493

Consolidated cases: n/a

The only disputed issue is the nature and extent of the injury. An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable William R. Gallagher, Arbitrator of the Commission, in the city of Springfield, on February 11, 2014. By stipulation, the parties agree:

On the date of accident, October 12, 2011, Respondent was operating under and subject to the provisions of the Act.

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

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

Timely notice of this accident was given to Respondent.

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

In the year preceding the injury, Petitioner earned $41,859.48; the average weekly wage was $804.99.

At the time of injury, Petitioner was 51 years of age, married, with 0 dependent child(ren).

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

Respondent shall be given a credit of $0.00 for TTD, $0.00 for TPD, $0.00 for maintenance, and $0.00 for other benefits, for a total credit of $0.00. The parties stipulated at trial that all TTD benefits and medical had been paid in full.

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

ORDER

Respondent shall pay Petitioner the sum of $482.99 per week for a period of 56.925 weeks, because the injuries sustained caused a 22 1/2 % loss of use of the left arm as provided in Section 8(e) of the Act.

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

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

William R. Gallagher, Arbitrator

March 3, 2014
Date

MAR 11 2014

Findings of Fact

Petitioner filed an Application for Adjustment of Claim which alleged he sustained an accidental injury arising out of and in the course of his employment for Respondent on October 12, 2011. According to the Application, Petitioner sustained an injury to the left upper extremity when he lifted a sheet of plywood. There was no dispute in regard to accident and the parties stipulated that all temporary total disability benefits and medical had been paid. Accordingly, the only disputed issue at trial was the nature and extent of disability.

Petitioner testified that he worked most of his life as a carpenter; however, at the time he sustained the accident he was employed by Respondent as an instructor and his job duties required him to teach inmates at the Taylorville Correctional Center how to do carpentry work. On October 12, 2011, Petitioner went to Menards to get some building materials which included plywood. As Petitioner was in the process of lifting a sheet of plywood, he felt what he described as two "snaps" in his left arm and elbow which caused him to experience extreme pain. Petitioner described the sound of this as similar to a pencil being broken.

Petitioner initially sought medical treatment from Dr. Diana Widicus, his family physician, who saw him on October 13, 2011. Dr. Widicus ordered x-rays of the left arm which were negative for fractures. Because of his continued symptoms, Dr. Widicus ordered an MRI of the left elbow which was performed on October 3, 2011. The MRI revealed a disrupted biceps tendon with a full thickness tear and retraction (Petitioner's Exhibits 3, 4 and 5).

Petitioner was subsequently seen by Dr. George Maender, an orthopedic surgeon, on October 9, 2011. Dr. Maender examined Petitioner, reviewed the MRI scan and confirmed the diagnosis of a distal biceps rupture. Dr. Maender performed surgery on November 22, 2011, the procedure consisted of repair of the biceps tendon that required the use of a surgical screw (Petitioner's Exhibit 6).

Following the surgery, Petitioner remained under Dr. Maender's care and he ordered physical therapy. When Petitioner was seen on February 8, 2012, Petitioner had a full range of motion with the exception of pronation. Dr. Maender released Petitioner to return to work without restrictions at that time. When Dr. Maender saw Petitioner on May 9, 2012, Petitioner informed him that he had returned to work; however, Petitioner also informed him that he was not lifting plywood. On clinical examination, Dr. Maender observed that Petitioner had full range of motion with the exception of pronation and supination. Dr. Maender opined that Petitioner could continue to work as tolerated without restrictions and that he was at MMI (Petitioner's Exhibit 6).

At the direction of the Respondent, Petitioner was examined by Dr. Frank Petkovich, an orthopedic surgeon, on October 11, 2012. In connection with his evaluation of Petitioner, Dr. Petkovich reviewed medical records provided to him by the Respondent. On clinical examination, Dr. Petkovich noted that the range of motion of flexion and supination were both mildly limited and Petitioner complained of some discomfort when his range of motion was tested. Dr. Petkovich also noted that the forearm circumference was 29 cm on the left as compared to 30 cm on the right. Dr. Petkovich opined that Petitioner sustained a ruptured biceps tendon for which he received appropriate treatment, he was at MMI and could continue to work

without restrictions. Dr. Petkovich also opined that Petitioner had an AMA impairment rating of five percent (5%) of the left upper extremity (Respondent's Exhibit 4; Deposition Exhibit 2).

Dr. Petkovich was deposed on November 18, 2013, and his deposition testimony was received into evidence at trial. Dr. Petkovich's testimony was consistent with his medical report and he reaffirmed his opinion that Petitioner had an impairment rating of five percent (5%) of the left upper extremity. Dr. Petkovich stated that there was a slight decreased range of motion in regard to flexion and supination. In respect to the difference observed in the circumferences of Petitioner's forearms, Dr. Petkovich testified that the right arm measured 35 cm (not 30 cm as stated in his report) and that the left measured 29 cm. He explained that Petitioner had not regained all of the muscular mass in his left forearm (Respondent's Exhibit 4).

On cross-examination, Dr. Petkovich agreed that the concepts of impairment and disability are not synonymous. Dr. Petkovich was questioned at considerable length about the fact that he did not have Petitioner complete a Quick DASH functional assessment outcome questionnaire which is a statement of the examinee's levels of subjective complaints, required by the AMA assessment guidelines. However, Dr. Petkovich testified that, based on the information he obtained from the Petitioner during the course of his evaluation, that the absence of this form did not impact or affect his opinion as to the level of impairment (Respondent's Exhibit 4).

At trial Petitioner testified that he returned to work to the same position that he had at the time of the accident and that he continued to work in that job for approximately nine months. The only task Petitioner avoided performing during that period of time was lifting plywood. Petitioner stopped working for Respondent in August, 2013, to care for his mother who was in poor health. At the time of trial, Petitioner was not working and he stated that he and his wife were planning to purchase homes, renovate them and then resell them. Part of the underlying reason that he decided to engage in this type of work is that he could better control the use of his left arm.

Petitioner testified that he was very happy with the results of his surgery; however, he still had complaints in regard to his left arm. Petitioner stated that his left arm feels weaker than his right and, because of this, he has made adjustments and makes greater use of his right arm. Petitioner stated that when he lifts anything heavy, he feels tension in his left elbow and that twisting his wrist from side to side causes an abnormal sensation in his elbow.

Conclusions of Law

The Arbitrator concludes that Petitioner has sustained permanent partial disability to the extent of 22 1/2% loss of use of the left arm.

In support of this conclusion the Arbitrator notes the following:

Dr. Petkovich examined Petitioner at the direction of Respondent and opined that there was an AMA impairment rating of five percent (5%) of the left upper extremity.

While Petitioner did not complete a Quick DASH functional assessment activity questionnaire at the time he was evaluated by Dr. Petkovich, Dr. Petkovich testified that, based on the

information he obtained from Petitioner during his evaluation, that the lack of completion of this form did not have any impact or effect on his opinion of the degree of impairment.

Petitioner did not submit an AMA impairment rating so the only AMA impairment rating is that of Dr. Petkovich.

The Arbitrator finds that the AMA impairment rating of Dr. Petkovich is valid; however, the Arbitrator does note that impairment is not the equivalent of disability.

Petitioner was employed as a carpenter instructor at the time of the accident; however, Petitioner's primary occupation for most of his working life was that of a carpenter. Working as a carpenter does require the active use of both upper extremities. Due, at least in part, to Petitioner's being able to control the use of his left arm, he decided to remodel and sell houses.

At the time of the accident Petitioner was 51 years of age meaning he will have to live with the effects of this injury for the remainder of his working and natural life.

There was no evidence that this injury will have any effect on Petitioner's future earning capacity.

The medical treatment records clearly show that Petitioner sustained a ruptured biceps tendon which required surgery that included the use of a surgical screw. Both Petitioner's primary treating physician, Dr. Maender, and Respondent's examining physician, Dr. Petkovich, described some diminished range of motion. Further, Dr. Petkovich observed a loss of muscular mass of the left forearm as compared to the right (one cm difference in the report, but six cm difference when he was deposed).

The Arbitrator finds Petitioner's complaints to be credible and consistent with the nature of injury that he sustained.

The Arbitrator gives greater weight to factors two, three and five than factor number one. The fact that Petitioner has a feeling of weakness in his left arm is consistent with the diminished muscular mass as noted by Dr. Petkovich. Petitioner's customary occupation as a carpenter requires the active use of both upper extremities and Petitioner has credible complaints regarding the use of his left arm.

The Arbitrator gives no weight to factor number four because Petitioner was able to return to work and presented no evidence that the effects of this injury will cause any effect on his future earning capacity.

William R. Gallagher, Arbitrator

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Elizabeth McKinley,

Petitioner,

vs.

14IWCC1007
NO: 10 WC 43687

Metro Staff,

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, permanent partial disability, penalties/fees, and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed August 12, 2013, is hereby affirmed and adopted.

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

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

DATED: NOV 24 2014
CJD:yl
o 11/12/14
49

Charles J. DeVriendt

Daniel R. Donohoo

Ruth W. White

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

McKINLEY, ELIZABETH
Employee/Petitioner

Case# **10WC043687**

METRO STAFF
Employer/Respondent

14IWCC1007

On 8/12/2013, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

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

BART DURHAM & ASSOC LTD
400 N SCHMIDT RD
SUITE 200
BOLINGBROOK, IL 60440

0766 HENNESSY & ROACH PC
JASON D KOLECKE
140 S DEARBORN 7TH FL
CHICAGO, IL 60603

STATE OF ILLINOIS)
)SS.
COUNTY OF MCHENRY)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

14IWCC1007

ELIZABETH MCKINLEY
Employee/Petitioner

v.

Case # **10** WC **43687**

METRO STAFF
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 Erbacci**, Arbitrator of the Commission, in the city of **Woodstock**, on **June 6, 2013**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

14IWCC1007

FINDINGS

On **October 28, 2010**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

On this date, Petitioner ***did 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 **$15,305.16**; the average weekly wage was **$294.33**.

On the date of accident, Petitioner was **31** years of age, ***single*** with **4** dependent children.

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

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

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

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

ORDER

The Petitioner's claim for compensation is denied.

No benefits are awarded herein.

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

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

Arbitrator Anthony C. Erbacci

August 1, 2013
Date

AUG 12 2013

14IWCC1007

FACTS:

On October 28, 2010, the Petitioner was employed by the Respondent, a temporary agency, and she was performing the duties of an assembly line worker at the Weber Grill assembly plant in Huntley, IL. The Petitioner's work duties at this location consisted of working in various positions assembling grills. The various physical duties the Petitioner performed included putting together card board boxes, putting grill parts into boxes, and other necessary tasks to complete the assembly of a grill. The Petitioner testified that during her eight hour shift, from 6:00am to 2:00pm, she never performed the same task for more than two hours continuously. At least every two hours if not sooner, she would be rotated to a different work position on the assembly line.

The Petitioner testified that on October 28, 2010, her supervisor assigned her to a position she had never worked before. She testified that this position required her to lift pieces of grill frames out of a bin and then place the pieces into a box on the assembly line. The Petitioner described the pieces as "heavy" and she testified that she was required to do this job in a "confined space". The Petitioner testified that she started her shift at 6:00 am and that at about 11:00 am she began to notice that her back began to stiffen and get "tense". She testified that she continued working and completed her regular eight hour shift and then went home. The Petitioner testified that she did not report her back stiffness to her supervisor or anyone else before she left to go home and that she did not seek any medical treatment that day.

The Petitioner testified that her back stiffness increased while she was at home and that when she awoke the next day, which was a Saturday, her back was "hurting a lot". She testified that she stayed home hoping the pain would subside, but it did not go away. The Petitioner testified she did not seek any medical treatment on that day.

The Petitioner testified that on Sunday, which was Halloween, she had difficulty walking due to back pain. She testified that she started to go trick or treating with her children, but the pain increased to the point she was unable to participate in the activity and had to go home and lay down. The Petitioner did not seek treatment on this day either.

On Monday, November 1, 2010, the Petitioner returned to work and began her shift at 6:00am. The Petitioner testified that she mentioned her back pain to one of the Respondent's managers and she testified that she was assigned to a different job. She testified that she worked for about 15 minutes and then had to stop. She testified that she informed a supervisor of her condition and was sent to the nurse's station. The Petitioner testified that she was then sent to Physicians Immediate Care and was driven there by one of the Respondent's employees.

At Physicians Immediate Care, a history was taken and a physical exam was performed, along with x-rays of the thoracic spine. The history noted indicates that the Petitioner developed left sided mid back pain on October 28, 2010, as a result of putting five to ten pound grill grates in a box for about an hour. The physical exam revealed normal back

range of motion, no lumbosacral lordosis, and no spinal kyphosis or scoliosis. Abnormal findings included tenderness of the left thoracic paravertebral musculature and pain with lateral rotation. The Petitioner rated her pain at 5 out of 10. X-rays of the thoracic spine were found to be normal. The diagnosis at that time was a lumbar strain. The Petitioner was provided pain medication and work restrictions consisting of no lifting greater than 10lbs from floor to waist and no lifting greater than 5lbs from waist to shoulder.

The Petitioner testified that she provided these restrictions to her employer, but was never contacted about returning to work. Monique Edwards testified that these restrictions would have been within the Petitioner's everyday job activities and thus there would be no reason to have to make any accommodation in order for the Petitioner to be physically able to return to work. The Petitioner testified that after November 1, 2010 she never returned to work for the Respondent nor did she ever attempted to.

The Petitioner returned to Physicians Immediate Care on November 8, 2010. The record indicates that the Petitioner reported some improvement in her back pain which she rated at 3 out of 10. She denied any radiation into the upper or lower extremities and the physical findings remained the same as the prior visit. The diagnosis was improving thoracic strain. The Petitioner was provided medication and her restrictions were lessened to no lifting greater then 10lbs floor to waist and no lifting greater than 15lbs waist to floor. The Petitioner was instructed to follow up in one week.

The Petitioner testified that instead of returning to Physicians Immediate Care, she sought alternative care with a chiropractor, Daniel Horn, at Advanced Medical and Wellness Center. The Petitioner treated with this facility for the first time on November 8, 2010, the same day as her visit with Physicians Immediate Care. The Petitioner provided a history of developing pain in the left mid back as a result of lifting parts at work on October 28, 2010 and she rated her pain at 3-5 out of 10. She reported no weakness, but reported that she did have radiation on the left side near the rib cage. The records from that initial visit do not indicate that any work restrictions were prescribed.

The Petitioner returned to Advanced Medical on November 10, 2010. The records from that visit indicate that the Petitioner reported that her pain had increased to 7 out of 10 and that she had developed weakness in the left and right arm. It was recommended that the Petitioner undergo chiropractic manipulations and physical therapy at the same time, five times per week for the first week. No work restrictions were provided at the time of this visit.

The recommended treatment program began on November 12, 2010. On November 15, 2010 the Petitioner reported that her pain had decreased to 3 out of 10. The Petitioner was provided with work restrictions for the first time after this visit. These restrictions consisted of no lifting greater than 10lbs, no standing more then 4-6 hours, no sitting more than 4-6 hours, no repetitive hand motions with the left hand more then 3-4 hours. She was also to avoid repetitive bending, carrying, overhead reaching, twisting, pulling. These restrictions were in effect until November 29, 2010.

The records from Advanced Medical and Wellness indicate that the Petitioner's pain rating had decreased to 1-2 out of 10 by November 22, 2010. On November 23, 2010, the pain rating was 1 out of 10, with the same finding on November 24, 2010 and November 29, 2010. On December 1, 2010, the Petitioner provided a pain rating of 1 out of 10. She was offered an EMG test, but she declined. She was recommended to continue with the chiropractor's plan of treatment. No work restrictions were provided to the Petitioner at the time of his examination. During her treatment visit on December 3, 2010 the Petitioner reported no pain, only stiffness. The Petitioner also reported no pain on December 7th, 8th, and the 10th. On December 14, 2010 the Petitioner provided a pain rating of 0-1 out of 10 and she reported that the frequency was only 2 times per week with no weakness or radiation. It was recommended that the Petitioner continue with chiropractic treatment and physical therapy for an additional four weeks. No written work restrictions were provided.

From December 14 2010 through January 11, 2011, the Petitioner attended therapy twelve times and missed treatment six times. The records demonstrate that, when the Petitioner did attend therapy, her pain rating was never above 2 and she often reported no pain. During this time no written work restrictions were provided. On January 11, 2011, the Petitioner reported pain of 1-2 out of 10, with a frequency of once to twice a week. It was recommended that the Petitioner continue with a supervised exercise program three times per week for four weeks and therapy was continued through January 20, 2011.

At the request of the Respondent, the Petitioner was seen by Dr. Babak Lami, an orthopedic spine surgeon, on January 26, 2011. At the time of this visit the Petitioner provided a history of taking 5lbs pieces of a grill and turning and putting them in a box on October 28, 2010. She indicated she was performing this task in a limited space. The Petitioner told Dr. Lami that she did not feel pain until October 31, 2010. The Petitioner reported that her initial pain was 9 out of 10 but that she did not feel any pain at the time of the visit. Dr. Lami performed a physical exam, which he indicated was completely normal, and he also reviewed the Petitioner's treatment records from Physicians Immediate Care and Advanced Medical and Wellness Center. Subsequent to Dr. Lami's physical exam and review of the treatment records, he provided an opinion that no accident had occurred on October 28, 2010, whether acute or repetitive and that the extensive chiropractic treatment the Petitioner received was excessive and unnecessary. Dr. Lami opined that the Petitioner was capable of working in a full duty capacity and no further treatment was needed.

On January 27, 2011 the Petitioner returned to Chiropractor Daniel Horn. It was noted that the Petitioner rated her pain at 1 out of 10 and reported that she experienced pain at the end of the day once to twice a week. No work restrictions were provided at the time of this exam. Subsequent this visit, the Petitioner did not participate in any additional therapy and she was released from care on February 8, 2011. The chiropractor placed her at maximum medical improvement at this time with no restrictions.

The Petitioner testified that she has not sought or received any treatment for her back since February 8, 2011, and that she was released to return to work without any restrictions at that time. The Petitioner testified that her back feels "better" and she "is doing fine". She

further testified that she currently has no symptoms or problems with her back. The Petitioner testified that she started another job in March of 2011 and that she is currently a full time student.

On cross examination, the Petitioner again testified that her pain began on October 28, 2010. She testified that the new assignment she was given required her to lift metal grates that weighed one pound each and that she was required to lift twenty of those grates at a time. When it was pointed out that October 28, 2010 was a Thursday, the Petitioner testified that "It happened on a Friday" and she then indicated that it must have happened on the 29th. The Petitioner also acknowledged that the restrictions imposed on her by Physicians Immediate Care were not job prohibitive as her normal job was within those restrictions.

The Respondent presented the testimony of Monique Edwards, an 18 year employee of the Respondent. Ms. Edwards described the various jobs performed by the Respondent's employees at the Weber Grill assembly plant including the job performed by the Petitioner. Ms. Edwards acknowledged that the Respondent did receive a copy of the initial work restrictions placed on the Petitioner by Physicians Immediate Care but she testified that the Petitioner's regular job requirements were within those restrictions. The Arbitrator notes that Ms. Edwards' testimony regarding the assembly line jobs at the Weber Grill assembly plant contradicted the Petitioner's testimony as to the nature of the line and the physical activities involved in working on the line.

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:

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 that the Petitioner failed to meet that burden here. Specifically, the Arbitrator finds that the Petitioner failed to prove that an accident arising out of and in the course of her employment with the Respondent occurred on October 28, 2010.

Initially, the Arbitrator notes that the mere onset of symptoms while working does not, in itself constitute an "accident" as contemplated by the Act. The Petitioner testified that she began to notice stiffness in her back while she was working on October 28, 2010. She did not testify to an acute onset of pain while lifting a specific object or performing a specific task. While she testified that she was repetitively lifting heavy objects in a confined space, that testimony was not supported by the credible evidence in the record. The Petitioner's own testimony and the testimony of the Respondent's witness demonstrate that the Petitioner exaggerated the weight of the objects she was required to lift and that the Petitioner rotated between positions on the assembly line every two hours.

Additionally, the Petitioner's testimony as to the date of her alleged accident was inconsistent with the credible evidence. The Petitioner testified that her back symptoms

commenced while she was working on October 28, 2010 and all of the histories provided by the Petitioner to her medical providers indicated that her onset of back symptoms started on October 28, 2010. On cross examination however, the Petitioner testified that her symptoms must have started on October 29, 2010 because "it happened on a Friday". The Arbitrator notes that October 28, 2010 was a Thursday.

Finally, the Petitioner's testimony as to the onset and progression of her back complaints is suspect. The Petitioner testified that her symptoms began early in her shift on a Friday. (She initially testified that they started on October 28, 2010 which was a Thursday.) She did not report her symptoms to anyone on the day they commenced and she continued to work her entire shift that day. She testified that her symptoms increased while she was at home over the weekend, to the point that she had difficulty walking and she was unable to continue trick or treating with her children on Sunday. The Petitioner testified that she reported her back pain when she arrived at work on Monday, November 1, 2010 and that she was given a different work assignment. She testified that she was only able to perform that work for fifteen minutes before she had to stop due to her pain. On cross examination however, the Petitioner acknowledged that she "may have worked most of the day" on that Monday.

The Arbitrator notes that an alleged injury on a Friday with no report of that alleged injury until the following Monday, after a holiday weekend, is sufficient, in itself, to cause some suspicion. Further, the Arbitrator finds it difficult to believe that had the Petitioner's pain increased over the entire weekend to the point that she had difficulty walking and had to stop her Halloween trick or treating with the children as she testified, she would wait until after she had "worked most of the day" on Monday before she sought medical treatment for her complaints. The totality of the Petitioner's testimony and the evidence presented causes the Arbitrator to doubt the reliability of the Petitioner's testimony.

Based upon the foregoing, and having considered the totality of the evidence adduced at hearing, the Arbitrator finds that the Petitioner failed to prove that an accident occurred which arose out of and in the course of the Petitioner's employment with the Respondent on October 28, 2010.

Having found that the Petitioner failed to prove that an accident occurred which arose out of and in the course of the Petitioner's employment with the Respondent, determination of the remaining disputed issues is moot. The Petitioner's claim for compensation is denied and no benefits, penalties or attorney's fees are awarded herein.

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

Carolyn Coffman,

Petitioner,

14IWCC1008

vs.

NO: 13 WC 22608

Memorial Medical Center,

Respondent.

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed May 6, 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.

14IWCC1008

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: NOV 2 4 2014

Charles J. DeVriendt

Ruth W. White

Daniel R. Donohoo

DJD/gaf
O: 11/5/14
45

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

COFFMAN, CAROLYN
Employee/Petitioner

Case# **13WC022608**

14IWCC1008

MEMORIAL MEDICAL CENTER
Employer/Respondent

On 5/6/2014, 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 0.45% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

2427 KANOSKI BRESNEY
THOMAS R EWICK
2730 S MacARTHUR BLVD
SPRINGFIELD, IL 62704

0490 SORLING NORTHRUP HANNA ET AL
GARY A BROWN
1 N OLD STATE CAPITOL PLZ #20
SPRINGFIELD, IL 62701

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 **14IWCC100**

CAROLYN COFFMAN,
Employee/Petitioner

v.

MEMORIAL MEDICAL CENTER,
Employer/Respondent

Case # **13** WC **22608**

Consolidated cases: _____

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Maureen Pulia**, Arbitrator of the Commission, in the city of **Springfield**, on **4/16/14**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☐ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☐ What was the date of the accident?
E. ☐ Was timely notice of the accident given to Respondent?
F. ☒ Is Petitioner's current condition of ill-being causally related to the injury?
G. ☐ What were Petitioner's earnings?
H. ☐ What was Petitioner's age at the time of the accident?
I. ☐ What was Petitioner's marital status at the time of the accident?
J. ☒ Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. ☒ 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 14IWCC1008

On **10/5/10**, 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 **$27,878.24**; the average weekly wage was **$536.12**.

On the date of accident, Petitioner was **60** years of age, ***single*** with **no** dependent children.

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

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

Respondent shall be given a credit of **$00.00** for TTD, **$00.00** for TPD, **$00.00** for maintenance, and **$00.00** for other benefits, for a total credit of **$00.00**.

Respondent is entitled to a credit of **$34,386.00** under Section 8(j) of the Act.

ORDER

Respondent shall pay Petitioner temporary total disability benefits of $357.41/week for 8-4/7 weeks, commencing 11/29/12 through 1/27/13, as provided in Section 8(b) of the Act.

Respondent shall pay reasonable and necessary medical services for petitioner's left knee from 10/5/10 through 1/27/13, as provided in Sections 8(a) and 8.2 of the Act, as well as petitioner's out of pocket expenses for these reasonable and necessary medical services.

Respondent shall be given a credit of $34,386.00 for medical benefits that have been paid, and Respondent shall hold petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act.

Respondent shall pay Petitioner permanent partial disability benefits of $321.67/week for 75.25 weeks, because the injuries sustained caused the 35% loss of the petitioner's left leg, as provided in Section 8(e) of the Act.

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

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

Signature of Arbitrator

4/30/14
Date

ICArbDec p. 2

MAY - 6 2014

THE ARBITRATOR HEREBY MAKES THE FOLLOWING FINDINGS OF FACT:

Petitioner, a 60 year old operating room scheduler/secretary sustained an accidental injury to her left knee that arose out of and in the course of her employment by respondent on 10/5/10. On the date of accident petitioner had worked for respondent for about 5 years. Her duties included scheduling surgeries in advance for doctors' offices. Her job is primarily sedentary in nature. Prior to 10/5/10 petitioner had been diagnosed with arthritis in both knees. At times petitioner would have pain in her knees, but had no trouble walking and did not have a limp.

Petitioner testified that she did not undergo any specific treatment for her knees prior to 10/5/10. When she would see her doctor for other reasons she may tell the doctor about her arthritis symptoms that included some pain and swelling in her hips, knees and neck. Petitioner never had any physical therapy for her left knee, an MRI of her left knee, aquatic therapy for her left knee, buckling of her left knee, or any workers' compensation cases for her left knee prior to 10/5/10.

On cross-examination petitioner testified that her primary care physician from 1990 was Dr. Hale. She stated that in 1995 she discussed her overall arthritis with Dr. Hale and he prescribed Mobic. Prior to then petitioner was taking Naprosyn and Aleve for her arthritis in her shoulder and other joints. At one point after 1995 petitioner saw Dr. Ramsey who prescribed Celebrex. Petitioner tried this medication but stated that it did not help.

On 10/5/10 petitioner was working in the main operating room, which was in the cellar of the main hospital, in the Baylis Building. As she was coming out of the locker room, which had a tight hinge on the door, she had opened the door and with the door open, stopped to see if anyone was coming down the hall before she fully exited the doorway. As she was standing in the doorway and looking to make sure the hallway was clear, the door closed fast and hit her in the back and hips with her left knee planted. Petitioner was pushed forward by the force of the door. Petitioner's left knee twisted, she heard a loud pop, and her left knee buckled. Petitioner had immediate pain in her left knee.

Petitioner reported the accident to her supervisor Sandy Flattery following the injury. She did not seek immediate treatment that day, thinking that it might feel better the next day. A few days later petitioner completed an accident report, and was sent for treatment by respondent. The Event Information petitioner entered was "door on locker room closes excessively hard - It pushed me out and I twisted my knee-I get really bad pain that goes up and down my leg from my knee. Usually I can get it to let me walk after a few minutes- I

do not want to follow.." Corrective Actions Taken were identified as "Engineering contacted. Informed that door closure required repair and immediately accomplished."

On 10/11/10 petitioner was sent by respondent to Midwest Occupational Health Associates (MOHA). Petitioner gave a consistent history of the accident. Petitioner complained of left knee swelling, and worsening pain after sitting for prolonged periods of time. She denied any buckling, but reported weakness in the left knee. She denied any prior injuries to her left knee or any previous problems with her left knee. Petitioner was seen by the nurse practitioner. Following an examination, the nurse practitioner diagnosed a left knee strain and ordered x-rays of petitioner's left knee. Petitioner was given a prescription for Tramadol and was instructed to continue taking Mobic. She was released to full duty work.

X-rays of the left knee were performed on 10/13/10. The impression was mild to early moderate tricompartmental osteoarthritis. Following the x-rays petitioner followed up at MOHA on 10/18/10 without any improvement, and was maybe even a little worse. Petitioner was prescribed physical therapy and underwent a 2-3 week course of physical therapy. She continued to work full duty.

On 11/10/10 petitioner returned to MOHA and reported no improvement of her left knee. She reported that the physical therapy had helped her calf and Achilles tendon, but not her knee. An MRI of the left knee was ordered. This was performed on 11/19/10. The impression was a radial tear of the posterior horn of the medial meniscus with peripheral extrusion of the body of the medial meniscus; marked osteoarthritis in the medial and patellofemoral compartments; knee effusion with an associated popliteal cyst, and loose bodies within a popliteal cyst; and mild patellar tendinopathy.

On 11/30/10 petitioner returned to MOHA. She stated that her left knee was a little better, and then on 11/22/10 it popped and has felt a little better since then. She rated her pain at a 5/10. She stated that she was taking Mobic, but not Tramadol. She reported that her left knee hurts worse at night. Petitioner asked for a referral to Dr. Borowiecki, who she had already showed the results of the MRI. She requested this referral because she had worked with him in the operating room and he had been recommended by others in the operating room. Petitioner was continued on regular duty. Physical therapy was suspended.

On 12/2/10 petitioner presented to Dr. Borowiecki for an evaluation of her left knee. Following an examination and record review, Dr. Borowiecki's impression was degenerative arthritis in the knee with medial meniscal tear that could be associated with the petitioner's injury on 10/5/10. Dr. Borowiecki assessed left knee joint pain, localized osteoarthritis of the left knee, and an acute medial meniscus tear. He told petitioner that sh had two problems: preexisting osteoarthritis of the left knee and a superimposed injury on this as a result of the

twisting injury she described. Dr. Borowiecki was of the opinion that the meniscal tear may potentially be a result of the injury on 10/5/10, but he could not opine. Dr. Borowiecki injected petitioner's left knee with corticosteroid. Petitioner testified that this injection provided some relief for a while.

On 12/7/10 petitioner returned to MOHA. She reported that Dr. Borowiecki gave her an injection into the left knee and her knee felt about 60% improved. She rated her pain at a 3/10. Petitioner was continued on regular work and given a refill of her Ultram.

On 1/13/11 petitioner returned to Dr. Borowiecki. Petitioner reported that she was 80% improved. Dr. Borowiecki recommended continued observation. He was hesitant to recommend an arthroscopy because he did not believe it would give her complete relief.

On 1/26/11 petitioner followed-up at MOHA. She reported that overall she was doing a lot better. She stated that she was 80% improved. Petitioner reported that she was not taking any medications for her left knee. An examination of the left knee revealed no edema, a probable Baker's cyst located at the posterior knee, tenderness at the posterior knee area with palpation, good flexion and extension, and crepitus. Petitioner was continued on regular duty work.

On 3/10/11 petitioner returned to Dr. Borowiecki. Dr. Borowiecki performed a repeat injection into petitioner's left knee due to recurring symptoms. Petitioner was released on an as needed basis.

While petitioner was treating with Dr. Borowiecki, she was also following up at MOHA. On 3/15/11 petitioner returned to MOHA and reported that she was doing great. She rated her pain level at 1/10. She stated that she had a cortisone injection on 3/10/11 and felt great. Petitioner reported a little stiffness up to the posterior aspect of the left knee on occasion to a minor degree. She stated that she was doing regular work without difficulty. She noted that she was taking no medications specifically for her left knee. Petitioner was continued on full duty work, and was released from care by MOHA on an as needed basis.

On 5/9/11 petitioner returned to MOHA due to increased pain in her left knee for a week. She stated that her job requires her to be up and down a lot more at work. She stated that she did not know if this irritated her left knee. Petitioner denied any new injuries. She rated her pain at a 6/10.

On 5/12/11 petitioner returned to Dr. Borowiecki. Petitioner reported that the relief she had from the last injection only lasted about a month before it started to wear off. Petitioner complained of quite a bit of discomfort. She reported that the temporary relief she received following the injection on 3/10/11 had worn off. Dr. Borowiecki was of the opinion that the MRI showed pretty advanced arthritis of the left knee with

narrowing of the joint spaces, and marginal osteophyte formation. He also noted that the MRI showed a degenerative complex-type tear over the posterior horn of the medial meniscus, and the patellofemoral compartment showed severe degenerative changes. Dr. Borowiecki gave petitioner a few options. One was to proceed with viscosupplementation with Hyalgan, a 3-injection series. Two, would be to consider an arthroscopy. Since he could not address any of the arthritic findings at all during this surgery, his suspicion was that petitioner would not get dramatic symptom relief from an arthroscopy, and if she did it would be short lived. A third option was a total knee arthroplasty. Petitioner did not want surgery unless absolutely necessary, and selected the injections.

On 5/20/11 petitioner followed-up at MOHA. Nurse practitioner Bowers was of the opinion that Dr. Borowiecki noted that most of petitioner's symptoms were probably due to her arthritis, and recommended a series of three Hyalgan injections. He also discussed a total knee arthroscopy. Petitioner indicated that she wanted to undergo the recommended injections. She stated that she has been on her feet a bit more while working and this could be the cause of her increased pain in her left knee. She reported pain and stiffness in the morning when she wakes up, and pain when getting out of a chair. Bowers noted that they were waiting for approval of the injections from respondent and she was to continue working regular duty.

On 5/26/11 petitioner presented to Dr. Clem at MOHA. She noted that she had undergone 2 injections. She noted that they were trying to decide if her symptoms were related to the meniscal problem or the arthritis. Dr. Clem examined petitioner and recommended a course of aqua therapy. Petitioner was released to full duty work.

From 6/1/11-6/23/11 petitioner underwent a course of aqua therapy. She testified that the therapy would help her on the days she had therapy and for a little while after.

On 6/9/11 petitioner followed-up with Bowers at MOHA. She reported that the Aleve helps more than the Mobic. She also stated that the aqua therapy was helping. She rated her pain level at a 4/10. She denied any locking, buckling, or giving out of the knee. Petitioner was continued in aqua therapy and instructed to continue to take Aleve. She was continued on regular duty work.

On 6/23/11 petitioner returned to MOHA and was examined by Bowers. It was noted that petitioner had not had much improvement with any medications they had tried. Petitioner continued to complain of increased pain at work with getting up and down on a frequent basis. She reported that her knee was better overall with the aqua therapy. She stated that she was no longer interested in surgery at that time. Petitioner stated that the Hyalgan injections were denied by respondent. Petitioner was examined and assessed with a left knee strain on

top of chronic arthritis. Petitioner stated that she had no follow-ups scheduled with Dr. Borowiecki. She was given one more week of aqua therapy and again released on an as needed basis.

On 7/20/11 petitioner returned to MOHA and was seen by Bowers. Petitioner reported a fall secondary to her left knee buckling. She stated that the fall occurred when she was going up stairs at home. She stated that her knee was bent and was on the upper step, and as she pushed up on the leg, her left knee buckled and gave out on her causing her to fall. Petitioner was concerned that her left knee was worsening. Petitioner complained of persistent symptoms. Her symptoms were in the medial and posterior aspects of her left knee. She stated that her left knee felt like it was going to give out on her since the injury, but this was the first time it happened. Bowers felt it was appropriate for petitioner to see if there were any other options for her besides surgery. A consultation was set up with Dr. Wolters. Petitioner was released to full duty work.

On 7/26/11 petitioner presented to Dr. Wolters for a second opinion. Dr. Wolters reviewed the diagnostic tests and performed an examination. He was of the opinion that petitioner would not be a candidate for a knee arthroscopic debridement, since he did not believe it would result in any relief of her pain. He recommended Hyalgan injections. He believed these could delay her need for a total knee arthroplasty. He was of the opinion that petitioner would need a knee replacement sometime in the near future.

On 7/27/11 respondent decided that they would not authorize this treatment and stopped petitioner's workers' compensation benefits on 7/27/11. Petitioner testified that respondent informed her that they would only pay for an arthroscopy.

On 8/12/11 petitioner returned to MOHA and was examined by Bowers. Bowers noted that Dr. Wolters was not recommending surgery at that time. She noted that he did recommend the Hyalgan injections. Petitioner stated that she would put these injections through her personal insurance since workers' compensation had already denied them. Petitioner also stated that she began taking Osteo Bi-flex 2 weeks ago and it was helping. She stated that her pain was localized to the medial and posterior aspects. She also stated that she was doing exercises in the pool that she learned in aqua therapy. Petitioner was instructed to continue with her home exercise program. Petitioner was released on an as needed basis and released to full duty work.

Dr. Wolters performed a series of 3 Hyalgan injections on 8/25/11, 9/1/11 and 9/9/11. Petitioner testified that the injections helped for a little while, but then her pain would return.

In August of 2011 petitioner had a unrelated small heart attack. Petitioner treated for this condition and had a stent implanted. Following this unrelated procedure, petitioner was told that she could not undergo any surgical procedures for a year.

On 9/23/11 petitioner followed-up with Dr. Wolters. Petitioner reported that the Hyalgan injections were not working. She requested other treatment. Petitioner stated that she could not take anti-inflammatories due to her heart condition. Petitioner stated that she could not walk due to the sharp pain in the medial aspect of her knee. Due to petitioner's cardiac stent, Dr. Wolters recommended conservative treatment for her left knee until cleared by the cardiologist. Dr. Wolters injected petitioner's left knee.

On 2/1/12, 2/24/12 and 3/2/12 petitioner underwent another course of 3 Hyalgan injections. On 5/14/12 petitioner underwent a cortisone injection to the left knee.

On 8/24/12 petitioner returned to Dr. Wolters wanting to talk about a total knee replacement. She also requested another injection. Dr. Wolters performed another injection to the left knee. Petitioner's left knee was really bothering her. She rated her pain at a 9/10. She stated that she could not walk more than a block without pain. She stated that she was taking Tramadol for her pain. She stated that she wanted to undergo a left knee replacement in the near future.

On 11/22/12 petitioner returned to Dr. Wolters. She stated that she was ready to proceed with the total arthroscopy. Dr. Wolters recommended that petitioner go ahead with the total left knee arthroplasty. On 11/29/12 petitioner underwent a full left knee replacement that was performed by Dr. Wolters. Her postoperative diagnosis was left knee degenerative joint disease. Petitioner was authorized off work by Dr. Wolters from 11/29/12 through 1/27/13. Respondent did not pay petitioner any temporary total disability benefits. Petitioner used her sick time when she was off, and her group carrier paid for the surgery and post-operative treatment. Petitioner also testified that she incurred some out of pocket expenses.

Petitioner underwent post operative physical therapy from 12/17/12 to 1/18/13. Petitioner testified that most of the pain in her left knee resolved after the surgery and post-operative treatment. She stated that she no longer experiences any stabbing pain in her left knee.

On 10/31/13 Dr. Wolters drafted a letter to petitioner's attorney, Ewick. Dr. Wolters opined that as a resul of the accident on 10/5/10 petitioner aggravated and caused an acute exacerbation of her preexisting osteoarthritis and it was inevitable that her osteoarthritis would advance to a symptomatic state. Dr. Wolters opined that the effusion was probably associated with the acute injury. He noted that it was difficult to tell

whether or not petitioner had an effusion or a radial tear of the posterior horn of the medial meniscus prior to the injury. He was of the opinion that many patients with osteoarthritis do develop tears within the medial meniscus, especially the posterior horn region. Dr. Wolters opined that the injury accelerated the arthritis that the petitioner demonstrated. He further opined that the meniscal tear may have been caused by the injury. He opined that petitioner's arthritis was so advanced that most likely the treatment of the meniscus would not deem her knee asymptomatic following any arthroscopic intervention. Dr. Wolters further opined that the left total knee arthroplasty was necessary because of the petitioner's preexisting condition of osteoarthritis. He was of the opinion that her symptoms did improve per the medical record with conservative treatments including cortisone injections as well as physical therapy, however, her advancing arthritis most likely caused the knee replacement that was performed. Dr. Wolters did not think the injury caused any future limitations. He believed her arthritis had just advanced to the point where she needed an arthroplasty. He believed that ongoing symptoms were unlikely given the fact that her arthritis had been removed, as well as her meniscus tear.

On 11/22/13 petitioner last followed up with Dr. Wolters. Petitioner stated that she was doing very well. She reported very little pain in her left knee. She reported occasional catching of her kneecap. Dr. Wolters recommended that petitioner continue with her home exercise program. Petitioner testified that she still performs the home exercises recommended by Dr. Wolters. Dr. Wolters placed petitioner at maximum medical improvement (MMI) on 11/23/13 and told her to follow-up in a couple of years.

On 3/21/14 the evidence deposition of Dr. Wolters, an orthopedic surgeon, was taken on behalf of the petitioner. Dr. Wolters opined that when someone hears a pop in their knee it can be related to an ACL or MCL tear and consistent with an acute trauma. Dr. Wolters opined that a person who had the same findings as those demonstrated on petitioner's left knee MRI could be completely asymptomatic, and a twisting type injury can make these findings symptomatic. Dr. Wolters opined that it is certainly possible that the radial tear of the posterior horn of the medial meniscus occurred during the injury. He also noted that these types of tears are very common in patients petitioner's age with osteoarthritis. He stated that he recommended Hyalgan injections to control the pain that was most likely related to the osteoarthritis and delay the knee replacement given her relatively young age.

Dr. Wolters opined that petitioner exacerbated her existing osteoarthritis in her left knee as a result of the injury on 10/5/10. He further opined that as a result of the injury petitioner may have sustained effusion, swelling, and a tear of the posterior horn of the meniscus. Dr. Wolters opined that the accident petitioner described and he reviewed in the medical records, may have advanced petitioner's need for a total knee

arthroscopy. He based this opinion on the fact that petitioner had more pain after her injury that did not completely go away, and the fact that petitioner was asymptomatic prior to the injury.

Currently, petitioner is still working the same job she was working on 10/5/10. She reported that when she is sitting at work her left knee gets stiff sometimes, and it is hard for her to get up. Petitioner testified that her job is a sedentary job, and she sits most of the time. Petitioner is working the same hours she did before the injury. Petitioner can sit up to 3-4 hours at a time. She reported that she does get up and walk around a little bit during her shift. Petitioner testified that although there are stairs at work she chooses to use the elevator because she does not trust her left knee on the stairs. Petitioner is currently 63 years old. Petitioner stated that her future earning capacity has not been diminished by the injury since she is still working the same job, for the same amount of hours, at the same hourly rate.

Petitioner testified that her left knee is numb, and gets stiff at least once a day. Petitioner does not take any pain medications for her left knee. When petitioner performs activities around the house, she has trouble vacuuming as it causes her pain in her left knee. Petitioner stated that she only goes downstairs when she has to do laundry 3-4 times a week. Petitioner is careful on the steps so that her knee does not buckle. Petitioner testified that she cannot walk the dog very far, and has to rest her left knee because it hurts. Petitioner was of the opinion that the surgery improved her left knee. Petitioner testified that x-rays taken of both knees prior the accident showed arthritic changes in both knees that were similar.

F. IS PETITIONER'S CURRENT CONDITION OF ILL-BEING CAUSALLY RELATED TO THE INJURY?

The threshold issue in this case is whether or not petitioner's current condition of ill-being as it relates to her left knee is causally related to the injury she sustained on 10/5/10. The only causal connection opinions offered with respect to petitioner's left knee and the accident on 10/5/10 were those of Dr. Borowiecki and Dr. Wolters.

It is unrebutted that prior to the injury on 10/5/10 petitioner had preexisting arthritis in her joints, including her knees. Petitioner was taking Mobic for her arthritis before the accident date, but had had no specific treatment related to her left knee. Prior to the injury, when petitioner would see her doctor for other unrelated issues she may mention the arthritis in her joints. Prior to the injury, petitioner never had any physic therapy for her left knee, an MRI for her left knee, buckling of her left knee, surgery recommendation for her left knee, or restrictions related to her left knee. Until 10/5/10 petitioner was able to work her sedentary job without any restrictions.

Following the unrebutted accident on 10/5/10 petitioner reported immediate pain in her left knee for which she sought treatment within a few days following the accident. Petitioner treated at MOHA at the directive of respondent. Petitioner reported swelling, pain, and some weakness in her left knee. X-rays of the left knee on 10/13/10 only showed mild to early moderate tricompartmental osteoarthritis.

When petitioner's pain did not improve, she underwent an MRI of the left knee that revealed a radial tear of the posterior horn of the medial meniscus with peripheral extrusion of the body of the meniscus; marked osteoarthritis in the medial and patellofemoral compartments; knee effusion with an associated popliteal cyst, with loose bodies within a popliteal cyst; and mild patellar tendinopathy.

On 12/2/10 Dr. Borowiecki evaluated petitioner and his impression was degenerative arthritis in the knee with medial meniscal tear that could be associated with the petitioner's injury on 10/5/10. Dr. Borowiecki was of the opinion that petitioner had preexisting osteoarthritis of the left knee with a superimposed injury on this as a result of the injury on 10/5/10.

Petitioner underwent conservative treatment at MOHA and with Dr. Borowiecki and Dr. Wolters that included a course of physical therapy, aqua therapy, cortisone injections and Hyalgan injections over the next year or so, all of which would result in immediate relief, sometimes up to 80-90%, that would then gradually wear off to the point where petitioner had significant pain. In 7/20/11 petitioner's left knee actually buckled on her when she was walking up the stairs of her home.

In May of 2011 and July of 2011 both Dr. Borowiecki, and Dr. Wolters, respectively, were of the opinion that petitioner would not be a candidate for a knee arthroscopy because it would not address the osteoarthritis and give lasting relief. Hyalgan injections were recommended in order to buy petitioner time until she would need a total knee arthroscopy. Petitioner underwent two series of Hyalgan injections, but eventually did not have any lasting relief.

Petitioner sustained an unrelated heart attack in August of 2011, had a stent implanted, and was told that she was unable to undergo any surgical procedures for a year.

In August of 2012 Dr. Wolters and petitioner discussed the option of total knee arthroscopy. Her pain at that time was a 9/10. By November 2012 petitioner's pain was constant and she was ready to undergo the total knee arthroscopy. This was performed on 11/29/12.

On 10/31/13 Dr. Wolters drafted a letter to petitioner's attorney in response to a letter he had sent. Dr. Wolters opined that as a result of the accident on 10/5/10 petitioner aggravated and caused an acute

exacerbation of her preexisting osteoarthritis and it was inevitable that her osteoarthritis would advance to a symptomatic state. Dr. Wolters opined that the injury accelerated the arthritis that the petitioner demonstrated, and that the meniscal tear may have been caused by the injury. He also opined that petitioner's arthritis was so advanced that most likely the treatment of the meniscus would not deem her knee asymptomatic following any arthroscopic intervention. Dr. Wolters opined that the left total knee arthroplasty was necessary because of the petitioner's preexisting condition of osteoarthritis. He was of the opinion that her symptoms did improve per the medical record with conservative treatments including cortisone injections as well as physical therapy, however, her advancing arthritis most likely caused the knee replacement that was performed. He believed her arthritis had just advanced to the point where she needed an arthroplasty.

In his deposition Dr. Wolters, clarified some of the opinions stated in his letter dated 10/31/13. Dr. Wolters opined that when someone hears a pop in their knee it can be related to an ACL or MCL tear and consistent with an acute trauma, and for that reason believed the tear of the medial meniscus was related to the injury on 10/5/10. Dr. Wolters opined that even if the tear was present before the injury it was asymptomatic, and a twisting type injury can make these findings symptomatic. Dr. Wolters opined that it is certainly possible that the radial tear of the posterior horn of the medial meniscus occurred during the injury.

Dr. Wolters opined that petitioner exacerbated her existing osteoarthritis in her left knee as a result of the injury on 10/5/10. Dr. Wolters opined that the accident petitioner described and he reviewed in the medical records, may have advanced petitioner's need for a total knee arthroscopy. He based this opinion on the fact that petitioner had more pain after her injury that did not completely go away, and the fact that petitioner was asymptomatic prior to the injury.

Based on the above, as well as the credible evidence, the arbitrator adopts the findings of both Dr. Borowiecki and Dr. Wolters and finds although the petitioner had osteoarthritis, and a possible tear of the medial meniscus prior to the injury, and some day would most likely need a total knee arthroplasty as a result of her osteoarthritis, the injury on 10/5/10 exacerbated her existing osteoarthritis, possibly caused the tear of the medial meniscus, and took a relatively asymptomatic left knee and made it acutely symptomatic. Despite extensive measures of conservative treatment following the injury, these modes of treatment never resulted in long lasting improvement of petitioner's knee condition, thus causing a left total knee arthroscopy sooner than Dr. Wolters opined petitioner would probably have needed the procedure. Both Dr. Borowiecki and Dr. Wolters both opined that a simple arthroscopic procedure would not have alleviated petitioner's symptoms, and for that reason opined that a left total knee arthroscopy. Following the left total knee arthroscopy petitioner's

left knee condition improved significantly. Respondent did not have a doctor examine petitioner or perform a record review, and offer any causal connection opinion.

Based on the above, the arbitrator finds the petitioner's current condition of ill-being as it relates to her left knee is causally related to the injury on 10/5/10. The arbitrator finds the injury of 10/5/10 aggravated the petitioner's preexisting osteoarthritis in petitioner's left knee, and either aggravated or caused the medial meniscus tear, thus requiring the left total knee arthroscopy sooner than she would have needed it without the injury. The arbitrator also finds it significant that the x-rays of the left knee performed on 10/13/10, performed only 8 days after the injury, only showed mild to early moderate tricompartmental osteoarthritis, and there existed no opinion at that time that petitioner was a candidate for a total knee arthroscopy.

J. WERE THE MEDICAL SERVICES THAT WERE PROVIDED TO PETITIONER REASONABLE AND NECESSARY? HAS RESPONDENT PAID ALL APPROPRIATE CHARGES FOR ALL REASONABLE AND NECESSARY MEDICAL SERVICES?

The Arbitrator adopts her findings of fact and conclusions of law contained above with respect to the issue of causal connection and incorporates them herein by this reference.

The petitioner is claiming that all medical services provided to petitioner for her left knee including the left total knee arthroscopy were reasonable and necessary to cure or relieve petitioner from the effects of the injury on 10/5/10. Respondent claims the left total knee arthroscopy is not causally related to the injury 10/5/10, but rather to her preexisting osteoarthritis.

Having found the petitioner's left total knee arthroscopy was causally related to the injury petitioner sustained on 10/5/10, the arbitrator finds all treatment petitioner received for her left knee from 10/5/10 until 11/23/11 was reasonable and necessary to cure or relieve petitioner from the effects of the injury she sustained on 10/5/10.

The arbitrator finds the respondent shall pay all reasonable and necessary medical services for petitioners left knee from 10/5/10 through 11/23/13 pursuant to Sections 8(a) and 8.2 of the Act.

Respondent shall be given a credit of $34,386.00 for medical benefits that have been paid, and Respondent shall hold petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act.

K. WHAT TEMPORARY BENEFITS ARE IN DISPUTE?

The Arbitrator adopts her findings of fact and conclusions of law contained above with respect to the issue of causal connection and incorporates them herein by this reference.

The petitioner claims she was temporarily totally disabled from 11/29/12 through 1/27/13. Respondent claims it is not liable for this period of temporary total disability because petitioner's total knee arthroscopy is not causally related to the injury on 10/5/10.

Having found the petitioner's total knee replacement is causally related to the injury on 10/5/10, and Dr. Wolters had authorized petitioner off work from 11/29/12 through 1/27/13 following her total knee arthroscopy and post-operative treatment until she was released to full duty work, the arbitrator finds the petitioner was temporarily totally disabled from 11/29/12 through 1/27/13 a period of 8-4/7 weeks.

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

The Arbitrator adopts her findings of fact and conclusions of law contained above with respect to the issue of causal connection and incorporates them herein by this reference.

As a result of the injury on 10/5/10 petitioner underwent extensive conservative treatment that consisted of physical therapy, aqua therapy, cortisone injections, Hyalgan injections and a left total knee arthroscopy. Following post-operative treatment petitioner was released to full duty work without restrictions on 11/23/13. At her last visit with Dr. Wolters on 11/23/13 petitioner stated that she was doing very well. She reported very little pain in her left knee. She reported occasional catching of her kneecap. Dr. Wolters recommended that petitioner continue with her home exercise program. Petitioner testified that she still performs the home exercises recommended by Dr. Wolters. Dr. Wolters placed petitioner at maximum medical improvement (MMI) on 11/23/13 and told her to follow-up in a couple of years.

Currently, petitioner is still working the same job she was working on 10/5/10. She reported that when she is sitting at work her left knee gets stiff sometimes, and it is hard for her to get up. Petitioner testified that her job is a sedentary job, and she sits most of the time. Petitioner is working the same hours she did before the injury. Petitioner can sit up to 3-4 hours at a time. She reported that she does get up and walk around a little bit during her shift. Petitioner testified that although there are stairs at work she chooses to use the elevator because she does not trust her left knee on the stairs. Petitioner is currently 63 years old. Petitioner stated that her future earning capacity has not been diminished by the injury since she is still working the same job, for the same amount of hours, at the same hourly rate.

Petitioner testified that her left knee is numb, and gets stiff at least once a day. Petitioner does not take any pain medications for her left knee. When petitioner performs activities around the house, she has trouble vacuuming as it causes her pain in her left knee. Petitioner stated that she only goes downstairs when she has t

do laundry 3-4 times a week. Petitioner is careful on the steps so that her knee does not buckle. Petitioner testified that she cannot walk the dog very far, and has to rest her left knee because it hurts.

Based on the above, as well as the credible evidence, the arbitrator finds the petitioner sustained a 35% loss of use of the left leg pursuant to Section 8(e) of the Act.

STATE OF ILLINOIS)
) SS.
COUNTY OF WILL)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Lawrence Sullivan,

Petitioner,

14IWCC1009

vs.

NO: 13 WC 31878

Premier Transportation,

Respondent.

DECISION AND OPINION ON REVIEW

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

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

14IWCC1009

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

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

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $50,000.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: NOV 2 4 2014

Charles J. DeVriendt

Daniel R. Donohoo

CJD/gaf
O: 10/22/14
49

Dissent

I respectfully dissent from the majority opinion. I would have found that Petitioner failed to sustain his burden of proving either accident or causal connection to an alleged current condition of ill-being of his right knee. Therefore, I would have reversed the Decision of the Arbitrator and denied compensation.

Petitioner testified he fell out of his truck while backing out of it at the end of his shift at around 12:30 pm on August 7, 2013. He testified he injured both knees. He landed on his knees and possibly twisted his right knee in the process. He stayed on the ground for 15 to 20 minutes before being able to get up. Surveillance video in the lot taken at 12:41 pm on the date of the alleged accident showed Petitioner walking without limp or any apparent difficulty. Petitioner continued to work for another two weeks. The left knee condition resolved but the right knee condition did not. The right knee appeared to be getting better initially but then was getting worse.

Petitioner also testified on August 23, 2013, he told his general manager that his knee was getting worse. He informed Petitioner to write up a report, took a photograph of Petitioner's knee, and advised him to seek medical attention. On that date an examination showed no joint effusion, minimal ecchymosis, and some tissue swelling. A knee contusion was diagnosed. Petitioner had physical therapy and an injection, but his complaints increased. An MRI was

14IWCC1009

performed, which Petitioner's treating doctor and Respondent's section 12 medical examiner, interpreted as essentially normal. In addition Respondent's medical examiner noted a normal physical examination, found symptom magnification, and concluded there were no objective findings to support Petitioner's significant subjective complaints.

I do not believe Petitioner sustained his burden of proving accident or causation. His testimony that he could not get off the ground for 15 to 20 minutes due to extreme pain is inconsistent with the video taken within 10 minutes of the alleged accident. In addition, Petitioner's continuing to work and his failure to file an accident report or seek medical treatment for two weeks after the accident militate against any causal connection between the alleged accident and any current condition of ill being of Petitioner's right knee. Finally, the lack of objective findings to support Petitioner's significant subjective complaints puts his credibility in doubt.

For the reasons noted above I would have reversed the Decision of the Arbitrator and denied compensation. Accordingly, I respectfully dissent from the majority opinion.

Ruth W. White

Ruth W. White

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

14IWCC1009

SULLIVAN, LAWRENCE
Employee/Petitioner

Case# **13WC031878**

PREMIER TRANSPORTION
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:

0059 BAUM RUFFOLO & MARZAL LTD
RICHARD W BRAUN
33 N LASALLE ST SUITE 1710
CHICAGO, IL 60602

2965 KEEFE CAMPBELL BIERY & ASSOC
SHAWN R BIERY
118 N CLINTON ST SUITE 300
CHICAGO, IL 60661

STATE OF ILLINOIS)
)SS.
COUNTY OF WILL)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

14IWCC1009

LAWRENCE SULLIVAN
Employee/Petitioner

v.

PREMIER TRANSPORTATION
Employer/Respondent

Case # 13 WC 31878

Consolidated cases: _____

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **FALCIONI**, Arbitrator of the Commission, in the city of **New Lenox**, on **11/20/2013**. 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 **FUTURE MEDICAL TREATMENT**

14IWCC1009

FINDINGS

On **8/7/2013**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$57,500.04**; the average weekly wage was **$1,105.77**.

On the date of accident, Petitioner was **56** years of age, ***single*** with **2** dependent children.

Necessary medical services ***have not*** been provided by the Respondent.

To date, **$0.00** has been paid by the Respondent for T.T.D. and/or maintenance benefits.

ORDER

- **THE RESPONDENT SHALL PAY THE PETITIONER TEMPORARY TOTAL DISABILITY BENEFITS OF $780.00/WEEK FOR 12-5/7 WEEKS, FROM 8/23/2013 THROUGH 11/20/2013, WHICH IS THE PERIOD OF TEMPORARY TOTAL DISABILITY FOR WHICH COMPENSATION IS PAYABLE.**
- **THE RESPONDENT SHALL PAY THE FURTHER SUM OF $11,214.45 FOR NECESSARY MEDICAL SERVICES, AS PROVIDED IN SECTION 8(A) OF THE ACT.**
- **THE RESPONDENT IS ORDERED UNDER SECTION 8(A) TO AUTHORIZE PRESCRIBED RIGHT KNEE SURGERY AS FURTHER SET FORTH HEREIN.**
- **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 ATTORNEY'S FEES, AS PROVIDED IN SECTION 16 OF THE ACT.**

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

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

Signature of Arbitrator

December 3, 2013
Date

DEC 20 2013

STATE OF ILLINOIS)
) SS
COUNTY OF WILL)

14IWCC1009

BEFORE THE WORKERS' COMPENSATION COMMISSION
IN THE STATE OF ILLINOIS

Lawrence SULLIVAN, Petitioner,	)	
vs.	)	No. 13 WC 31878
PREMIER TRANSPORTATION, Respondent.	)	

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19B

An Application for Adjustment of Claim was filed on this matter and Notice of Hearing was mailed to each party. The matter was heard by the Honorable Robert Falcioni, Arbitrator of the Illinois Workers' Compensation Commission, in the City of New Lenox on November 20, 2013. The issues in dispute included whether Petitioner suffered an accident which arose out of and in the course of Petitioner's employment by Respondent, whether Petitioner provided Notice of the alleged accident, whether Petitioner's current condition of ill-being was causally related to the injury, medical and TTD liability and prospective medical treatment of Dr. Chudik.

THE ARBITRATOR MAKES THE FOLLOWING FINDINGS OF FACT

Petitioner testified to his name, address and employment with Respondent as a truck driver which began approximately two and a half years prior. Petitioner testified he had a special license for driving which was a CDL 8 and that he drove semi/tractor trailer trucks for Premier. Petitioner testified he had been a truck driver in some capacity for approximately 38 years.

Petitioner testified he reported to work at approximately 430 a.m. on August 7, 2013 and at the close of his shift, while turning backward and exiting his truck cab, he slipped and fell out of the truck striking both knees on the steps. Petitioner testified the cab was approximately 4-5 feet from the ground with the steps starting about a foot from the floor.

Petitioner testified he was removing his log, cooler and lunch from the cab while exiting and he grabbed for the handle when falling however he caught the seatbelt which extended and didn't slow his fall.

Petitioner testified he felt pain in both knees and sat on the ground for several minutes until the immediate pain subsided and he then moved his items to his vehicle.

Petitioner testified he finished his work and continued working for the next several weeks. Petitioner testified on the day of the August 7 accident, he noted his fall to Lilly in the facility because the supervisor was at lunch. Petitioner testified he continued to work until August 23, 2013 and was limping off and on but attempted to work through it. Petitioner testified he had pain mostly in the right knee and while he had initially also struck his left knee, it cleared up. Petitioner testified he didn't believe he had injured any other parts of his body.

Petitioner testified he had mentioned his injury to several other people and he recalled specifically telling Bruce Johnson at the August 17 safety meeting after Mr. Johnson asked him why he was limping. Petitioner testified he also told a corporate safety person and an individual named Heath at that time. Petitioner testified he explained the fall from the truck in detail after being questioned at that time.

Petitioner testified he was still in pain at that time and he was sent to the company clinic. Petitioner testified Bruce Johnson had suggested he present to the MD at Medworks and Petitioner also noted he was asked to create a written statement and noted a photo was taken of his knee as well.

Petitioner testified he did attend a visit at Medworks and they performed an x-ray as well as prescribing medication for the pain. Petitioner testified he was also provided a knee brace and on a second visit was prescribed crutches and an MRI was to be performed.

Petitioner testified he used a cane and agreed that the cane wasn't prescribed, only crutches—however he had switched to the cane after difficulty navigating with the crutches.

Petitioner testified he underwent therapy as well as having the MRI. Petitioner testified he underwent therapy at ATI through November 16. Petitioner testified he was also referred to a specialist, Dr Chudik and upon exam he provided Dr. Chudik with his history of falling from the truck and striking his knee. Petitioner testified he underwent exam and also had an injection in the knee which provided approximately 4 days relief. Petitioner testified Dr. Chudik then recommended arthroscopic surgery.

Petitioner testified to multiple notes which were marked as exhibit 6 to confirm that they were various work restriction notes. Petitioner testified he was taken off work however he asked for light duty to be able to return to some work. Petitioner testified he had provided the work status to Bruce Johnson and was advised that light duty was not available unless signed off by corporate. Petitioner testified light duty wasn't offered.

Petitioner testified he had received no benefits except a prescription card which he had used once and then had it cancelled. Petitioner testified he had received no monetary benefits.

Petitioner testified to multiple medical bills which were marked as exhibit 7 and confirmed he didn't believe any of the bills had been paid. Petitioner also testified to receiving a TENS unit and testified to a document noted as exhibit 8 which was a letter in regard to that unit. Petitioner testified he had not yet received a bill for the TENS unit.

Petitioner testified he had never suffered a prior injury to his knees and further testified that his knee was getting worse without treatment with increase pain and increased difficulty walking, standing and with stairs.

On cross exam, Petitioner testified there were no witnesses to his accident as far as he knew. Petitioner testified he also was able to walk without a limp at times and individuals may have seen him both limping or not limping at times.

Petitioner testified he presented for an exam with Dr. Walsh at the request of the insurance company. Petitioner testified he believed he gave Dr. Walsh a complete history. Petitioner testified Dr. Walsh didn't review the MRI disc in his presence.

Petitioner also testified to job logs being offered as Respondent Exhibit 2 and confirmed he didn't personally fill out the logs although he believed they may have been the logs completed by security. Petitioner agreed that there was no accident noted on any of the logs which were for dates from August 7 through August 23, 2013.

Petitioner testified he also agreed that security cameras were present at the facility and that the video evidence being submitted as Respondent Exhibit #3 did appear to be accurate video from the facility.

Petitioner further testified he had no specific ability to confirm the wage payments listed in the document marked as Respondent Exhibit #4 were not accurate. Petitioner testified at some point the drivers had been placed on salary in questioning regarding potential mileage additions to wages.

On re-direct, Petitioner testified he was paid a flat rate of $225 per day and worked Saturdays for 6 day weeks at least from November to February. Petitioner further testified that Dr. Walsh had spent ten to fifteen minutes with him in exam.

The parties entered multiple exhibits. Petitioner offered Petitioner Exhibit 1—Medworks records; Petitioner Exhibit No. 2—ATI records; Petitioner Exhibit No. 3—Midwest Open MRI records; Petitioner Exhibit No. 4—Hinsdale Orthopedic records; Petitioner Exhibit No. 5—records of Dr. Steve Chudik; Petitioner Exhibit No. 6—work status notes; Petitioner Exhibit No. 7—medical expense statements and Petitioner Exhibit No. 8—TENS unit confirmation letter.
Respondent offered Respondent Exhibit No. 1—October 27, 2013 record of Dr. Kevin Walsh; Respondent No. 2—trailer activity logs from August 7-23, 2013; Respondent

Exhibit No.3—video footage of security cameras and Respondent Exhibit No. 4—wage statement.

THE ARBITRATOR MAKES THE FOLLOWING CONCLUSIONS OF LAW

Longstanding Illinois law mandates a claimant must show that the injury is due to a cause connected to the employment to establish it arose out of employment. *Elliot v. Industrial Commission*, 153 Ill. App. 3d 238, 242 (1987). The burden of proof is on a claimant to establish the elements of his right to compensation, and unless the evidence considered in its entirety supports a finding that the injury resulted from a cause connected with the employment, there is no right to recover. *Board of Trustees v. Industrial Commission*, 44 Ill. 2d 214 (1969).

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

The Arbitrator notes Petitioner confirmed in his testimony that he suffered some accident on August 7, 2013 and his testimony was consistent with the medical records. It is noted the video evidence doesn't appear to show any significant deficits and that the trailer logs do not indicate any reporting of an accident. However, Petitioner's testimony supports a finding that an accident did occur which arose out of and in the course or Petitioner's employment with Respondent.

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

The Arbitrator finds that there is no evidence to rebut the allegations of Petitioner in his testimony that he reported some accident occurring on August 7, 2013 with the 45 day time frame necessary to comply with the Workers' Compensation Act of Illinois and his testimony was consistent with the initial medical. In that regard, Petitioner's testimony supports a finding that Notice of an accident occurring on August 7, 2013 was provided to Respondent.

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

The Arbitrator finds that while an accident did occur which arose out of and in the course or Petitioner's employment with Respondent, the evidence presented at hearing with regard to medical evidence is extremely probative.

It is initially noted that the competing opinions of Dr. Chudik and Dr. Walsh for the basis for the disputes with regard to causal connection. Dr. Chudik diagnosed osteochondral injury of the lateral femoral condyle and provided an injection while noting surgery was an

option if not improved. After Dr. Chudik reviewed the MRI, he recommended a right knee diagnostic arthroscopy. Dr. Chudik does not appear to have provided an opinion of causation within a reasonable degree of medical and surgical certainty

Dr. Walsh noted objectively normal physical exam as well as normal MRI and noted the symptoms were disproportionate to the objective findings along with an element of symptom magnification. Dr. Walsh stated that at best that Petitioner suffered a contusion.

After Petitioner's accidental injury on August 7, 2013, he credibly testified and it is unrebutted and supported by the medical records that Petitioner suffered pain, swelling and limping with his right knee. He was given crutches, but uses a cane instead to assist in walking.

The medical records support that after trying to work for 2 weeks, he sought medical attention and has continued to treat for his injury since August 23, 2013. He treated with Medworks from August 23, 2013 to October 17, 2013. Medworks ordered an MRI of his right knee, which was performed on September 17, 2013. He started physical therapy with ATI on September 24, 2013 and continues in therapy to the present. He saw Dr. Steven Chudik on two occasions 10/30/13 and 11/11/13 and Dr. Chudik has prescribed right knee surgery.

As *International Harvester v. Industrial Commission*, 93 Ill. 2d 59, 442 N.E. 908, 66 Ill. Dec. 347 (1982) states;

> *A chain of events which demonstrates previous condition of good health, accident, and subsequent injury resulting in disability may be sufficient circumstantial evidence to prove a causal nexus between accident and employee's injury.*

In the present case the Arbitrator notes that there has been no evidence presented of a pre existing condition with respect to Petitioner's right knee, that Dr. Walsh agreed that Petitioner had sustained at least a sprain to the right knee, that the initial medical records indicate that Petitioner still had ecchymosis two weeks after the accident, the consistent nature of the complaints and the positive findings on the MRI in concluding that there is in fact a causal connection between Petitioner's current condition of ill being and the accident alleged herein.

G. What were Petitioner's earnings?

Petitioner testified he was paid a flat rate of $225 per day and worked Saturdays for 6 day weeks at least from November to February. However Petitioner also testified that he didn't

have any recollection of his wages with regard to verifying or denying the wage payments listed in the wage statement.

Reviewing the record and evidence considered in its entirety, the wage statement entered as Respondent Exhibit No. 4 is the best evidence of wages and supports an average weekly wage rate of $1,105.77. The Arbitrator so finds.

J. Were 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 Petitioner treated at Medworks, the company clinic in Joliet, Illinois, ATI in Bolingbrook for physical therapy and with the orthopaedic specialist, Dr. Steven Chudik at Hinsdale Orthopaedics in Westmont, Illinois.

The Arbitrator finds the following changes of these three facilities, reasonable and necessary to cure and relieve the effects of Petitioner's work injury to his right knee.

The Arbitrator finds these three charges related to Petitioner's work injury at Premier Transportation, which arose out of and in the course of his employment.

These charges are:

1.	ATI	$ 9,363.95
2.	Medworks	$ 856.50
3.	Hinsdale	$ 994.00
	TOTAL	$11,214.45

The arbitrator awards these medical bills and orders Respondent to pay these bills according to the Illinois Workers' Compensation fee schedule outlined in Section 8.2 of the Act.

K. Is Petitioner entitled to any prospective medical care?

Petitioner has undergone consistent extensive conservative care to date without any cure or relief for his right knee condition, which Dr. Chudik describes as an osteochondral injury to the lateral femoral condyle.

Conservative care at Medworks in the form of bracing, crutches and testing has not been effective in relieving Petitioner's condition. Physical therapy at ATI in Bolingbrook hasn ot provided relief either. A knee injection by Dr. Chudik to Petitioner's right knee only provided brief temporary relief.

Finally, on November 11, 2013, Dr. Chudik recommended and prescribed a right knee diagnostic arthroscopy with possible microfracture of the LFC of the right knee. (Pet. Exh. #4 & #5) The Respondent, Premier Transportation has not authorize the prescribed right knee surgery and since the Arbitrator finds said treatment reasonable, related and necessary the Arbitrator orders Premier Transportation to authorize and pay for the surgery and the subsequent follow up care as prescribed by Dr. Chudlik.

L. What temporary benefits are in dispute? TTD

Petitioner stopped working on August 23, 2013, the same day he went to the company clinic, Medworks in Joliet. Medworks treated him from August 23, 2013 until October 17, 2013. (Pet. Exh. #1) He was released to light duty or restricted work on several occasions, but the employer, Premier Transportation never tendered light work or restricted work for Petitioner.

When Petitioner started treating with Dr. Steven Chudik at Hinsdale Orthopaedics, he was prescribed no work, given documents to that effect and prescribed surgery for his right knee.

Based on the record as a whole , the Arbitrator finds that the Petitioner temporarily totally disabled from. from August 23, 2013 to the date of hearing November 20, 2013 or 12-5/7 weeks at a rate of $737.18 per week.

Respondent shall have credit for all amounts 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 of _____% shall accrue from the date listed below to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

STATE OF ILLINOIS)
) SS.
COUNTY OF)
JEFFERSON

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

George Engleby,

Petitioner,

vs.

NO: 09 WC 15433

14IWCC1010

Western Express,

Respondent.

REMAND

Timely Petition for Review having been filed by the Respondent herein and notice given to all parties, the Commission remands this matter back to the Arbitrator with instructions that he prepare a written decision with findings of fact and conclusions of law.

This matter proceeded to trial before the Arbitrator on November 8, 2013 under 19(b). The issues in dispute were causal connection, both prospective and incurred medical and temporary total disability. The parties went on to prepare a four volume transcript of those trial proceedings.

At the time of trial both attorneys advised the Arbitrator that they are not requiring a written decision containing findings of fact and his conclusions of law. They agreed to this, even though they offered four volumes of medical records and took depositions in this case.

Respondent reviewed the Arbitrator's decision which did not contain findings of fact or conclusions of law.

14IWCC1010

The Commission finds that without the Arbitrator's findings of fact or conclusions of law it is unable to properly review the Arbitrator's decision. Therefore, the Commission remands this matter back to the Arbitrator and instructs him to issue a full decision containing findings of fact and conclusions of law.

DATED: NOV 24 2014

Charles J. DeVriendt

Daniel R. Donohoo

Ruth W. White

HSF
O: 9/24/14
049

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)	☐ Reverse	☐ Second Injury Fund (§8(e)18)
WILLIAMSON		☐ PTD/Fatal denied
	☒ Modify up	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

CHRISTOPHER HURST,

Petitioner,

14IWCC1011

vs.

NO: 11 WC 24720

RUSTY'S HOME 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 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.

1. Petitioner performed general maintenance outside of Respondent's lumber yard, delivered materials to customers and unloaded trucks.

2. While walking inside on November 12, 2010, Petitioner was struck with a forklift tire on his foot and fell to the ground. The forklift then ran over his right shin.

3. Petitioner was admitted to Carbondale Memorial Hospital and was diagnosed with a grade 1 open right tibia fracture, compartment syndrome and mild complex regional pain syndrome. He underwent emergency surgery. A steel rod was placed in his leg and was screwed in. He then treated there for 18 months, along with physical therapy and work hardening.

4. Petitioner last treated at Carbondale Memorial for this injury on September 9, 2013. He returned to work 7 months after surgery but realized he could not jump or run anymore, and walked with a limp.

14IWCC1011

5. Petitioner has undergone two subsequent surgeries to remove screws from his leg because they were irritating him. The steel rod in his leg remains.

6. Currently he has purple, black and blue foot discoloration most of the day. He does not play golf as much as he did prior to the accident, feels right leg pressure when he picks up heavy items and experiences occasional ankle swelling.

The Commission affirms the Arbitrator's rulings on the issues of accident, causal connection and the permanent partial disability award of a 2.5% loss of use of his right foot.

The Commission, however, modifies the Arbitrator's ruling on permanent partial disability benefits related to Petitioner's leg. The Commission views the evidence slightly different than does the Arbitrator, and finds that Petitioner suffered a 42.5% loss of use of his right leg.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $220.00 per week for a period of 91-3/8 weeks, as provided in §8(e) of the Act, for the reason that the injuries sustained caused the 42.5% loss of use of his right leg.

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

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

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $18,400.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: NOV 2 4 2014
O: 9/24/14
DLG/wde
45

David L. Gore

Mario Basurto

Stephen Mathis

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

HURST, CHRISTOPHER
Employee/Petitioner

Case# **11WC024720**

14IWCC1011

RUSTY'S HOME CENTER
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:

FOLEY & DENNY
JOHN D FOLEY
PO BOX 685
ANNA, IL 62906

0299 KEEFE & DePAULI PC
NEIL GIFFHORN
#2 EXECUTIVE DR
FAIRVIEW HTS, IL 62208

STATE OF ILLINOIS)
)SS.
COUNTY OF WILLIAMSON)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
NATURE AND EXTENT ONLY

14IWCC1011

CHRISTOPHER HURST
Employee/Petitioner

Case # 11 WC 24720

v.

Consolidated cases: None

RUSTY'S HOME CENTER
Employer/Respondent

The only disputed issue is the nature and extent of the injury. An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable Molly Dearing, Arbitrator of the Commission, in the city of Herrin, on November 14, 2013. By stipulation, the parties agree:

On the date of accident, **November 12, 2010**, Respondent was operating under and subject to the provisions of the Act.

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

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

Timely notice of this accident was given to Respondent.

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

In the year preceding the injury, Petitioner earned **$18,656.65**, and the average weekly wage was **$358.78**.

At the time of injury, Petitioner was **21** years of age, ***single*** with **0** dependent children.

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

Respondent shall be given a credit of $- for TTD, $- for TPD, $- for maintenance, and **$308.92** for other benefits, for a total credit of **$308.92 as an overpayment of TTD to be credited against PPD**.

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

ORDER

Respondent shall pay Petitioner the sum of $220.00/week for a further period of 84.8 weeks, as provided in Section 8(e)(11) and 8(e)(12) of the Act, because the injuries sustained caused 2.5% loss of use of the right foot and 37.5% loss of use of the right leg, less Respondent's credit of $308.92 for overpayment of temporary total disability benefits.

Respondent shall pay Petitioner compensation that has accrued from September 9, 2013 through November 14, 2013, and shall pay the remainder of the award, if any, in weekly payments.

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

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

Signature of Arbitrator

Date

DEC 10 2013

STATE OF ILLINOIS)
)SS.
COUNTY OF WILLIAMSON)

14IWCC1011

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
NATURE AND EXTENT ONLY

CHRISTOPHER HURST,
Employee/Petitioner

v. Case 11 WC 24720

RUSTY'S HOME CENTER,
Employer/Respondent.

MEMORANDUM OF DECISION OF ARBITRATOR

FINDINGS OF FACT

As of the date of the accident, Petitioner was twenty four years old and employed by Respondent, a lumber yard located in Anna, Illinois. At or near the time of his accident, Petitioner's job duties included delivering materials to customers, unloading materials from trucks onto forklifts, and general maintenance.

On November 12, 2010, Petitioner was struck by a forklift driven by another employee. He was immediately taken to Memorial Hospital of Carbondale, and on November 12, 2010, Dr. C. David Wood performed a right tibia intramedullary nailing, irrigation and debridement of a grade 1 open right tibia fracture, four compartment fasciotomies of the right leg, and measurement of intercompartmental tissue pressures to address a grade 1 open right tibia fracture and impending compartment syndrome. This surgery required the implantation of hardware into Petitioner's right leg. Petitioner was eventually released from the hospital on November 15, 2010. PX 1.

Petitioner followed up with Dr. Wood on November 18, 2010, at which time Petitioner was noted to be doing well post-surgery, and Dr. Wood ordered Petitioner to return the following day to the operating room for a fasciotomy wound closure. On November 19, Petitioner underwent irrigation and debridement of fasciotomy wounds or the right leg with delayed primary closure. PX 2.

On November 30, 2010, Petitioner was diagnosed with right leg painful hardware. Dr. Wood noted a 3 mm gap at the fracture site that he opined would benefit from dynamization of tibial nail. Petitioner underwent physical therapy. On December 17, 2010, Dr. Wood performed a dynamazation of the right leg tibial nail. Thereafter, Petitioner underwent Exogen bone stimulation therapy and Petitioner's physical therapy was put on hold. Dr. Wood released Petitioner to return to work without restrictions as of March 9, 2011. PX 2.

Following his return to work, Petitioner complained of pain and swelling in his leg and toes. Dr. Wood authorized Petitioner to work four hours per day, and then undergo work conditioning the remainder of the day. Petitioner underwent work hardening from March 15, 2011 through March 28, 2011. PX 2.

On March 29, Petitioner returned to Dr. Wood with complaints of more pain and discomfort from his last visit. He specifically complained of pain on the plantar aspect of his foot and around the interlocking bolts distally. Radiographs obtained that day demonstrated more callus formation than previously seen, specifically over the posterior aspect of the fractures and the region over the anterior aspect. Dr. Wood recommended physical therapy address his plantar fascia. He allowed him to return to full work days, but restricted him from working on Saturdays and Sundays, and reduced his work hardening down to three days per week. PX 2.

Petitioner returned to work hardening from April 4 through May 9, 2011, at which time he was discharged. Upon discharge, Petitioner was noted to have met all of his goals, and to be tolerating work hardening in conjunction with his work activities. The plantar fasciitis on his right foot had also improved, and a return to work full duty was recommended. PX 2.

On May 10, 2011, Petitioner presented to Dr. Wood. He was doing fairly well after returning to work full duty, but voiced concerns about remaining sensitivity in and around his open injury. Radiographs obtained on that date demonstrated bony consolidation across the tibia fracture interval, and intact hardware without evidence of complication. Dr. Wood noted that his area of sensitivity may improve with time, and would not limit him in anything he wanted to do. He indicated that Petitioner's leg would never be the same again, however, it should not limit him in his activities. In regard to the possibility of additional medical care, Dr. Wood contemplated the possibility of removing the interlocking bolts as they are somewhat palpable on Petitioner's medial distal leg. Petitioner was discharged from Dr. Wood's care as of that date. PX 2.

Petitioner returned to Dr. Wood on March 12, 2012 with complaints of swelling, discoloration, and numbness and tingling in his right lower extremity. He reported continued difficulties with the right leg due to shooting pain and dysesthesias down into his foot associated with coldness and discoloration. A physical examination revealed no significant swelling. Dr. Wood was able to see all the veins down into the right foot. The right foot was cold, a bit sweaty, and somewhat purple in color. Dr. Wood noted some hair formation but not anymore than on the contralateral side. Petitioner had good range of motion in the ankle and non specific dermatographia. He had excellent range of motion in the knee and well-healed incisions. The proximal screw was unremarkable, and the nail insertion area was benign on examination. His open wound area was sensitive to taping Tinel's type examination, and the two distal interlocking bolts were very prominent. Radiographs obtained demonstrated normal bony anatomy and intact hardware. Dr. Wood's attributed Petitioner's symptomatology to injury in his saphenous vein, and indicated that the interlocking bolts could contribute to that as they are within the zone of the saphenous nerve. Dr. Wood prescribed Lyrica, and recommended the removal of the distal interlocking bolts. PX 2.

Petitioner underwent a Section 12 examination with Dr. Gary Schmidt on June 4, 2012. Dr. Schmidt's impression was that Petitioner had no sequelae from a compartment syndrome of healed tibial fracture. There was no explanation for complaints of weakness, nerve pain, or reported worsening of symptoms. Dr. Schmidt noted inconsistencies on examination as well as no atrophy or significant objective findings. He had no treatment recommendations for Petitioner, other than he found the removal of the distal locking screws to be reasonable. Dr. Schmidt recommended Petitioner continue to work full duty without restrictions, and opined that after the screw removal, no further treatment would be required. PX 3.

On September 21, 2012, Petitioner underwent a removal of painful internal fixation hardware with Dr. Wood. Petitioner was taken off work for a period of time, and again released to return to full duty work on October 4, 2012. PX 2.

On November 15, 2012, Petitioner followed-up with Dr. Wood, who noted Petitioner's leg to be substantially better. Petitioner was no longer having any popping sensation after the bolts had been removed, he had full range of motion of both his ankle and knee, his wounds were well-healed without evidence of infection or complication, he had good strength on examination, but he ambulated with a minimal limp on the right side as compared to the left. Dr. Wood released him from care and placed at maximum medical improvement. PX 2.

Petitioner returned to Dr. Wood on September 9, 2013 with complaints of continual numbness and pain over the right lower leg. He did not complain of the plantar or dorsal foot areas, but reported occasional numbness in the lower leg when waking up. The physical examination revealed normal range of motion, good motor strength, and sensation was good as well. Dr. Wood noted that that skin color was normal, but noted that Petitioner "indicates that occasionally, especially when he has rested for a period of time, his foot has a tendency to get very red or purple in nature." Radiographs were reviewed and found to show good healing with no evidence of complications. Dr. Wood's impression was that Petitioner suffered from persistent complaints of the right lower extremity after an open fracture complicated by compartment syndrome, with mild elements of hyper sympathetic flow and a "very, very mild" complex regional pain syndrome. Dr. Wood indicated that he did not think Petitioner's condition would improve, but indicated that it would not worsen. He was again released from care. PX 2.

At Arbitration, Petitioner testified that upon his return to work, he noticed that everything was different. He was unable to run or jump. Instead, he limped. Petitioner is presently working for Respondent loading and unloading materials for customers, delivering materials, cleaning up the lumber yard, unloading semi-truck trailers, and stacking lumber. Petitioner testified that he is essentially doing the same duties post-accident as he was before same. His is able to do his job satisfactorily.

Presently, Petitioner does not take medication, but he believes he may need to return to the doctor again. He testified to a limited ability to golf because of the turning and twisting mechanisms required in his right leg, and limitations in playing basketball. Petitioner notices a constant limp in his gait, which causes a callus to form on his right great toe. He testified that his right foot becomes discolored on the inner part of his right foot. Petitioner is unable to jump off of objects, as doing so creates a shock-like sensation in his right leg. Picking up objects puts

pressure on his right leg, so he limits the amount of weight he lifts. Petitioner's right leg condition is affected when he is on his feet for long periods of time, and he can feel changes in the weather. Petitioner currently has one screw in his right knee and a steel rod that runs inside of his bone from his knee to his ankle.

CONCLUSIONS OF LAW

Based upon the foregoing and the record in its entirety, as a result of his accident of November 12, 2010, Petitioner sustained a grade 1 open right tibia fracture and compartment syndrome, the condition and residual symptoms for which were surgically treated in three procedures, as well as with a bone stimulator, physical therapy, and work hardening. Petitioner was also diagnosed with extremely mild complex regional pain syndrome following the development of persistent symptomatology in his right foot. He returned to work full duty for Respondent, and by his own testimony, is able to continue to work the same duties following his return to work. Petitioner does not take medication. Petitioner still has a metal rod in his right leg spanning from his knee to his ankle, and a remaining screw in his knee from his original surgery. He testified that he walks with a limp in his gait, which was noted by Dr. Wood in his treatment record of March 12, 2012, that Petitioner indicated causes a callus to form on his right great toe.

The Arbitrator, having had an opportunity to view Petitioner's right lower leg and foot, and compare the same to his left lower extremity, notes that Petitioner has two discolored scars, each approximately five inches in length, on his right lower leg. The Arbitrator was able to observe pink and purple discoloration on the inner part of Petitioner's right foot and a callus on Petitioner's right great toe, which are consistent with his testimony at Arbitration regarding the current condition of his right lower extremity.

The Arbitrator finds Petitioner to be a credible witness at trial, as his testimony appeared to be candid and forthcoming. Petitioner testified to subjective complaints from his right knee into his right foot and right toes, and limitations in same following his accident and treatment, which the Arbitrator finds to be reasonable in light of the condition he suffered and the treatment he received. Therefore, in light of the severity of Petitioner's injury, the treatment received for his condition, Petitioner's continued complaints and limitations, and Petitioner's young age, the Arbitrator finds that Petitioner sustained permanent partial disability to the extent of 2.5% of his right foot and 37.5% loss of use of his right leg under Sections 8(e)(11) and 8(e)(12). Respondent shall receive credit for an overpayment of temporary total disability benefits in the amount of $308.92 against the permanent partial disability benefits. Therefore, Respondent shall pay Petitioner the sum of $220.00 per week for a period of 84.8 weeks, representing 2.5% loss of use of the right foot and 37.5% loss of use of the right leg, less Respondent's credit of $308.92.

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 down	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Joan Anderson,

Petitioner,

14IWCC1012

vs.

NO: 11 WC 02786

Steak-N-Shake,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of accident, causal connection, temporary total disability, medical expenses, prospective medical care, and permanent partial disability and being advised of the facts and law, modifies temporary total disability 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 45 year old employee of Respondent, who described her job as waitress/trainer/manager. Petitioner began working for Respondent as a waitress in March 2004 and was promoted to trainer before she became manager. Petitioner testified she had worked since she was 15, always in the food industry. She had gone to beauty school and became a licensed beautician, but she always did something with her hands. On the date of accident, May 30, 2008, Petitioner testified that they were busy and she was trying to keep the dining room cleaned up. Petitioner stated she was bussing tables and carrying back bus tubs. Petitioner testified she was wiping off the table and she was in a hurry and she had wiped off the table and felt and heard a pop in her right hand. Petitioner stated that it was really loud and the pain was excruciating like she had never

felt before; it just shot up all the way across her hand. Petitioner testified that she had never experienced any type of pain in her right hand prior to that and she had never before then received any treatment with a doctor for that. Petitioner testified of no prior treatment for pain in any joints in her body prior to this accident.

- Petitioner testified she told the managers on duty (either Matt Boyer or Paul Shaffer - she did not recall exactly) of the accident and she went home. Petitioner testified she had also told Brooke Tucker (the general manager) and other managers. She believed that Ms. Tucker was off until that Monday and she stated that she had also advised Dan Roark the district manager, of the incident. Petitioner again indicated that she felt the pop in her right hand when she was wiping off a table (indicating some movement). Petitioner testified that she was in a hurry that day because they were busy. Petitioner stated that as she was wiping the table she felt and heard the pop in her hand around the thumb joint around her wrist and she felt excruciating pain. She again indicated they were busy "as all get out." Petitioner subsequently did seek medical treatment that afternoon, May 30, 2008. Petitioner went to Dr. Hoffman; she could not get in to see her doctor so she saw her spouse's doctor. Dr. Hoffman examined Petitioner and referred her to Dr. Triana, an orthopedic surgeon, about June 10-11, 2008. Petitioner saw Dr. Triana who ordered an MRI and examined Petitioner. Petitioner had the MRI and returned for a follow up with Dr. Triana; in the interim Petitioner had seen her family doctor, Debbie Hayes, whom Petitioner had been seeing for 20 years. Petitioner testified her doctor referred her to Dr. Williams, another orthopedic surgeon. Petitioner indicated she went to the other orthopedic doctor because Dr. Triana said the condition was out of his realm, out of his specialty and he was not comfortable with it. Petitioner testified that Dr. Triana stated that the condition was more complicated than what he felt comfortable with and he wanted Petitioner to see a hand specialist. Petitioner had first seen Dr. Williams in October 2009 and subsequently had surgery to the thumb area of her hand on November 13, 2009. Petitioner understood the surgery was to replace the thumb joint. Post surgery, Petitioner was placed in an Ace bandage and then into ma cast. She had treated with him until January 2010 and was released. Petitioner stated then the pain had increased and was a little bit worse, the surgery had not helped; it was bad. Petitioner indicated in November (November 2009, shortly after the surgery) she had gone to the emergency room. Petitioner indicated she had been letting the dog out (big black lab) and was not going fast enough for the dog. The dog hit the door and the door hit her hand. Petitioner stated that she was worried that she had messed it up and that was why she had gone to the emergency room; to get her hand checked out to be sure it was okay. Petitioner had been examined at the ER and released. Petitioner testified that the incident did increase the pain in her thumb for a little while. She indicated that the dog incident had made it a little bit worse but then it went back to her normal level of pain. Petitioner testified she did not go back for treatment for that particular incident.

- Petitioner testified in February 2010 she had a subsequent surgery. Petitioner stated at that time her body started to reject the joint and the pin that was holding the joint in actually came out through her hand. Petitioner testified she had gone back to Dr. Triana and the doctor said he had to take the joint back out because Petitioner's body was rejecting it. The replacement of the thumb joint had been done by Dr. Williams but she

had gone back to Dr. Triana to have him look at it when the pins were coming out. Petitioner indicated Dr. Triana went in and took the joint out and the hardware and put a spacer in. Petitioner indicated there was an abscess around the bone so the doctor wanted to test it to make sure it was okay and he went in again about a week later and put in another joint (around March 5-6, 2010). Post surgery, Petitioner was referred for physical therapy at Atrium at Methodist, and she went and had completed that. Petitioner testified her pain had gotten no better at all post surgery and the more she moved it, the more it hurt. Petitioner stated that it would cramp and she noted that it shrank, the muscle was gone, and it was disfigured. Petitioner had another surgery with Dr. Triana in late June 2010. Petitioner indicated that she understood that the scar was too wide and had deep tissue growing out of it and they had to go in and cut that off that tissue. Petitioner had further therapy after that surgery at Atrium at Methodist.

- Petitioner testified after that, Dr. Triana left town so she did not have a doctor and she had tried calling other orthopedic doctors. Petitioner stated that she had called Dr. Mitzelfelt; however, when he found out about the surgery Dr. Triana had performed, he refused to see her. Petitioner testified she tried to return to Dr. Williams but he also refused to see Petitioner as she had gone to Dr. Triana. She indicated she had tried every doctor in Peoria. Petitioner testified that she eventually found Dr. Rhode, from Rush in Chicago. Petitioner stated that Dr. Rhode would come down there every other week so she went to see him April 6, 2011 (Dr. Rhode deposition was noted). Petitioner believed she had seen Dr. Rhode about 10 times.

- Petitioner testified that she was still in pain and that was when the muscle atrophied even more and became more disfigured. Dr. Rhode wanted Petitioner to see Dr. Frederick at Rush as he is a hand specialist who deals with more complicated cases. Petitioner indicated they had been trying to make an appointment and get it approved through WC, but she did not see him as Respondent sent Petitioner to see Dr. Wysocki (for a §12 examination [IME], October 19, 2011) who was in the same group. After the IME she received a call from Dr. Frederick's nurse saying they could not see Petitioner. She indicated that was kind of the end of things. Petitioner had not seen any other doctors since. Petitioner testified that she understood her options for treatment was either leave it as is and deal with the pain, or have her thumb cut off and have her index finger moved there, but that did not guarantee the pain would go away. She indicated the Dr. could not say if it would be any better with that surgery. The other option was getting the joint fused so it looked normal, but again, that would not take the pain away. Petitioner indicated at her age (51) she did not care how her hand looked. She had been through 4 surgeries and had enough and they could not say further care would make it any better. Petitioner testified that it hurts all of the time; it is a dull ache all the time. Petitioner stated that if she bumps it or strains it, it will hurt and now her whole hand is starting to cramp up. Petitioner testified the doctor said her thumb was of no useful consequence and she agreed pretty much with that.

- Petitioner stated that she was taken off work when she initially saw Dr. Hoffman, May 30, 2008 and then Dr. Triana kind of went back and forth. Dr. Triana would sometimes say she could do one handed work (work left handed only) but that was about it.

Petitioner indicated that if she would be in more pain he would take her back off of work. Petitioner was terminated by Respondent on September 30, 2008. Petitioner did not work again until June 2011 because she had to. She indicated her teen son had committed suicide in their backyard and she needed money. Petitioner testified she had a neighbor who had a cleaning business and she offered Petitioner some things to take up Petitioner's time to get out of the house. Petitioner testified at that point Dr. Rhode had released Petitioner to one handed work and Petitioner worked for her neighbor (Linders Cleaners). Petitioner testified she worked one handed as more of a supervisor, she would dust occasionally with her left hand, but it was more supervisory. Petitioner no longer worked for them as the Linder's had moved to Iowa. Petitioner currently does work as she owns her own cleaning business with two employees. Petitioner sets the appointments and takes the checks and goes with the employees to make sure they are doing the job, and she talks to the customers to make sure they are happy. She is still released to only one hand work. Petitioner testified she does try sometimes to use her right hand; she had learned to adapt. Petitioner indicated you cannot get dressed with one hand and you cannot do a lot of things; you cannot tie your shoes with one hand; with no right thumb use she indicated she had learned to manipulate with getting dressed and cooking. She can use her fingertips but that is causes pain; she can lift with her fingertips as she does not have a choice. Petitioner stated that she does garden as her spouse will till and she tries to use her left hand. She may have to balance with her right hand, but nothing heavy. She indicated she can steady a pan with her hand when cooking an egg, but she cannot pick up the pan and move it. Petitioner testified her hand was atrophying, fading away from non-use. Petitioner stated that she takes Norco occasionally for the pain (prescribed by her primary doctor); however, she tries not to take it because it is addictive. Petitioner indicated that if she is in a lot of pain and cannot sleep it will dull the pain, but does not really take the pain away. Petitioner indicated she had taken it for so long that it only dulls the pain a little. Other than her primary doctor, she was not seeing any other doctors. Petitioner stated that she had been on short term and long term disability. Petitioner agreed there is an itemization of outstanding medical bills (PX17) and she indicated it was accurate and up to date. Petitioner had no plans of seeking additional medical care as there was nothing else they could do.

The Commission finds that there is no evidence Petitioner had any problems of significance with her right hand or thumb prior to this reported incident. The medical records support her ongoing complaints and symptoms since the date of accident throughout her treatment and is consistent with Petitioner's testimony. The surveillance video does not reveal anything to be contrary to Petitioner's testimony. Petitioner had some apparent pre-existing mild arthritic condition, but again there was no evidence of symptoms prior to this incident. The evidence and testimony appears consistent and supportive that Petitioner had sustained an accident May 30, 2008 and there is evidence in support of a causal relationship with the medical records noting her history of injury on the job similar to her testimony. There was a period from October 13, 2008 through June 29, 2009 where there is no evidenced treatment, which raises the issue of an ongoing causal connection given the approximate 8 month gap in treatment. Petitioner's complaints, symptoms and findings thereafter are still consistent with the 2008 treatment and then throughout the remainder of her treatment (through injections and the multiple surgeries) up to her testimony at

hearing. Petitioner clearly evidenced and the Arbitrator had the opportunity to view Petitioner's right hand and thumb to see the end result. While there is no explanation for the break in treatment, everything is still consistent and supportive of an ongoing causal connection to Petitioner's current condition of ill-being, despite Respondent's IME's (Dr. Wysocki) opinion that the incident did not cause or aggravate a pre-existing condition, given the treating medical records clearly reflecting the ongoing condition since the date of this incident. Petitioner's testimony is really unrebutted and the evidence and testimony does support a finding that Petitioner sustained an accident that arose out of and in the course of her employment with the evidence further supporting a causal connection (cause or aggravation of a pre-existing condition) to her current condition of ill-being. 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 of accident, as well as, affirms and adopts the Arbitrator's finding as to causal connection.

The Commission notes, regarding the issue of temporary total disability (TTD) that the Arbitrator found that Petitioner was entitled to an award of 152-3/7 weeks of temporary total disability benefits (6/11/08-1/18/10 & 2/15/10-6/9/11) at a rate of $442.31 per week under §8(b) of the Act ($67,420.68 total TTD). Respondent paid $-0- in TTD benefits and received a credit of $19,083.60 for Long & Short term disability paid to Petitioner. The Commission finds the first awarded period of TTD fully supported by the evidence presented by Petitioner. After the initial surgery and some recovery time, Petitioner was released from the care of Dr. Williams. Petitioner did remain symptomatic and Petitioner had evidenced post-operative complications and sought further care which required additional surgical procedures and, unfortunately complications, the final surgery being irrigation and debridement and wound closure June 24, 2010. The medical records indicated a three to six month recovery period post surgery. Given Petitioner's apparently poor recovery rate the Commission considers her recovery at six months, December 24, 2010 (as the assumed MMI date). At that point Petitioner's condition appeared to have stabilized/plateaued. Medical records are rather silent as to stating specifically her work status, but there is no evidence Petitioner had reached maximum medical improvement or that her condition had in any way stabilized prior to that point. It is also clear that Petitioner did not first see Dr. Rhode until April 6, 2011, when he then took Petitioner off of work, and it is not clearly evidenced what went on during that interim period. The appointments with Dr. Rhode give no indication of any real treatment which further supports the position that Petitioner's condition had by then stabilized. Given the documentation of the expected recovery period, and the gap in documented treatment, it is difficult to find Petitioner entitled to any lost time benefits with the start of seeing Dr. Rhode in April 2011 when then there was no clear treatment provided. Additionally, Dr. Rhode was also Petitioner's third choice of 'treaters'. The Commission, therefore, modifies the TTD award to find Petitioner proved entitlement to benefits June 11, 2008 through January 18, 2010 and February 15, 2010 through December 24, 2010 (128-6/7 weeks at $442.31 per week [total TTD=$56,994.80] with Respondent entitled to the disability credits totaling $19,083.60). The Commission finds the decision of the Arbitrator not totally contrary to the weight of the evidence and herein modifies the Arbitrator's finding as to total temporary disability as noted above.

14IWCC1012

The Commission further finds, with the above finding of accident and causal connection to Petitioner's condition of ill-being, that the medical records of her treatment consistent with the testimony. Accordingly the Commission finds that Petitioner met the burden of proving entitlement to the awarded benefits and affirms the award as is regarding medical expenses. The Commission finds Dr. Rhode as a third choice of medical providers and that there had been a significant gap in treatment before Petitioner even sought out his care. The Commission can find 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/prospective medical care.

The Commission, with the above finding of accident and causal connection to her condition of ill-being, finds regarding permanent partial disability (PPD), the medical records of Petitioner's treatment consistent with testimony and affirms the award as is to find Petitioner met the burden of proving entitlement to the awarded PPD benefits. The awarded PPD benefits are well supported with the evidence, especially given the multiple surgeries and post-operative complications. 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 Permanent partial disability.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed January 3, 2014, (other than the below noted TTD modification), is hereby affirmed and adopted.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $442.31 per week for a period of 128-6/7 weeks, that being the period of temporary total incapacity for work under §8(b) of the Act. Respondent entitled to a credit of $19,083.60 for short term and long term disability benefits paid to Petitioner.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $398.08 per week for a period of 112.75 weeks, as provided in §8(e)(9) of the Act, for the reason that the injuries sustained caused the 55% loss of use of Petitioner's right hand.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay all reasonable and necessary medical bills for services, with the exception of the medical bills from Dr. Blair Rhode, as provided in §8(a) and §8.2 of the Act, subject to the fee schedule. Respondent is not liable for medical bills incurred by Petitioner for the services of Dr. Rhode.

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

14IWCC1012

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: NOV 24 2014
o-9/24/14
DLG/jsf
45

David L. Gore

Stephen Mathis

Mario Basurto

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

ANDERSON, JOAN
Employee/Petitioner

Case# **11WC002786**

14IWCC1012

STEAK N SHAKE
Employer/Respondent

On 1/3/2014, 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 0.09% 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:

0192 CUSACK GILFILLAN & O'DAY
DANIEL P CUSACK
415 HAMILTON BLVD
PEORIA, IL 61602-1102

1832 ALHOLM MONAHAN KLAUKE ET AL
GEORGE F KLAUKE JR
221 N LASALLE ST SUITE 450
CHICAGO, IL 60601

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 14IWCC1012

JOAN ANDERSON
Employee/Petitioner

Case # 11 WC 02786

v.

Consolidated cases: ____

STEAK N SHAKE
Employer/Respondent

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable Molly Dearing, Arbitrator of the Commission, in the city of Peoria, on October 24, 2013 and October 29, 2013. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

14IWCC1012

On **May 30, 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 **$34,499.92**; the average weekly wage was **$663.46**.

On the date of accident, Petitioner was **45** years of age, ***single*** with **1** dependent children.

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

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

Respondent shall be given a credit of **$0.00** for TTD, **$0.00** for TPD, **$0.00** for maintenance, and **$19,083.60** for short term and long term disability benefits, for a total credit of **$19,083.60**.

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

ORDER

Respondent shall pay all reasonable and necessary medical services, with the exception of medical bills from Dr. Blair Rhode, as provided in Sections 8(a) and 8.2 of the Act, subject to the fee schedule. Respondent is not liable for medical bills incurred by Petitioner for the services of Dr. Rhode.

The parties stipulated that Respondent is entitled to a credit of $19,083.60 for short term and long term disability benefits paid to Petitioner. Respondent shall pay Petitioner temporary total disability benefits of $442.31 per week for a total period of 152 3/7 weeks, representing June 11, 2008 through January 18, 2010, and February 15, 2010 through June 9, 2011, less Respondent's credit of $19,083.60. Respondent shall pay Petitioner the temporary total disability benefits that have accrued from May 30, 2008 through October 29, 2013, and shall pay the remainder of the award, if any, in weekly payments.

Respondent shall pay Petitioner permanent partial disability benefits of $398.08/week for 112.75 weeks, because the injuries sustained caused the 55% loss of use of the right hand, as provided in Section 8(e) of the Act.

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

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

Signature of Arbitrator

December 19, 2013
Date

JAN 3 - 2014

STATE OF ILLINOIS)
)SS.
COUNTY OF PEORIA)

14IWCC1012

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

JOAN ANDERSON,
Employee/Petitioner

v. Case 11 WC 02786

STEAK N SHAKE,
Employer/Respondent.

MEMORANDUM OF DECISION OF ARBITRATOR

FINDINGS OF FACT

At the time of her accident, Petitioner was forty five years of age. She began working for Respondent in March 2004 as a waitress. Petitioner was then promoted to a trainer before becoming a manager. On May 30, 2008, Respondent's restaurant was busy. Petitioner was attempting to keep the dining room clean by bussing and cleaning tables. She was hurriedly wiping down a table when she felt a pop in her right thumb followed by excruciating pain shooting up through her hand. Petitioner immediately told the manager on duty, who, according to Petitioner, would have been Matt Boyer or Paul Shaffer. Petitioner testified that she also told Brooke Tucker, the General Manager, the following Monday, and Dan Roark, a district manager. Petitioner had never experienced pain in her right hand prior to the work incident, nor had she been treated by a physician for any right hand symptoms.

Because she could not get in to see her primary care provider, Petitioner presented to Dr. Daniel Hoffman, on May 30, 2008. Petitioner presented to Dr. Hoffman with symptoms of right hand swelling. Dr. Hoffman noted tenderness and swelling over the dorsal aspect of the right hand, and assessed Petitioner's condition as a soft tissue injury versus ganglionic cyst. Dr. Hoffman prescribed medication and referred her to Dr. Jeffrey Traina. PX 1.

Petitioner presented to Dr. Traina on June 11, 2008 complaining of a problem in her wrist. She reported that she was at work a week and a half prior when she was cleaning a table and had immediate pain in her hand. Petitioner reported to Dr. Traina "one episode of previous pain before in her hand but it has never been as severe as it was ten days ago." A physical examination revealed tenderness over the base of the second metacarpal, some localized swelling in the area, relatively little pain in her wrist, no swelling at the carpal joint, and a normal carpometacarpal joint. Dr. Traina's impression was edema with pain over the second metacarpal secondary to overuse. He ordered her off work, prescribed a wrist brace and anti-inflammatory medication, and ordered her to return in ten days. PX 2.

Petitioner returned to Dr. Traina on June 23, 2008, at which time she reported doing better, but still symptomatic. He ordered her to return in three weeks, and continued her off work status until that time. PX 2. Subsequently, Petitioner continued to treat with Dr. Traina, wherein Petitioner continued to experience symptomatology at the base of the second metacarpal of her right hand with little improvement utilizing the brace. Dr. Traina ordered an MRI. PX 2.

The MRI of July 24, 2008 revealed no acute abnormality within the base of the right second digit, mild thickening and findings suggestive of chronic injury to the first metacarpal joint, and mild degenerative changes of the first CMC and MTP. Following her MRI, Petitioner followed-up with Dr. Traina on July 28, at which time he ordered her to one-handed work only, prescribed therapy and anti-inflammatory medication.

Petitioner again saw Dr. Traina on August 12, 2008 with continued symptomatology and reported that she was unable to attend therapy as of yet due to a family emergency. He ordered her to continue use of the brace, and indicated if there was no improvement with same, then he would try a cortisone injection. PX 2. Continued modalities of treatment were attempted, including a thumb spica brace and a cortisone injection in the CMC joint with Celestone, all of which were unsuccessful in relieving her pain. Dr. Traina referred Petitioner to a hand surgeon. PX 2.

On June 15, 2008, Petitioner completed a Short Term Disability Claim Form, wherein she alleged that her disability was due to an illness. Dr. Traina completed the physician's portion of the disability form on June 20, 2008. In response to the question, "Is condition work related?" he checked the box "No". RX 3.

The Arbitrator finds no treatment records in evidence between Petitioner's treatment with Dr. Traina on October 13, 2008, and treatment with Dr. Hoffman on June 29, 2009, an approximately eight month gap in treatment.

Petitioner returned to Dr. Hoffman on June 29, 2009 with continued complaints of pain on the dorsal aspect of her right hand, which showed tenderness and swelling upon examination. Dr. Hoffman's impression was tendonitis or possible RSD. He ordered her to remain off work and advised her return to Dr. Traina for additional studies. PX 1.

Petitioner testified that in the meantime, she sought treatment with her primary care provider, Debbie Hays, a nurse practitioner, who referred her to Dr. James Williams. A singular treatment record from Debbie Hayes with a date of service of August 31, 2009 appears amongst the records of Dr. Williams.

On October 22, 2009, Petitioner presented to Dr. Williams at the Midwest Orthopaedic Center with complaints of right thumb basilar joint pain, which reportedly began in May while wiping up a table as a manger at Steak N Shake. After reviewing her MRI and radiographs, and performing a physical examination of her showing tenderness over the joint, Dr. Williams recommended a right thumb CMC joint arthroplasty as an outpatient procedure. Petitioner underwent that procedure on November 13, 2009 at Methodist Medical Center of Illinois. PX 4.

Seven days after surgery, on November 20, 2009, Petitioner presented to the Emergency Department at Methodist Medical Center of Illinois with a history of catching her thumb in a door, feeling a pop, and experiencing pain. Radiographs were taken, which showed surgical placement of K-wire across the carpometacarpal junction of the right wrist at the level of the trapezium and base of the second metacarpal. Petitioner was given pain medication and discharged. PX 5.

Post-operatively, Petitioner experienced pain with finger movement, which resolved. Dr. Williams noted that her post-operative radiographs looked fantastic. Petitioner underwent therapy, and was released to work without restrictions on December 1, 2009. At her final visit with Dr. Williams on January 18, 2010, Petitioner was experiencing some residual tenderness, which Dr. Williams thought would resolve, and she reported an inability to fully lay her thumb flat or hyperextend her thumb. Dr. Williams believed both limitations were due to the increased laxity at Petitioner's metacarpophalangeal joint. He indicated that both limitations could only be prevented by a complete fusion to that joint, but he did not recommend that procedure. Dr. Williams released her from his care on that date. PX 4.

On February 15, 2010, Petitioner returned to Dr. Traina, and reported no relief from the surgery performed by Dr. Williams. A physical examination revealed tenderness over the CMC joint with motion of the thumb, some swelling, no redness, heat or warmth, diffuse tenderness without apparent abnormality, and a well-healed incision. Dr. Traina's assessment was a questionable problem versus infection, for which he ordered radiographs to ascertain questionable fracture of the metacarpal and blood work. He applied a short-arm thumb spica and asked her to return in one week. RX 2.

Radiographs of the right hand obtained on February 15, 2010 revealed postoperative changes and a vertical fracture line extending along the shaft of the proximate first digit metacarpal. PX 8.

Petitioner returned to Dr. Traina on February 22 with complaints of feeling like the pin in her hand was coming out. Dr. Traina noted that radiographs confirmed showed the pin to be migrating, and a bone scan obtained on February 18, 2010 was abnormal and showed increased uptake, but did not reveal any fracture. RX 2, 9. Petitioner was having significant pain and some tinting of the skin. Dr. Traina recommended removing the pin and exploration of the CMC joint. RX 2.

On February 23, 2010, Petitioner presented to the Emergency Department at Methodist Medical Center of Illinois with complaints of a pin protruding out of her right wrist. She reported that she had difficulties with one of the pins coming out of her wrist following her surgery with Dr. Williams, and that Dr. Traina had scheduled her for surgery to remove the pin, but she indicated the pin seemed to be protruding farther than normal on this date. A physical examination revealed that the pin was not "through and through, but it is quite pronounced." Radiographs obtained showed a metallic pin tenting the skin. The Emergency Department personnel spoke with Dr. Traina, who recommended her wrist be splinted with a dressing, and Petitioner was discharged. PX 11.

On February 25, 2010, Dr. Traina performed a removal of carpometacarpal implant of the right thumb with irrigation and debridement and insertion of antibiotic cement spacer and removal of retaining pins. PX 2, PX 12. One week later, on March 4, 2010, Dr. Traina performed a carpometacarpal reconstruction of the right wrist at the first metacarpal with a graft jacket implant. PX 13. Post-operatively, she was placed in a thumb spica cast, but developed an open area with deep tissue coming out. Dr. Traina attempted to excise this in the office on June 18, 2010 without success secondary to discomfort. He scheduled her for surgery to further excise the tissue. On June 24, 2010, Dr. Trina performed a right thumb irrigation and debridement. Petitioner did well post-operatively with the aid of a thumb splint. PX 2.

Petitioner began therapy on July 19 and reported some relief from treatment. She was discharged from therapy on December 15, 2010. PX 15.

On August 4, 2010, Petitioner returned with complaints of a burning sensation in her hand, which Dr. Traina noted to be a relatively new finding. Petitioner had a significant contracture of the MCP joint. Petitioner was undergoing therapy, and Dr. Traina recommended continued aggressive therapy. She thereafter failed to present to her office visit of August 25, 2010. Dr. Traina noted on September 17, 2010 that physical therapy wanted to restart therapy, which Dr. Traina could not order until Petitioner re-presented to him. Dr. Traina was leaving the Peoria area and indicated she would need to find another orthopedic provider. PX 2.

Petitioner returned to Dr. Traina on October 23, 2010 and reported an inability to continue therapy due to the recent suicide of her son. She complained of pain over the CMC joint and weakness bilaterally. Dr. Traina restarted physical therapy, ordered pain medication, and referred her to Great Plains Orthopedics. PX 2.

After concluding treatment with Dr. Traina, Petitioner testified that she attempted to seek treatment with other doctors, such as Dr. Mitzelfelt of Pekin, and attempted to return for treatment with Dr. Williams, but both physicians declined to treat her because of her previous treatment with Dr. Traina. She stated that she "tried every doctor in Peoria", but without success. Eventually, she saw Dr. Rhode, who was referred to her by her attorney.

Petitioner presented to Dr. Rhode on April 6, 2011. His impression was that she suffered from a painful CMC graft jacket. Dr. Rhode believed this to be a "complicated condition that I believe requires a subspecialist in hand surgery." He recommended Petitioner follow-up with Dr. John Fernandez at Rush, and ordered her off work until she was evaluated by a hand specialist. PX 16.

Before Petitioner could secure an appointment with Dr. Fernandez, she was scheduled for a Section 12 examination with Dr. Wysocki at Rush Hospital. Due to the Section 12 examination, Dr. Fernandez's office would not see Petitioner because she had already seen another physician within the group. Dr. Rhode referred Petitioner to Dr. Mark Cohen, who refused to see her for similar reasons as Dr. Fernandez. Dr. Rhode then referred her to Dr. Oakey. PX 16.

On March 7, 2012, Petitioner presented to Dr. Rhode with no reported change in symptoms. He believed that she had plateaued secondary to her inability to gain access to

medical treatment. Dr. Rhode opined that Petitioner's right wrist would not improve and would likely worsen without further medical treatment. He stated that she had essentially lost all opposition and key pinch strength, and continued to experience debilitating pain at the first CMC joint. He recommended she take oral pain medication indefinitely and indicated she may benefit from steroid injections into the first CMC joint. PX 16.

On April 18, 2012, Petitioner followed-up with Dr. Rhode, who indicated that Petitioner's treatment options consisted of a revision fusion versus a foam amputation. Dr. Rhode ordered permanent restrictions on Petitioner of no use of the right upper extremity, and placed Petitioner at maximum medical improvement. PX 16.

Dr. Rhode testified by way of evidence deposition. Dr. Rhode felt that because Petitioner's case was a complex hand case, he did not want to "do something that I felt was outside the scope of my practice, which I felt this was, so I felt most appropriate to refer her to a subspecialist." PX 19, Pg. 10. He recommended Petitioner see Dr. John Fernandez at Rush Hospital, a hand specialist, but because Petitioner was scheduled for a Section 12 examination with one of Dr. Fernandez's partners, she was unable to see Dr. Fernandez. Even after Petitioner was unable to treat with Dr. Fernandez, Dr. Rhode did not want to surgically treat Petitioner because "[a]gain this is out of the scope of practice for what I do." PX 19, Pg. 11. Dr. Rhode then referred her to Dr. Mark Cohen, a hand specialist, who was unable to treat Petitioner for a similar reason. Dr. Rhode hoped that someone would do a fusion with bone graft on Petitioner, but stated "I would hope–and it's out of the scope of my practice. As I said before, I don't feel comfortable treating this patient surgically." PX 19, Pg. 13.

Dr. Rhode indicated that Petitioner has a painful "floppy finger" that could benefit with a higher level of function and a lower impairment and disability if the thumb was linked back to the wrist. If she were to undergo an amputation of the thumb, Dr. Rhode indicated that it would be devastating to her function in that wrist. Absent any surgery, Dr. Rhode did not anticipate Petitioner being able to resume using her right hand for work. With regard to causation, Dr. Rhode opined that Petitioner aggravated her pre-existing arthritis, causing her thumb to become symptomatic and precipitated surgery. In formulating his opinion, Dr. Rhode testified that he reviewed an MRI of July 24, 2008, a verbal history from Petitioner, radiographs obtained in his office, and a Section 12 examination report from Dr. Wysocki. He did not have the records of Dr. Hoffman, Dr. Traina or any other physicians. Dr. Rhode acknowledged that he did not treat Petitioner, other than having discussions with her regarding an injection and an assessment with a hand specialist. PX 19.

Petitioner was examined by Dr. Wysocki at the request of Respondent on October 19, 2011 pursuant to Section 12. Dr. Wysocki reviewed the treatment records of Dr. Hoffman, Deborah Hayes, Dr. Williams, and Dr. Traina as well as operative reports from Methodist Hospital. Dr. Wysocki also reviewed radiographs, the MRI and a bone scan. He performed a physical examination, performed radiographs in his office, and took a history from Petitioner. Petitioner described wiping down a table with a relatively sudden onset of pain in the right thumb. She did not recall having any problems in her hand prior to the May 30 incident, and at the time she saw Dr. Wysocki, she reported that her hand was essentially useless to her in that she did not use her right thumb whatsoever. The only way she utilized her hand was to perform

a small amount of pinching between any combination of the index through small fingers with no use of the thumb. Dr. Wysocki's assessment was right thumb pain, stiffness, and dysfunction stats post surgical treatment of CMC arthritis. Based on his review of records, the history obtained from Petitioner, and the physical examination, Dr. Wysocki opined that Petitioner's current thumb condition was not casually related to the work injury of May 30, 2008, reasoning that he would not expect performing wiping motions over a table would be significant enough injury to alter the natural history of underlying thumb CMC arthritis or cause a new onset of thumb CMC arthritis. Dr. Wysocki stated that he would recommend a thumb MCP arthrodesis, thumb MCP joint fusion, a ligament reconstruction suspensionplasty, or thumb amputation. Dr. Wysocki placed her at maximum medical improvement barring any further surgical intervention to the right hand, and he believed an appropriate work restriction would be no lifting, pushing, pulling greater than five pounds with the right hand for gross motor only, with no fine motor use. Dr. Wysocki also suggested a functional capacity evaluation to more accurately set her permanent restrictions. RX 1.

Dr. Wysocki testified by way of evidence deposition on February 1, 2013 concomitantly with his report. Dr. Wysocki testified that with regard to causation, he did not expect a low energy activity and mechanism such as wiping down a table to be significant enough trauma to a thumb CMC joint to either generate CMC arthritis or serve as a significant trauma to cause an aggravation of a pre-existing condition. He defined "aggravation" to be performing an activity or sustaining trauma such that it alters the natural history of whatever the underlying process is. "If someone undergoes an activity or undergoes a trauma that is so intense that it alters the natural history of it and causes almost irreversible damage to that underlying condition, that would be considered a kind of permanent and an effective aggravation of that preexisting condition, something more than just something that brings out manifestations." RX 1, Pg. 45.

Dr. Wysocki attributed the onset of symptomatology following the May 30, 2008 accident to a manifestation of symptoms. He testified that the accident manifested a potentially mild underlying CMC thumb arthritis, and that the pain Petitioner experienced following the accident drove her to have the surgical procedures she underwent prior to presenting to him. He indicated that the symptoms she was currently experiencing could be triggered by a reaction to the graft jacket implant, symptomatic impingement as the metacarpal approaches the scaphoid, or pain upon substantial hyperextension at the MCP joint. Dr. Wysocki testified that the restrictions he recommended for Petitioner were not caused or aggravated by the events of May 30, 2008. Dr. Wysocki noted that Petitioner was primarily problematic in the radial side of the right hand and in the right thumb, and testified that Petitioner's right hand had significant restrictions with thumb movement. Dr. Wysocki stated that even if Petitioner were to undergo additional surgery, she still had a guarded prognosis. RX 1.

At Arbitration, Petitioner testified that she has been given three options for treatment. She can leave her hand and thumb as they are, have the thumb amputated and move her index finger to the location of her thumb, or have the thumb joint fused. If her physician was confident that her thumb would work and be less painful, she indicated that she may undergo surgery. However, her physician has indicated that the thumb amputation may not alleviate her pain, and the fusion may not provide her additional functionality. As such, she has elected to forego any further treatment.

During her treatment, Petitioner testified that Dr. Hoffman took her off work on May 30, 2008. Petitioner stated that Dr. Traina "went back and forth" regarding her off work status, taking her off work when her hand became painful, and returning her to restricted work of one-handed work only at other times. Although Petitioner initially testified Respondent could not accommodate her restrictions, she later testified that she does not remember if she returned to Respondent after her accident to request employment within her restrictions.

Petitioner was terminated from her employment with Respondent on September 30, 2008. She received short term and long term disability from Respondent from June 2008 until July 10, 2009. She did not work again until June 10, 2011, when she began working for Linder's Cleaning Service in a one-handed capacity in what Petitioner described as a supervisory position. Linder's Cleaning moved out of state, and in December 2012, Petitioner began her own cleaning company. She employs two other individuals. Petitioner testified that she sets appointments, takes checks, accompanies her employees to cleaning jobs to ensure their performance, talks to the customers, and ensures the happiness of the customers.

Regarding her limitations in her right hand, Petitioner testified on direct examination that her thumb is of no useful consequence. She presently experiences a dull ache sensation all of the time, and if she bumps or strains it, it causes pain. Petitioner also experiences cramping in her entire right hand. She indicated that she has to use her right hand "sometimes", and she has learned to manipulate her right hand to get dressed or cook. Petitioner can pick up objects using her fingertips, and may steady a pan with the right hand, but she cannot pick it up and move it with her right hand. She continues to garden with her wife using her left hand. Petitioner takes Norco for pain relief, which is prescribed by Debbie Hayes.

On cross examination, Petitioner testified that in her supervisory capacity for Linder's Cleaning, she would only lift things using her right fingertips. Petitioner acknowledged that she can drive as long as she does not have to make any sharp moves. Although she indicated that she cannot carry things, such as a plate or cup of coffee, because her hand cramps up, she testified that she can "sometimes" carry paper or a folder, and "on a good day" carry a binder. According to Petitioner, she cannot carry a tray, a spatula, turn a key, or vacuum with her right hand. She has no problems with her left hand, and her right arm is well. On redirect examination, Petitioner indicated that when she visits her cleaning sites, she pitches in and helps her staff carry in items.

Respondent admitted Restroom(s) Daily Cleaning Checklist and Service Work Verification Sheet forms as RX 4. The Restroom Daily Cleaning Checklists include Petitioner's signature as the cleaning service representative, and indicate twelve items that are checked off by both the cleaning service and the General Manager. The Service Work Verification Sheets represent the date, time, and vendor performing the cleaning service and the service performed, as well as the signature of the servicers and the general manager. RX 4.

Chad Wahl testified for Respondent. He is employed by Menards as a General Manager. Mr. Wahl testified as to RX 4, documents that require a manager's signature to verify that the restrooms at Menards were cleaned as indicated. Mr. Wahl testified that he is familiar with Linder's Cleaning Service, as they performed cleaning services for Menards. He indicated that several individuals have cleaned the bathrooms, and he personally observed Petitioner cleaning

the bathrooms "quite frequently." Although he could not give dates of service, he saw her mop, wipe down the restrooms, and sweep on several occasions. He could not attest to whether he was using one hand or two.

Petitioner was called as a witness by Respondent. Petitioner testified that her signature appears in RX 4, and that the "JA" is her signature as well. When asked if Petitioner cleaned at Menards or simply signed the records in RX 4 in a supervisory capacity, Petitioner stated that she "occasionally would clean a mirror or wipe off the counter. I always had someone with me that would mop, that would do the sweeping. There was [sic] always two of us. I signed in a supervisory role." Petitioner indicated that Menards' managers rarely saw what she did, and she would often have to track one down to sign the verification.

Four surveillance videos with dates of September 13 through September 20, 2011, October 5 through October 7, 2011, April 23 through April 25, 2012, and July 16 through July 17, 2012 were admitted into evidence by Respondent. The videos reflect Petitioner using her right hand to open a car door with a key, open a bottle of motor oil, and lift, carry and push objects. They also reflect Petitioner entering individual homes and Menards to perform cleaning services. On some occasions, she is accompanied by another individual and on others, she cleans by herself. On the videos, Petitioner can be seen mopping utilizing both hands, and lifting and gripping objects with her right hand, such as a vacuum, bottles, garbage bags, buckets, brushes, cleaning supplies, pieces of paper, and rolls of paper. RX 7-10.

Steven White, Ryan Bordis, and Terry Norwicki testified as to the surveillance videos on behalf of Respondent. All gentlemen work for Robison Group as private investigators, and all were assigned to survey Petitioner on various dates. Mr. White, Mr. Bordis and Mr. Norwicki testified that their respective cameras were in good working condition during the surveillance of Petitioner, that the videos depict what each individual saw through their camera lens, and that the video tapes were not edited. Mr. Norwicki testified that he had a trainee with him during his surveillance activities, and both he and the trainee show the same video from different angles, which he reviewed. He indicated that although the video he took and that of the trainee are meshed together to constitute the videos that are admitted into evidence. He is unfamiliar with the process of meshing the two videos together, as he does not perform that activity himself.

Ashley McNamee, a news anchor for a local NBC affiliate, testified for Petitioner in rebuttal to the surveillance video. She stated that the surveillance videos were edited as evidenced by jump cuts, referring to the displaced timing sequences in the videos. On cross examination, Ms. McNamee stated that a jump cut could be due to the camera person stopping and starting the camera.

Petitioner was recalled as a witness on her own behalf after having viewed the surveillance videos admitted as RX 7-10. She testified that the videos were filmed after June 10, 2011, the date in which she began working for Linder's Cleaning, and after she was released to one-handed duty. Petitioner acknowledged that she can lift the vacuum, but stated she can do so only by utilizing her knee and the fingertips of her right hand while lifting the heavy part with her left hand. She also acknowledged her ability to use a "small mop" and to utilize a key to open a door with two fingers of her right hand.

CONCLUSIONS OF LAW

In regard to the disputed issue (C), Respondent disputed that Petitioner suffered an accident arising out of her employment.

To obtain compensation under the Illinois Workers' Compensation Act, a claimant must show by a preponderance of the evidence that he has suffered a disabling injury arising out of and in the course of his employment. 820 ILCS 305/2; *Metropolitan Water Reclamation District of Greater Chicago v. Illinois Workers' Compensation Comm'n*, 407 Ill. App. 3d 1010, 1013 (1st Dist. 2011). The "arising out of" component refers to an origin or cause of the injury that must be in some risk connected with or incident to the employment, so as to create a causal connection between the employment and the accidental injury. *Id.* Courts have recognized three general types of risks to which an employee may be exposed: (1) risks distinctly associated with the employment; (2) risks personal to the employee; and (3) neutral risks, which have no particular employment or personal characteristics. *Id.*; *Illinois Institute of Technology v. Industrial Comm'n*, 314 Ill. App. 3d 149, 162 (2000). Injuries resulting from a neutral risk are not generally compensable and do not arise out of the employment, unless the employee was exposed to the risk to a greater degree than the general public. *Metropolitan Water Reclamation District of Greater Chicago,* 407 Ill. App. 3d at 1014. "It is the function of the Commission to judge the credibility of witnesses, determine the weight to be given to their testimony, and to draw reasonable inferences from that testimony." *Nunn v. Industrial Comm'n*, 157 Ill. App. 3d 470, 478 (4th Dist. 1987).

In the present case, the Arbitrator finds that the risks to which Petitioner was exposed on May 30, 2008 were distinctly associated with her employment for Respondent. Petitioner testified that on May 30, 2008, the restaurant was especially busy and she, as a manager, was attempting to keep the dining room clean by bussing tables and then wiping them down. She was hurriedly wiping off a table with her right hand when she felt a pop around her thumb joint. Although Petitioner's job duties were not elicited during testimony, the Arbitrator reasonably infers that wiping down tables was within the purview of Petitioner's job duties that she may reasonably be expected to perform as manager in order to keep the dining room clean to facilitate an expeditious flow of diners. The Arbitrator finds that Respondent's daily operations, namely serving its dining customers, of its restaurant on the date of accident created an increased risk of injury, as it caused Petitioner to hurriedly wipe down the table at issue. Therefore, the Arbitrator finds that Petitioner has sustained an injury that arose out of and in the course of her employment with Respondent.

In regard to disputed issue (E), Respondent disputed that timely notice of the accident was given to Respondent, and Petitioner alleged that notice was given to Brooke Tucker with the job title of General Manager on May 30, 2008. Arb. X 1. Petitioner testified at Arbitration that on her date of accident, Petitioner told Matt Boyer or Paul Shaffer. Petitioner testified she also told Brooke Tucker, the General Manager, the following Monday, and Dan Roark, a district manager. Based upon Petitioner's unrebutted testimony, the Arbitrator finds that Petitioner has proven that notice of the accident was given within the time limits stated in the Act.

In regard to disputed issue (F), it is well settled in Illinois that employers take their employees as they find them. *Sisbro v. Industrial Commission*, 207 Ill.2d 193, 205 (2003). An employee will not be denied recovery simply because of the presence of a pre-existing condition so long as it can be shown that the employment was also a causative factor. *Id.* Recovery will depend on the employee's ability to show that a work-related accidental injury aggravated or accelerated the preexisting disease such that the employee's current condition of ill-being is causally connected to the work-related injury. *Id.* at 204-205. Further, the Workers' Compensation Act is a remedial statute and should be liberally construed to effectuate its main purpose–providing financial protection for injured workers. *Interstate Scaffolding, Inc. v. Illinois Workers' Compensation Comm'n*, 236 Ill.2d 132, 149 (2010); *Beelman Trucking v. Illinois Workers' Compensation Comm'n*, 233 Ill.2d 364 (2009)(the Workers' Compensation Act is a remedial statute intended to provide financial protection for injured workers and it is to be liberally construed to accomplish that objective).

The Arbitrator notes that no causation opinion appear in the records of Dr. Traina or Dr. Williams, both of whom surgically treated Petitioner's thumb. The solitary mention of work-relatedness from either physician appears in the Short Term Disability Claim Form of June 2008, in which Dr. Traina checked the box "No" in response to the question, "Is condition work related?" RX 3. The Arbitrator declines to find this response dispositive of the issue of causation, given the lack of explanation or basis for same.

In support of their respective causation positions, Petitioner tendered the opinions of Dr. Rhode, and Respondent proffered those of Dr. Wysocki. The Arbitrator finds the opinions of Dr. Wysocki to be more credible than that of Dr. Rhode, and accordingly gives the opinions of Dr. Wysocki more weight. Dr. Wysocki reviewed substantially more treatment records and studies than did Dr. Rhode. Dr. Rhode testified that in formulating his opinions, he reviewed the MRI of July 24, 2008, a verbal history from Petitioner, radiographs obtained in his office, and a Section 12 examination report from Dr. Wysocki. PX 19. He did not have the records of Dr. Hoffman, Dr. Traina, Dr. Williams, Deborah Hayes, or any additional studies. Dr. Wysoki, however, had reviewed all of the medical records as did Dr. Rhode, but also had reviewed the records of Dr. Hoffman, Deborah Hayes, Dr. Williams, Dr. Rhode, operative notes from November 13, 2009, February 25, 2009, March 4, 2010 and June 24, 2010, records from emergency department visits at Methodist Hospital on November 20, 2009 and February 23, 2010, and multiple imaging studies, including radiographs, MRI and bone scan dated June 11, 2008 through April 6, 2011. RX 1.

Additionally, Dr. Rhode did not render any actual, substantive treatment to Petitioner. Although Dr. Rhode saw Petitioner on nine separate occasions, he acknowledged that he did not render any treatment to Petitioner, other than referring her to physicians more specialized than him, because he stated that he did not want to "do something that I felt was outside the scope of my practice, which I felt this was." RX 19. As such, the medical monitoring and proffering of opinions that Dr. Rhode performed and proffered for Petitioner is not far afield from the services performed of Dr. Wysocki. As such, the persuasiveness of Dr. Rhode's opinions as a treating physician is limited by the lack of treatment actually rendered to Petitioner.

Similarly, the Arbitrator is not persuaded by the opinions of Dr. Rhode in light of his repeated testimony that "his is out of the scope of practice for what I do." (PX 19, Pg. 11) and that he did not "feel comfortable treating this patient surgically" because of same. PX 19, Pg. 13. Simply put, if Dr. Rhode felt that Petitioner's condition and requisite treatment were outside the scope of his practice and expertise, and more suited to that of a hand specialist, then the opinions of a hand specialist, such as Dr. Wysocki, should properly be given more weight.

Dr. Wysocki testified that the manifestation of symptoms following her work accident drove her to undergo surgery, but then later testified that the work injury was not a causative factor in her need for surgical intervention. RX 1, Pg. 46, 49. Dr. Wysocki further opined that Petitioner's current diagnosis was right thumb pain, stiffness and dysfunction status post surgical treatment of CMC arthritis, but also stated that her "current thumb condition" was not causally related to the work injury of May 30, 2008. RX 1. In applying the Act liberally, *see Interstate Scaffolding, Inc.*, 236 Ill.2d at 149, the Arbitrator adopts the more liberal interpretation of Dr. Wysocki's testimony and finds that as a result of the May 30, 2008 work accident, Petitioner suffered an aggravation of her pre-existing CMC joint arthritis, which caused her condition to become symptomatic and necessitated her subsequent surgical treatment.

Although the Arbitrator adopts the opinions of Dr. Wysocki, the Arbitrator notes that it is not necessary that Petitioner's work accident alter the natural state of her thumb condition to be considered a causative factor in the development of her condition, but rather, the accident need only aggravate or accelerate Petitioner's pre-existing condition such that Petitioner's current condition of ill-being can be said to be causally connected to the work injury. *See Sisbro,* 207 Ill.2d at 204-205.

In this case, Petitioner sought immediate treatment following her work accident, repeatedly gave a consistent history to her treating physician of a sudden onset of symptomatology in her right thumb and hand following the work accident, and continued to suffer constant symptomatology in same following the work accident. Additionally, Petitioner testified that she had not suffered any problems in her right hand before the work accident, nor had she been treated by a physician for any right hand symptoms. Although Respondent points to Dr. Rhode's treatment record of June 11, 2008 as evidence of prior right hand complaints, that record reveals Petitioner had a singular complaint of pain prior to May 30, 2008 that was less severe than the pain resultant from her work accident. PX 16. The Arbitrator finds that same is insufficient to negate the considerable amount of evidence that supports a finding of causation. Therefore, the Arbitrator finds that Petitioner's current condition of ill-being is causally related to the work accident of May 30, 2008.

With regard to disputed issue (J), Respondent disputed liability for medical bills based upon accident, and specifically disputed the reasonableness and necessity of the medical bills for Dr. Rhode and Comprehensive Emergency Solutions based upon an excessive choice of physicians and duplicity, respectively.

Pursuant to Section 8(a), Petitioner is entitled to two choices of "all medical, surgical and hospital services provided by the physician, consultant, expert, institution or other provider of services recommended by said initial service provider or any subsequent provider of medical

services in the chain of referrals from said initial service provider." The Arbitrator finds that Debbie Hays referred Petitioner for treatment with Dr. Williams (PX 4), as reflected in the records of Dr. Williams and per Petitioner's testimony regarding same. The Arbitrator finds that Dr. Hoffman referred Petitioner for treatment with Dr. Traina (PX 1), as reflected in the records of Dr. Hoffman and per Petitioner's testimony regarding same. With regard to Dr. Rhode, his records indicate that Dr. Hoffman referred Petitioner to him. PX 16. Dr. Hoffman's records, however, do not reflect any referral from Dr. Hoffman to Dr. Rhode. Petitioner testified that 'Penny [from her attorney's office] did tell me' to go see Dr. Rhode.

The Arbitrator finds that Petitioner's first choice of physician was Dr. Hoffman, and Dr. Traina to be in the chain of referrals with Dr. Hoffman. Debbie Hays was Petitioner's second choice of physician, with Dr. Williams in the chain of referrals with her. The Arbitrator notes that no bills appear in PX 17 from Debbie Hayes, and none of her records were offered as an exhibit into evidence. In the event that Petitioner is not tendering Ms. Hayes as a provider in this case, Dr. Williams then becomes Petitioner's second choice of physicians. Regardless, Petitioner's choice of Dr. Rhode constitutes Petitioner's third choice of physicians. Because Petitioner has exceeded her choice of physicians pursuant to Section 8(a) with the treatment with Dr. Rhode, Respondent is not liable for any medical bills associated with the services of Dr. Rhode.

Respondent also denied liability for medical bills from Comprehensive Solutions with dates of service of November 20, 2009 and February 23, 2010, contending that the bills were duplicative in that they were submitted and paid by the Illinois Department of Healthcare and Family Services, as reflected in PX 18. A review of the Department's payment information and the bills submitted in PX 17 reflect that the medical bills from Comprehensive Solutions are for emergency services rendered to Petitioner for complaints to her right hand and thumb. The Arbitrator finds the services reflected in the medical bills of Comprehensive Solutions to be reasonable and necessary in the care and treatment of Petitioner's condition.

Based upon the aforementioned findings and in light of the Arbitrator's conclusions with regard to disputed issues (C) and (F), Respondent shall pay all reasonable and necessary medical services, with the exception of bills from Dr. Rhode, as provided in Sections 8(a) and 8.2 of the Act, subject to the fee schedule. Respondent is not liable for medical bills incurred by Petitioner for the services of Dr. Rhode.

In regards to disputed issue (K), the issues of whether a claimant is temporarily totally disabled and the length of time for which he is entitled to temporary disability benefits are questions of fact to be resolved by the Commission. *Archer Daniels Midland Co. v. Industrial Comm'n*, 138 Ill. 2d 107, 118-119 (1990). In Illinois, it is well-settled that an employee is temporarily totally incapacitated from the time an injury incapacitates him from work until such time as he is far recovered or restored as the permanent character of his injury will permit. *Id.* at 118. In order to be eligible for temporary total disability benefits, a Petitioner must prove not only that she did not work but also that she was unable to work. *City of Granite City v. Industrial Comm'n*, 279 Ill. App. 3d 1087, 1090 (1996). "[W]hen an employee who is entitled to receive workers' compensation benefits as a result of a work-related injury is later terminated for conduct unrelated to the injury, the employer's obligation to pay TTD workers' compensation

benefits continues until the employee's medical condition has stabilized and he has reached maximum medical improvement." *Interstate Scaffolding, Inc.*, 236 Ill.2d at 135-136 (emphasis added).

Petitioner sought temporary total disability benefits from May 30, 2008 through June 9, 2011. Arb. X 1. Petitioner's employment with Respondent was terminated on September 30, 2008 while she was off work per Dr. Traina. PX 2.

Petitioner testified that Dr. Hoffman took her off work on May 30, 2008. However, the objective medical records of Dr. Hoffman do not indicate that he took her off work or restricted her work when she presented to him. Dr. Hoffman prescribed medication and referred Petitioner to Dr. Traina for further treatment. PX 1. In the absence of more substantive treatment to indicate that Petitioner was unable to work and without any notations from Dr. Hoffman regarding her work status, there is insufficient evidence to indicate that Petitioner was temporarily totally disabled at that time.

The records of Dr. Traina indicate that he took Petitioner off work beginning on June 11, 2008 and released her to one handed work on July 28, 2008. On August 27, 2008, Dr. Traina again took Petitioner off work until October 13, 2008, when she was released to one-handed work. PX 2.

Petitioner presented to Dr. Williams for treatment on October 22, 2009, and Dr. Williams performed surgery on Petitioner's right thumb on November 13, 2009. PX 4. Although Dr. Williams makes no mention of her work status during his treatment of her, he released her to work without restrictions on December 1, 2009, which reasonably supposes a period of temporary disability. Dr. Williams released her from his care on January 18, 2010. PX 4. The Arbitrator reasonably infers Dr. Williams intended some work restriction on Petitioner's right upper extremity until December 1, 2009 when he released her to full duty, and that her condition stabilized as of January 18, 2010 when Dr. Williams released her from his care.

Petitioner returned to Dr. Traina with continued complaints on February 15, 2010. Although Dr. Traina's records do not reflect that he restricted or removed Petitioner from work at that time, the record evidences that Petitioner's condition declined or destabilized following Dr. William's release of her from his care, given that Petitioner testified her pain increased at that time and that she subsequently underwent three additional surgical procedures to treat her right thumb condition. Specifically, Petitioner underwent a removal of carpometacarpal implant of the right thumb with irrigation and debridement and insertion of antibiotic cement spacer and removal of retaining pins on February 25, 2010. PX 2. On March 4, 2010, Dr. Traina performed a carpometacarpal reconstruction of the right wrist at the first metacarpal with a graft jacket implant, at which time she was placed in a thumb spica cast. PX 13. Petitioner underwent a third surgical procedure on June 24, 2010 to excise tissue protruding from her wound. PX 2. Considering the significant treatment she received in conjunction with Petitioner's testimony that Dr. Traina intermittently restricted her to one-handed work, the Arbitrator finds that Petitioner's condition had not stabilized nor was she at maximum medical improvement during this period of time, which the Supreme Court instructs is the determinative inquiry in ascertaining temporary total disability given Petitioner's termination on September 30, 2008. *Interstate Scaffolding, Inc.*,

236 Ill. 2d at 149. Therefore, Petitioner is entitled to temporary total disability benefits during this time period.

After concluding treatment with Dr. Traina, Dr. Rhode took Petitioner off work from April 6, 2011 through April 18, 2012, at which time he placed permanent restrictions on her of no use of the right upper extremity. PX 16. Although the Arbitrator finds the opinions of Dr. Rhode to be unpersuasive, there is nothing in the record to indicate that Petitioner's condition had stabilized and reached maximum medical improvement during the time period of April 6, 2011 until June 9, 2011 to contradict Dr. Rhode's orders for Petitioner to remain off work. Dr. Wysocki placed Petitioner at maximum medical improvement on October 19, 2011 at the time of his examination, barring any further surgical intervention, and testified that if she chose to undergo further surgical treatment, it would alter her status. Dr. Wysocki also testified that the pain she experienced following the work accident of May 30, 2008 drove her to have the four surgical procedures she underwent prior to being examined by him. RX 1. Given Dr. Wysocki's opinions and the permanent restrictions he recommended for her, it is reasonable to infer that Dr. Wysocki would not have placed Petitioner at maximum medical improvement during the time period in which Dr. Traina surgically treated Petitioner's right thumb, or between April 6, 2011 and June 9, 2011, the time period in which Petitioner was off of work per Dr. Rhode.

Based upon the foregoing, Respondent shall pay Petitioner temporary total disability benefits of $442.31 per week for a total period of 152 3/7 weeks, representing June 11, 2008 through January 18, 2010, and February 15, 2010 through June 9, 2011. By ceasing temporary total disability benefits on June 9, 2011, the Arbitrator is not concluding that Petitioner had reached maximum medical improvement on that date, but rather, June 9, 2011 is the last date in which Petitioner sought temporary total disability benefits. Arb. X 1. The parties stipulated that Respondent is due a credit of $1,674.00 for short term disability payments made to Petitioner, and $17,409.60 for long term disability payments made, for a total credit of $19,083.60 to be deducted from Petitioner's temporary total disability benefits.

In regard to disputed issue (L), based upon the foregoing and the record in its entirety, as a result of her work accident of May 30, 2008, Petitioner sustained an aggravation of her right thumb carpometacarpal joint arthritis, which necessitated a right thumb CMC joint arthroplasty and three subsequent remedial procedures, including a removal of the carpometacarpal implant of the right thumb with irrigation, debridement, and removal of retaining pins, a carpometacarpal reconstruction of the right wrist at the first metacarpal with a graft jacket implant, and a right thumb irrigation and debridement to excise tissue. Following treatment, Petitioner began working with restrictions for Linder's Cleaning Service on June 10, 2011, and thereafter became self-employed in December 2012 working in a permanently restricted capacity.

At Arbitration, Petitioner testified to severe limitations and near complete loss of use of her right hand and thumb, and she demonstrated an apparent inability to grip or lift objects. However, Petitioner's testimony is undermined by the surveillance videos admitted into evidence depicting Petitioner performing laborious activities with her right upper extremity, including cleaning the restrooms at Menards using her right hand just as often as her left, and carrying heavy objects into clients' homes with her right hand, including a fully stocked cleaning bucket and a vacuum, and other objects that require manual dexterity. The activities she is seen

performing on the surveillance videos casts into doubt her testimony that she is unable to lift basic objects with her right hand, such as a cup of coffee, paper, or a folder, or perform mundane activities. Although she testified that she "always" performed cleaning services with the aid of another individual who would mop and sweep, the surveillance videos revealed Petitioner oftentimes cleaning by herself and performing the activities she insinuated on direct examination she could not do with her right hand. Ultimately, the surveillance videos exhibit that Petitioner is physically capable of performing more activities with her right hand and thumb than what she testified to and exhibited at Arbitration.

Nonetheless, after observing Petitioner's right upper extremity at Arbitration, the Arbitrator finds that Petitioner suffered significant atrophy and deformity in her right thumb and hand as a result of the treatment for her right thumb condition that would reasonably inhibit the functionality of her right hand. Dr. Wysocki noted that Petitioner was primarily problematic in the radial side of the right hand and in the right thumb. He stated that her right hand had significant limitations with thumb movement, and recommended a work restriction of no lifting, pushing, pulling greater than five pounds for gross motor only, with no fine motor use. RX 1. Although additional surgical procedures have been recommended to Petitioner to lessen her reported pain and improve the functionality in her right thumb and hand, Petitioner has elected to forego those procedures.

In light of Petitioner's injury and the treatment it necessitated, her permanent restrictions of the right hand, Petitioner's continued complaints and limitations in her right thumb and hand, and taking into consideration the physical capabilities Petitioner exhibited on the surveillance videos, the Arbitrator finds that Petitioner sustained permanent partial disability to the extent of 55% loss of use of her right hand, pursuant to Section 8(e). Therefore, Respondent shall pay Petitioner $398.08 for 112.75 weeks, representing 55% loss of use of the right hand.

STATE OF ILLINOIS)
) SS.
COUNTY OF)
WILLIAMSON

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

LARRY WHARTON,

Petitioner,

14IWCC1013

vs.

NO: 10 WC 38986

THE AMERICAN COAL COMPANY,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by both the Petitioner and Respondent herein, and notice given to all parties, the Commission, after considering the issues of occupational disease, causal connection, evidentiary rulings and permanent partial disability, and being advised of the facts and law, reverses the Decision of the Arbitrator, which is attached hereto and made a part hereof.

1. Petitioner retired from Respondent on August 8, 2010. Prior to retirement, he had been a Coal Miner for 37 years and was regularly exposed to rock dust (mostly lime dust), silica dust, roof bolting glue, rock fiber for cement, diesel fumes and rock bond. Petitioner was also occasionally an Examiner, which required him to walk through return airway locations, which are areas that pick up all the dust from the air.

2. On his retirement date Petitioner was a Mechanic and had been exposed to all of the above mentioned fumes, dusts and glues on that day. He quit on that day, as he had begun to have breathing problems.

3. As a Mechanic, Petitioner worked on the ram cars, which are cars that Miners use to dump coal into that comes across on a conveyor belt. The cars have diesel engines. The engine has a scrubber system with water to cool the exhaust. The exhaust then comes out of a cone shaped paper filter. If the water gets too low the tank is supposed to shut down.

However, a few times it malfunctioned and the paper filter caught on fire, which emitted a thick smoke.

4. During a 1993 layoff from mining Petitioner worked for Walmart.

5. Petitioner smoked cigarettes until 1977. He smoked a pack per day.

6. While working for Respondent Petitioner developed a cough, would have shortness of breath and difficulty climbing multiple flights of stairs. In the 6 months prior to trial, Petitioner noticed that occasionally when he exerted himself, he would get dizzy and have to stop what he was doing to catch his breath.

7. Petitioner underwent black lung testing 6 times over the years. He also worked at other coal mines prior to working for Respondent, and thus could have been exposed to some of the same fumes and dust.

8. On May 4, 2007 a negative chest x-ray reading was found by Drs. Rosenberg and Meyer. This was supported by the independent readings of the NIOSH B-readers.

9. Further, a Dr. Houser's initial July 2011 exam did not reveal chronic bronchitis, as Petitioner detailed an insufficient history of cough and sputum production. Additionally, in the history given to a Dr. Instanbouly, no significant sputum production was mentioned by Petitioner.

10. Moreover, when Dr. Instanbouly evaluated Petitioner on January 20, 2014, the medical records of Dr. Davis, which he reviewed, did not support a diagnosis of chronic bronchitis. Dr. Davis' review of systems respiratory was negative.

11. Petitioner was diagnosed by Dr. Davis with acute bronchitis on May 14, 2013, and an upper respiratory infection and pharyngitis on September 11, 2013. There was no evidence of chronic bronchitis.

12. Regarding asthma, Dr. Houser testified that records indicate Petitioner had been diagnosed with asthma before he was ever employed as a coal miner.

After reviewing the transcript and evidence, the Commission reverses the Arbitrator's ruling and finds that Petitioner has failed to sufficiently allege a work-related occupational disease.

While it is clear that Petitioner had respiratory issues, medical records seem to indicate that none were related to his work duties. Dr. Houser testified that records indicate Petitioner had been diagnosed with asthma before he was ever employed as a Coal Miner. Further, Petitioner was not diagnosed with bronchitis until May 14, 2013, which is nearly 3 years after his retirement. The Commission notes that the bronchitis was acute rather than chronic. Lastly, the Commission finds credible the opinions of Drs. Rosenberg and Meyer, who noted a negative chest x-ray in May of 2007. Thus, after 34 years as a Miner, Petitioner did not have coal workers

14IWCC1013

pneumoconiosis. The Commission finds it highly unlikely that Petitioner developed coal workers pneumoconiosis in his final 3 years of work when he did not develop it in the 34 years prior.

Based on the medical evidence and testimony, the Commission reverses and vacates the Decision of the Arbitrator, finding that Petitioner failed to sufficiently claim an occupational disease.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed April 4, 2014 is hereby reversed and vacated as stated herein.

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

DATED: NOV 24 2014
O: 9/25/14
DLG/wde
45

David L. Gore

Mario Basurto

Stephen Mathis

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

WHARTON, LARRY
Employee/Petitioner

Case# **10WC038986**

14IWCC1013

THE AMERICAN COAL COMPANY
Employer/Respondent

On 4/4/2014, 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:

0755 CULLEY & WISSORE
HAROLD B CULLEY JR
300 SMALL ST SUITE 3
HARRISBURG, IL 62946

0143 CRAIG & CRAIG
KENNETH F WERTS
PO BOX 1545
MT VERNON, IL 62864

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

14IWCC1013

LARRY WHARTON
Employee/Petitioner

v.

THE AMERICAN COAL COMPANY
Employer/Respondent

Case # 10WC 38986

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 **Herrin**, on **February 7, 2014**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☒ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☐ What was the date of the accident?
E. ☐ Was timely notice of the accident given to Respondent?
F. ☒ Is Petitioner's current condition of ill-being causally related to the injury?
G. ☐ What were Petitioner's earnings?
H. ☐ What was Petitioner's age at the time of the accident?
I. ☐ What was Petitioner's marital status at the time of the accident?
J. ☐ Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. ☐ What temporary benefits are in dispute?
☐ TPD ☐ Maintenance ☐ TTD
L. ☒ What is the nature and extent of the injury?
M. ☐ Should penalties or fees be imposed upon Respondent?
N. ☐ Is Respondent due any credit?
O. ☒ Other **Sections 1(d)-(f) and 19(d) of the Occupational Diseases Act**

FINDINGS 14IWCC1013

On **August 10, 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's average weekly wage was **$1,413.49**.

On the date of accident, Petitioner was **64** years of age, ***married*** with **0** dependent children.

Petitioner claims no medical.

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

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

ORDER

The Respondent shall pay Petitioner $669.64/week for a period 50 weeks, as provided in Section 8d2 of the Act, because the injuries sustained caused 10% loss of use on a man as a whole basis.

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

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

Edward Lee
Signature of Arbitrator

3/21/14
Date

APR 4- 2014

COUNTY OF WILLIAMSON) SS.

14IWCC1013

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

LARRY WHARTON
Employee/Petitioner

Case # 10 WC 38986

v.

AMERICAN COAL CO, et. al.
Employer/Respondent

MEMORANDUM OF DECISION OF ARBITRATOR

FINDINGS OF FACT

Petitioner, Larry Wharton, was born on July 26, 1946 and was sixty seven years old on the day of arbitration. Petitioner began his thirty-seven years underground coal mining career in 1971. He was exposed to coal, rock, and silica dust, and fumes from roof bolting glue, cement fiber and diesel exhaust. Roof bolting involves drilling a hole and inserting a bolt and tube of glue to shore up the ceiling. Wood fiber cement was used in building brattices made of concrete blocks sealed with the adhesive. Rock dust is an explosion preventive dust used everywhere in the coal mine. The walls, roof, and floors are coated with it. It is sprayed on before or after shifts, and is thrown by hand on the wall after the roof is bolted. Later the area is dusted by machine.

Petitioner's last mining exposures occurred on August 8, 2010 at Respondent American Coal Company's Galatia Mine. He quit mining because his wife became eligible for social security benefits. Otherwise, he would have quit earlier. Petitioner was starting to have a breathing problem and was taking inhalers. He got tired of the dust which made it harder to breathe. In his last job as a mechanic Petitioner worked on a diesel-powered ram car, a machine which is loaded with coal from a conveyer belt behind the miner machine.

After leaving mining Petitioner found work for Southern Illinoisan News working about twenty four hours a week making $8.41 an hour. He loads paper bundles weighing about 20 pounds into a van and makes deliveries to areas that are short of papers. Petitioner has looked for other jobs, but he feels unqualified or no insurance is offered. He will lose his union health insurance if he makes over a thousand dollars a month. He feels lucky to have the job he has. At times he has difficulty exerting himself at work, but he stops what he is doing until he gets his breath back.

As a miner, Petitioner worked as a bottom laborer, a roof bolter, and a mechanic. He began noticing a change in his breathing in the late 1990's. He would have to stop what he was doing when he overexerted himself. Petitioner also developed a productive cough. Currently, he feels able to walk a block or two before becoming short of breath, but does not walk like he used to. Petitioner can climb a flight or two of stairs before having to stop and rest. In the last six to eight months he has noticed a change where sometimes he becomes dizzy exerting himself and must stop for thirty seconds because he is breathing so hard. He described an incident where after climbing three flights of stairs he had chest pain and difficulty breathing. He had an EKG, but

nothing was found. Petitioner began smoking when he entered the Marines, but quit in 1977. He averaged a pack per day, but smoked more while in Viet Nam. He would not return to the mines if offered a job because of his concern that the dust would make his breathing worse. Petitioner stated that he had screening x-rays done while mining.

At Petitioner's request, B-reader/Radiologist, Dr. Henry Smith reviewed Petitioner's August 17, 2010 chest film and found it positive for coal worker's pneumoconiosis (CWP). Dr. Smith saw abnormalities in all lung zones in a profusion of 1/0. Dr. Smith also found Petitioner's May 4, 2007 x-ray to be positive for CWP, category 1/0. (PX 2). Petitioner also submitted the x-ray reports of B-reader/Radiologist, Dr. Michael Alexander. Dr. Alexander interpreted the same films as Dr. Smith and agreed that they were positive, however he categorized them as having a 1/1 profusion. (PX 3). Both doctors found the films to be quality I.

Pulmonologist and Black Lung Clinic Head, Dr. William Houser, examined Petitioner at his attorney's request on July 19, 2011. Petitioner complained of dyspnea while using exercise equipment at the gym. He had a minimal cough with occasional sputum. Petitioner stated that he has had twenty to thirty episodes of bronchitis dating back to the 1960's. He smoked occasionally beginning at age eleven, then regularly from age fourteen to thirty, averaging a pack a day. However in Viet Nam he consumed two and one half packs per day. Dr. Houser noted that Petitioner coal mined for nearly thirty-eight years. Physical examination showed a few crackles at the left lung base. Pulmonary function testing was normal, but Petitioner's chest x-ray was positive for CWP category 1/0. (PX 1, Depo. Exh. 1, pp. 1-2). Dr. Houser took the B-reader exam in the 1980's and failed. (PX 1, p. 41). However, after that time he took particular care to closely work with his B-readers and discuss the films they had both read. (PX 1, pp. 47-48).

Pulmonologist, Dr. Istanbouly, has treated Petitioner on referral from his primary care physician, Dr. Davis. Petitioner related that his former pulmonologist, Dr. Tazbaz had left the area. Dr. Istanbouly is the only pulmonologist in Herrin, other than a doctor who comes once a week. He stated Petitioner had CWP based on his symptoms, exposure and chest x-ray. Petitioner had recently passed a cardiac test and so ischemia was excluded as a cause. (PX 13, pp. 6-8). By definition, Petitioner has chronic bronchitis which was caused or aggravated by his mining exposures. Additional exposure may cause it to progress. Chronic bronchitis may or may not resolve following mining exposure cessation. Dr. Istanbouly agreed that Petitioner has been treated for asthma over the past few years, but he had denied childhood asthma. Coal dust, and welding, diesel, and roof bolting glues fumes can all contribute to asthma. With his chest x-ray abnormality and symptoms, any further mining exposures would risk a reduced lung capacity. He would advise against any return to coal mining. (PX 13, pp. 9-14; See also PX 8).

Dr. Istanbouly's records document his January 20, 2014 black lung evaluation. Petitioner denied ever being diagnosed with asthma. He had a daily mild cough for the last few years, mostly in the mornings, with no significant sputum production. He complained of progressive exertional dyspnea over the past year and becomes short of breath climbing two flights of stairs. Previously he could climb four before experiencing breathing problems. He had a mild runny nose and post nasal drip. The chest x-ray of May 4, 2007 showed small round opacities bilaterally consistent with CWP. This was classified by a B-reader as 1/1. A repeat chest x-ray report of an August 17, 2010 film was again categorized as 1/1. Pulmonary function testing of July 19, 2011 was normal. Petitioner was taking Fluticasone nasal spray for rhinitis and Symbicort as needed, but he was not regularly using it. He had an Albuterol inhaler he used on an as needed basis. (PX 7,

p. 1-2). Petitioner's lungs were normal on physical exam. Dr. Istanbouly concluded that Petitioner had CWP based on his chest x-ray, symptoms, and history of exposure. (PX 7, p. 3).

At Respondent's request B-reader/Radiologist, Dr. Meyer, reviewed Petitioner's quality III chest film of August 17, 2010, finding it negative for CWP. (RX 1, depo. Exh. B). Dr. Meyer also interpreted Petitioner's quality I chest film of May 4, 2007 to be negative for CWP. (RX 2). Dr. Meyer testified that the 2010 film was quality III due to poor contrast and mottle. (RX 1, p. 40). Poor contrast can make it harder to evaluate the lung parenchyma, and mottle refers to the films' granular appearance. (RX 1, pp. 41-42). Quality III is the lowest quality before a film is considered unreadable. (RX 1, p. 76). Dr. Meyer defined a CWP macule as a collection of inflammatory cells which may have mild fibrosis or adjacent emphysema. At the site of the tissue reaction lung function is changed, whether measurable or not. (RX 1, pp. 55-56). CWP can be a chronic progressive disease in some miners even after exposure cessation, and can progress to life threatening conditions. (RX 1, pp. 58-59). He agreed that the only treatment for a person with CWP is removal from dust exposure. CWP first appears radiographically, and as it becomes more significant it causes pulmonary function or clinical abnormalities. (RX 1, pp. 60-61). CWP is very slow and insidious in its onset, and one might not know they have it until a positive x-ray. (RX 1, p. 66). Dr. Meyer had no reason to disagree with NIOSH or the Department of Labor about the causes of COPD or emphysema. (RX 1, pp. 63-64). He stated that secondary signs of emphysema can be seen on a chest x-ray. (RX 1, p. 59-60).

Dr. Meyer charges $115.00 per B-reading and does 160 to 200 B-readings each month. He does between zero and four depositions each month, charging $500.00 an hour. Dr. Meyer reads between 20 and 40 CT scans for occupational disease each month, charging $275.00 dollars for each scan. He is generally retained by the coal companies. He stated that coal macules can become calcified and can be the same size as a granuloma. (RX 1, pp. 66-69). It is possible for CWP to show up for the first time in the last month before the miner quits mining. (RX 1, p. 71). Dr. Meyer failed the B-reader exam the first time he took it. (RX 1, p. 75).

At Respondent's request, Pulmonologist/B-reader, Dr. Rosenberg, reviewed the records of the Carbondale and Herrin Clinics, Dr. Meyer and Smith's B-reading of the August 17, 2010 x-ray, Dr. Houser's July 19, 2011 evaluation, and the August 7, 2010 x-ray. (RX 3, depo exh. 2, p. 1). Dr. Rosenberg did not believe Petitioner had CWP, and felt that any bronchitis he had was a result of GERD because it improved with GERD treatment. He also felt that any mining-related chronic bronchitis would dissipate with the cessation of mining exposures. (RX 3, depo exh. 2, pp. 3-4).

On cross-examination Dr. Rosenberg acknowledged medical record entries regarding pulmonary symptoms and medications that were consistent with asthma. (RX 3, pp. 26-32). He agreed that roof bolting glues, adhesives used to repair chutes, and diesel fumes are all exposures in the mines that can cause or aggravate asthma. He conceded that the American Thoracic Society states that the most common cause of workplace asthma is the aggravation and worsening of pre-existing asthma. (RX 3, pp. 32-34). Asthma might make a person more susceptible to pulmonary infection. Petitioner has had problems with pneumonia. He agreed that Petitioner could have asthma or reactive airways disease. (RX 3, pp. 34-36). If Petitioner had difficulty with his asthma on a certain day he may have been incapable of heavy manual labor. Asthma is a condition that waxes and wanes. (RX 3, pp. 38-39).

Dr. Houser subsequently reviewed the records from the Carbondale Clinic, the Herrin Clinic, Dr. Davis, and Dr. Tazbaz's and Dr. Rosenberg's deposition. (PX 5). While initially he did not diagnose chronic bronchitis, he stated that the records did not rule in or rule out chronic bronchitis. (PX 12, p. 4). Additional mining exposures could worsen chronic bronchitis. (PX 12, pp. 6-7). The records demonstrated a history of asthma. He explained that coal mine exposures could have aggravated or caused the asthma. Additional mining exposures can aggravate Petitioner's asthma and cause it to progress. (PX 12, pp. 7-8). Dr. Houser disagreed with Dr. Rosenberg regarding a connection between GERD and chronic bronchitis, stating that there is not a lot of evidence connecting the two. Chronic bronchitis as well as asthma can be multifactorial and the mining environment could be a contributor. (PX 12, pp. 9, 11-12). Dr. Houser stated that mine-dust-related chronic bronchitis will likely improve with cessation of exposure, but in some patients it persists. He agreed that coal dust does not cause asthma, but it can aggravate it. Other mining exposures such as diesel exhaust and roof bolting glues can cause asthma. (PX 12, pp. 12-14). He also explained why he disagreed with Dr. Rosenberg's opinion that chronic bronchitis does not cause airflow obstruction. Although Dr. Rosenberg blamed Prinivil for any chronic bronchitis, Prinivil causes a dry, not a productive cough. It would have no bearing on whether coal dust caused chronic bronchitis. (PX 12, pp. 15-17). Dr. Houser also explained why Dr. Rosenberg incorrectly stated that emphysema caused by coal dust develops only if there is CWP. He stated that it is common knowledge that coal dust can cause emphysema independent of CWP. Dr. Houser provided references to support his opinion. (PX 12, pp. 17-19). He felt that the best action for an asthmatic miner is to avoid exposures that aggravate it. (PX 12, p. 20).

On referral from Dr. Davis Pulmonologist, Dr. Tazbaz, examined Petitioner on January 4, 2013 for CWP and cough. He noted that Petitioner coughed every day, ten to twelve times a day. The cough is productive and chronic bronchitis was a possibility. Petitioner wheezed about once a month, but had not taken medications which initially helped in the 1990's. Petitioner's GERD was under control, and for the last year and a half he can walk on a treadmill for up to 25 minutes. He has no shortness of breath. Dr. Tazbaz had no chest x-ray to confirm CWP, but opined to Petitioner's attorney that he read Petitioner's x-ray as positive for CWP category 1/0. (PX 4). Pulmonary function testing on January 18, 2013 was normal. (RX 9)

The parties introduced Petitioner's medical records from various entities, some of which were duplicative. Carbondale Clinic records indicate acute bronchitis was diagnosed on September 30, 2004. Bronchial problems since age 18 were reported. Advair was restarted, and Petitioner was given a Z-Pak and Robitussin p.m. (PX 9, p. 46). On May 3, 2001 a history of pneumonia, shortness of breath, and bronchitis were noted. (PX 9, p. 27). Acute bronchitis also was diagnosed on July 13, 1998, and November 23, 1990. (PX 9, pp. 47-48). A May 3, 2001 anesthesia questionnaire noted asthma as a baby. (p. 55).

Logan Primary Care Records show entries documenting cough, bronchitis, black lung, and/or inhaler use. (PX 6, pp. 11, 19-21, 26-28, 30, 40-43, p. 45-47). Petitioner's chest x-ray of June 18, 2013 noted no pulmonary vascular congestion and clear lungs. (PX 6, p. 32-33).

Herrin Clinic records indicate no pulmonary symptoms on many occasions. However, the entries also document cough, bronchitis, black lung, and/or inhaler use (PX 10, pp. 2, 5, 8-10, 27, 29, 31- 32, 37, 39, 42-45 65-66, 80-82). On June 9, 2009 Petitioner's GERD was controlled. (PX 10, p. 17). On March 16, 2009 Petitioner reported walking about 1.5 miles per week if the

weather is nice. (PX 10, p. 20). Petitioner's chest film showed no interstitial abnormality but calcified nodules in the right hilar region were observed. (PX 10. p. 69).

Respondent introduced records from NIOSH. On June 28, 2007 Petitioner was told that his May 4, 2007 spirometry was normal. Also submitted were x-ray reports from 1975-2007. The reports for early films are not relevant to whether Petitioner had CWP when he left the mines. Moreover on the first two reports, neither the date, nor Petitioner's name, nor the readers' name, nor the type of reading, A or B is designated. Many reports contain only the readers' initials. (RX 4).

Respondent also introduced VA Clinic records. A January 12, 2012 chest x-ray for black lung showed mild obstructive pulmonary disease and a hiatal hernia. (RX 7, p. 2-3). Shortness of breath on exertion was reported on September 24, 2013, and on minimal exertion on September 19, 2012. (RX 7, pp. 16, 22). In a January 23, 2012 questionnaire for disability benefits, a nurse practitioner noted that Petitioner had never been diagnosed with a respiratory condition. This observation may have been strictly based on the VA records, as it was later stated that his file was reviewed, and he had no ongoing diagnosis of respiratory disease or conditions other than environmental allergies. (RX 7, pp. 28, 42). The respiratory condition was related to bronchitis which did not require the use of inhaled medications or oral bronchodilators. The accuracy of this statement is debatable. (RX 7, pp. 30-31). Petitioner's condition required antibiotics. Petitioner reported a 38 year history of recurrent respiratory infections with 1-2 instances a year. He attributed this to his mining exposures and had been diagnosed with Black Lung. He has had only one instance of upper respiratory infection since retiring from the mines. (RX 7, p. 31). Petitioner also reported mild exertional dyspnea with activities such as climbing over two flights of stairs. He reported no ongoing cough, though he clears his throat a couple times a day. (RX 7, p. 39). Pulmonary function testing of January 2, 2012 suggested a very mild small airways obstruction. Enlistment papers showed childhood asthma. The respiratory condition was most likely due to his long history of occupational exposures as a coal miner and history of smoking. (RX 7, p. 43). Petitioner was diagnosed with bronchitis and was following up for a chronic problem. Shortness of breath on exertion was noted. (RX 7, pp. 45-46). Shortness of breath on exertion was again noted on August 16, 2010. (RX 7, pp. 50-51).

Petitioner introduced records showing his gross pay working for the Southern Illinoisan in 2013 was $8,279.44. He made less the previous three years. (PX 11).

CONCLUSIONS OF LAW

Issue (C): Did Petitioner suffer disease which arose out of and in the course of his employment by Respondent?

The Arbitrator resolves the issue of CWP in Petitioner's favor. Dr. Meyer became a B-reader in 1999 at the recommendation of his co-worker, Dr. Wiot, a prolific reader of x-rays for coal companies. (RX 1, p. 19-20). See, *Lefler v. Freeman United Coal Mining Co*, (9-25-08), 08 IWCC. 1097. Dr. Meyer also is generally retained by the coal companies. (RX 1, pp. 68). As noted in the facts he makes a considerable amount of money doing B-readings and CT exams in occupational disease cases. Dr. Houser does many coal miner examinations and depositions, but he has been the Medical Director of a Black Lung Clinic since 1979 and has done between three to four thousand black lung clinic exams. His opinions were candid and credible. (PX 1, pp. 4-5,

33-34). Dr. Houser is not a B-reader or radiologist, but has become competent by consulting with his B-readers over the years regarding their chest x-ray readings. (PX 1, pp. 47-48).

Dr. Smith has been a B-reader since 1987 and is a consultant to multiple occupational medical clinics. (PX 2, CV, pp. 2, 5). Dr. Alexander has been a B-reader since 1992 and has made presentations on the ILO classification system and the appearance of pneumoconiosis. (PX 3, Alexander CV, pp. 2, 5). Dr. Tazbaz and Dr. Istanbouly also concluded Petitioner had CWP. While the NIOSH exhibit indicates otherwise, most films predate Petitioner's last exposure by many years. Many of the reports, including the most recent report from the 2007 film appear to have been altered, inasmuch as the readers' social security numbers are blacked out by someone. (RX 4). The readers' affiliations are unknown. The arbitrator also considers negative treatment x-rays, but notes Dr. Meyer's testimony that a standard radiologist at a small hospital's failure to note CWP on a film taken for other purposes is less valuable. (RX 1, pp. 50).

Dr. Rosenberg's opinion was based solely on a records' review which did not include all the relevant records introduced at trial. He agreed that coal dust inhalation can cause emphysema, chronic bronchitis, and COPD, and can aggravate reactive airways disease. (RX 3, pp. 60-61). However, in many questions concerning the effects of coal mine dust, routinely opined that one must look at the specific individual and epidemiologic studies or what exists in the mining population. (RX 3, pp. 56-57, 63-66). However, he referenced no authorities supporting his qualified views. Dr. Rosenberg's view that minimal exposure is acceptable for CWP victims does not reflect medical objectivity. (RX 3, pp. 52-53). Even he agreed that the less exposure the better, and that for emphysema, bronchitis or COPD, the best medical advice is to stay away from exposures that can cause or aggravate it. (RX 3, p. 68). Contrary to the DOL and NIOSH, he does not believe that coal dust can cause emphysema absent CWP. (RX 3, p. 69-70). Dr. Houser stated it was common knowledge that this can occur, and cited references for his opinions. (PX 12, pp. 17-19). Dr. Rosenberg also felt that any mining related chronic bronchitis would dissipate with the cessation of mining exposures. (RX 3, depo exh. 2, pp. 3-4). However, Drs. Istanbouly and Houser testified that this is not always the case. (PX 12, p. 12; PX 13, p. 10). Dr. Rosenberg contended that chronic bronchitis does not cause obstruction. (RX 3, p. 64-65). Dr. Houser explained why that view is incorrect. (PX 1, p. 15-16). Dr. Rosenberg was not convincing on these topics.

The Arbitrator also concludes that Petitioner has an occupational bronchitic/asthmatic condition. Petitioner must prove his occupational exposure was a causative or aggravating factor in his disease. He need not prove it was "sole or even the principal causative factor." *Gross v. IWCC*, 2011 IL App (4th), 100615WC, ¶22. While the medical histories pertaining to a history of asthma and productive coughing conflict, Petitioner was taking medications designed to prevent cough or to treat asthma. (RX 3, pp. 30, 40-42). Dr. Rosenberg stated that a physician may diagnose bronchitis when the real problem is asthma. (RX 3, p. 30). The medical records of Logan Primary Care show on December 23, December 17, 2013, and November 19, 2013, black lung and COPD were included in Petitioner's major problems list. (PX 6, pp. 40-43, 45-47). VA Clinic records show a chest x-ray of January 12, 2002 was interpreted as showing mild obstructive pulmonary disease and a hiatal hernia. (RX 7, pp. 2-3). Pulmonary function testing of January 2, 2012 suggested a very mild small airways obstruction. (RX 7, p. 43). However, subsequent testing by Drs. Tazbaz and Istanbuoly were normal. It is clear that Petitioner had episodes of bronchitis, and more recently issues with dyspnea. Petitioner has been on inhalers

and his testimony was credible. There is no other credible explanation for his symptoms other than 37 years of mining exposures.

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

The lung tissue scarred by CWP cannot function and by definition there is impairment of function at the damage site. (PX 1, pp.13-14; RX 1, p. 56). The Commission has recognized that even in the absence of measurable impairment, a CWP diagnosis equates to disability under the Act. See, *e.g., Samuel v. FW Electric*, 08 IWCC 1296 (2008); *Cross v. Liberty Coal Co.*, 08 IWCC 1260 (2008); *Chrostoski v. Freeman United Coal Mining Co.*, 07 IWCC 0226 (2007). A concurrence of three justices in a recent Appellate Court decision also made such a conclusion. *Freeman United Coal Mining Co. v. Illinois Workers' Compensation Commission*, 2013 IL App (5th) 120564WC, ¶33-35 (concurrence).

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

Based on the above findings, which include CWP, shortness of breath, bronchitis and dyspnea, Petitioner is permanently and partially disabled under Section 8(d) (2) to the extent of 10% loss on a MAW basis. The Petitioner is not entitled to 8d1 benefits because "He quit mining because his wife became eligible for social security", supra, i.e, he left his mining job voluntarily.

Issue (O): Was there an injurious practice under Section 19(d)? Was disablement timely?

Respondent's injurious practice defense has no merit in this case. Petitioner's smoking history is remote, and the contention lacks legal foundation. *See, Global Products v. Workers' Compensation Commission*, 392 Ill. App. 3d 408, 911 N.E. 2d 1042, 1046 (1st. Dist. 2009),.

Petitioner's disability was timely under Section 1(f), as his symptoms and positive x-ray abnormalities were all present within two years from his last exposure date of August 8, 2010.

STATE OF ILLINOIS)
) SS.
COUNTY OF CHAMPAIGN)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Patricia O'Neal,
Petitioner,

vs. NO: 13 WC 25525

14IWCC1014

Adecco,
Respondent.

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed March 13, 2014, is hereby affirmed and adopted.

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

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

14IWCC1014

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 $6,800.00. 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: NOV 24 2014

Daniel R. Donohoo

Charles J. DeVriendt

Ruth W. White

o-11/05/14
drd/wj
68

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

O'NEAL, PATRICIA
Employee/Petitioner

Case# **13WC025525**

ADECCO
Employer/Respondent

14IWCC1014

On 3/12/2014, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

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

0157 ASHER & SMITH
CRAIG SMITH
PO BOX 340
PARIS, IL 61944

2904 HENNESSY & ROACH PC
STEPHEN KLYCZEK
2501 CHATHAM RD SUITE 220
SPRINGFIELD, IL 62704

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)

PATRICIA O'NEAL
Employee/Petitioner

v.

ADECCO
Employer/Respondent

Case # 13 WC 25525

Consolidated cases: N/A

14IWCC1014

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Nancy Lindsay**, Arbitrator of the Commission, in the city of **Urbana**, on **November 25, 2013** and in **Springfield** on **January 13, 2014.** After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☒ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☐ What was the date of the accident?
E. ☐ Was timely notice of the accident given to Respondent?
F. ☒ Is Petitioner's current condition of ill-being causally related to the injury?
G. ☐ What were Petitioner's earnings?
H. ☐ What was Petitioner's age at the time of the accident?
I. ☐ What was Petitioner's marital status at the time of the accident?
J. ☐ Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. ☒ 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, **03/05/2013**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$5,084.81**; the average weekly wage was **$338.98**.

On the date of accident, Petitioner was **40** years of age, ***single*** with **2** dependent children.

Respondent shall be given a credit of **$3,513.44** for TTD, **$633.71** for TPD, for a total credit of **$4,147.15**.

ORDER

Respondent shall pay Petitioner temporary total disability benefits of **$286.00**/week for **37 6/7th** weeks, commencing on **03/06/13** through **11/25/13** as provided in Section 8(b) of the Act. Respondent shall be given a credit of **$3,513.44** as stipulated to by the parties.

Petitioner is entitled to prospective medical care, in the form of left shoulder arthroscopic surgery, as recommended and outlined by Dr. John Rowe.

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.

Kenny Lindsey
Signature of Arbitrator

3.7.14
Date

ICArbDec19(b)

MAR 12 2014

FINDINGS OF FACTS and CONCLUSIONS OF LAW

This case involves a claim for prospective medical care. Petitioner alleges repetitive trauma to her left shoulder and arm which manifested itself on March 5, 2013. The issues in dispute are accident, causal connection, temporary total disability (TTD) benefits, temporary partial disability (TPD) benefits, and prospective medical care. Petitioner was the sole witness at the arbitration hearing which began on November 25, 2013; however, proofs remained open. Proofs were closed on January 13, 2014.

In conjunction with the submission of their proposed decisions, the attorneys for both parties submitted a Stipulation regarding TTD and TPD paid and TTD owed/claimed. A copy of that Stipulation is marked as Arbitrator's Exhibit 5 and has been made a part of the record.

The Arbitrator finds:

On March 5, 2013 Petitioner was working for Respondent, a temporary employment agency, as an assembler at the TRW Plant in Marshall, Illinois.

Petitioner testified that as an assembler, she worked on an assembly line comprised of four stations. For the first two stations Petitioner would face north and the components would come off a conveyor belt on her left side, which she would take off the conveyor belt and put on the machine using her left arm. On the last two stations, Petitioner would face south, which would require her to also take component parts off with her left hand and arm. The conveyor belt would always be bringing parts to Petitioner on her left side.

Petitioner's job consisted of putting together component parts for a box for automobile air bags. Petitioner described her job having a time element in that the hourly goal was completion of 190 parts. Petitioner testified that in the very first station ("the lead off station") she would attempt to do more than the quota for the day, stating that if the very first station does not get 190 parts or more, there is no way the rest of the stations will reach their quota because if the parts do not get the proper conformal coat, then the part will not pass to the next stations. Therefore, Petitioner has to do more than 190 parts at the first station in order to make sure they reached their quota for the day.

Petitioner described the conveyor belt as being approximately three feet wide, thereby requiring her to reach across the conveyor belt with her left arm to get the component parts and put them in a machine that is in front of her. Petitioner explained that she would extend her left arm, pick up the part, and proceed with putting it into the machine. Petitioner testified that her job requires her to pick up the parts and add them to a component (that was coming down the conveyor belt). Since the conveyor belt is located on Petitioner's left, she is required to reach across with

her left arm to pull the part and/or pick it up and to place it in front of a machine, which is in front of her.

Petitioner further testified that in the first station she would put the parts on the machine, and then she would go back to the conveyor belt and repeat the process with her left arm until she had handled the appropriate number of parts to reach her quota.

Petitioner described station two as being similar to a rotisserie chicken/ferris wheel in that it centers around a machine that goes round and round in a circular motion and contains bars (like seats on a ferris wheel). Petitioner testified there are thirty bars/slots. Petitioner explained that she takes the parts off the conveyor belt with her left hand and arm, and puts them in the slots. Petitioner further described the process as similar to a ferris wheel, and she described the ferris wheel has having thirty seats and each bar holds ten components that she would take off the conveyor belt. Her description was that the ferris wheel would have ten seats on each row, and if she did not get the ten loaded on the first run, then she would just have to go to the next one because once it goes so far down, one cannot put on any more parts because the machine has an automatic shutoff if you stick your hand in too far. Petitioner testified she worked at eye level and above with her hands and arms.

Petitioner further testified that she uses her left hand to make sure that her right hand does not push the part too far. Otherwise it will fall. If the part falls, or if one picks up the part without gloves, it is an automatic loss of the part because they are fragile. According to Petitioner, Respondent would then automatically scrap the part for safety reasons. Petitioner is required to load the bar/ferris wheel seat as it travels around on the ferris wheel, and then when it comes back to her, she has to take the parts off.

In station three, Petitioner would move to the opposite side of the conveyor belt, continuing to use her left hand and arm. Petitioner testified she would take components that come out of the conformal coat and flip them over. The part is read, and once the clear signal is given, she puts the parts together and puts them back on the conveyor belt with her left hand. Petitioner stated that she holds a cover with her right hand, and when the part comes off the conveyor belt, she uses her left hand to stick the part inside the casing, and then puts it back on the conveyor belt so that the casing will go to the next station.

According to Petitioner, station four is at the very end of the conveyor belt. Petitioner explained that she takes components off of the belt with her left hand, and places them in a machine that reads the numbers. There are then three stacks of lids that go on the compartments. At that time, she uses both of her hands to operate a screwdriver machine, which screws the lid on the box. Petitioner then will take them off of the machine, and put them on the rack with her left hand and arm. She described the rack as having a top shelf of about five feet and a bottom shelf of about knee level. The shelf will hold over one hundred of the compartments. At all four stations, the process continues to be timed, with the first, third, and fourth stations showing how many went out that hour.

Petitioner testified that she usually worked a ten hour day with is a morning break, a lunch period, and an afternoon break.

Petitioner testified that in late January, 2013, she began noticing problems with her left arm. According to Petitioner she continued performing her job as an assembler and in February and March, 2013, she started noticing that it was harder to hold her left arm up. Petitioner testified she could not put deodorant on, and she eventually required help with clothing because she could not lift her arm over her head. On March 5, 2013, Petitioner went to the Human Resources Office and requested that Respondent move her to a different location so that she would not be using her left arm all the time. According to Petitioner, Human Resources refused to move her. Instead, Petitioner was advised to go to Terre Haute Regional Hospital to Occupational Health and to fill out an accident report.

Petitioner testified that she filled out an Incident Report on March 5, 2013, underwent a urine analysis at a medical facility in Marshall, Illinois, and then proceeded to Terre Haute Regional Hospital, where she was seen by Dr. Singh in the Occupational Medicine Clinic. According to the Report and the records, Petitioner gave a history of having sustained an accident on/approximately January 28, 2013. Petitioner explained that she began working at TRW in October and began having shoulder problems in November. Petitioner initially attributed her symptoms to getting used to her new job. She could not recall a specific accident or date; rather her arm had just been hurting – in particular raising her arm over her head. When doing so Petitioner would notice radiating pain from her shoulder into her left neck and chest. Occasionally, Petitioner noticed her shoulder felt stiff and tight. It was worse at night and she was having trouble dressing herself or putting deodorant on. Petitioner rated the pain as constant and a 9-10/10. Petitioner denied any numbness, tingling, or weakness in her left arm. According to Dr. Singh, Petitioner had tried Biofreeze, heat and ice with no relief. She had been wearing a makeshift sling at home and trying Tylenol with codeine (which a doctor had given her while treating for another injury). Petitioner was unable to take Ibuprofen or aspirin due to side-effects. Petitioner was noted to have previously undergone a left-sided carpal tunnel release, cubital tunnel release and ulnar nerve release. Petitioner denied any previous left shoulder injuries. (AX 4 - PX1, Amended)

On physical examination Petitioner had tenderness to her AC joint and the posterior distal region of her shoulder. She exhibited pain into the muscles on the left side of her neck and experienced pain with forward flexion at 45 degrees, abduction at 45 degrees, adduction at 30 degrees. Petitioner was unable to perform internal or external rotation due to pain. X-rays of Petitioner's left shoulder were negative. Petitioner was diagnosed with left shoulder pain. She was given Tylenol # 3 to take, as needed, and advised to continue using her available prescription medication. She was instructed to alternate using ice and heat. Due to the length of time Petitioner had been having problems and the fact she couldn't raise her arm overhead she was advised to undergo an MRI. Petitioner was also given a restriction of no lifting, carrying, pushing, or pulling over 6 – 10 pounds or reaching above her shoulders. (AX 4 - PX 1, Amended; RX 1)1

1 That same day Dr. Singh issued a written report to Respondent and TRW Automotive summarizing the visit (AX 4 - PX 1, Amended)

Petitioner underwent an MRI on March 7, 2013 which showed slight osteoarthritis in the AC joint and a small cyst in the proximal humerus. (AX 4 - PX 1, Amended)

Petitioner was re-examined by Dr. Singh at Terre Haute Regional Hospital (Occ Med Dep't) on March 8, 2013. She continued to complain of pain in the region of the AC joint and biceps head. She denied any radiating pain down her left arm but still complained of neck stiffness. She had been following the doctor's earlier instructions but with no relief of pain. Although there wasn't much to be seen on the MRI, the doctor still felt she should see an orthopedic specialist due to her limited range of motion and inability to raise her arm over her head. Treatment recommendations and work restrictions remained unchanged. (AX 4 - PX 1, Amended) Dr. Singh again followed up the exam with a letter to Respondent and TRW.

Petitioner was next seen by Dr. Jeffery Bollenbacher at Sports & Orthopedicss, P.C. on March 15, 2013. According to his office note (labeled "New Patient Evaluation Workmens' Compensastion [sic]") Petitioner gave the same history as when she presented to Dr. Singh. She acknowledged that nothing at her workplace was heavy but she was on an assembly line and engaged in a lot of repetitive motion. Petitioner did not think the ergonomics at work were very good. Petitioner had not been working since March 5, 2013 but her condition wasn't improving. Petitioner described it as an occasional stabbing pain and, other times, an ache. According to Petitioner her bra strap really made her shoulder hurt. Upon examination Petitioner's ability to lift her left arm was limited to 90 degrees, extension to 40 degrees, and external rotation to 35 degrees. Jobe's and Neer's signs were positive. The doctor's impression was adhesive capsulitis, impingement syndrome, an AC joint sprain/strain, and mild osteoarthritis of the AC joint. He injected Petitioner's shoulder and advised her to begin a home exercise program. Formal occupational therapy was also recommended subject to approval from workers' compensation. Petitioner was also advised to use ice for pain as needed and to continue with her home medications and add Celebrex if her family doctor concurred. Petitioner was further advised that she could return to work with a lifting limitation of 10 lbs. and no reaching above the shoulders. (AX 4 - PX 3, Amended; PX 1, Amended; RX 3)2

Petitioner returned to see Dr. Bollenbacher on April 12, 2013 as instructed. She reported the injection helped but also reported increased discomfort due to having to drive a stick-shift truck while her regular car was being worked on. She had been attending physical therapy at the doctor's office until the previous week when she was sick. Petitioner was noted to be right hand dominant. Her diagnoses remained unchanged and her treatment recommendations were only modified to add a Medrol Dosepak. Her restrictions remained unchanged and she was to return in three weeks. (AX 4 - PX 3, Amended; PX 1, Amended)

On May 3, 2013 Petitioner returned to see Dr. Bollenbacher. Petitioner reported that on April 23, 2013 (approximately a day after a physical therapy visit) she "couldn't" move her neck and experienced left shoulder pain. She ended up calling the doctor about it. Petitioner reported "throbbing pain" in her left shoulder that would come and go after her exercise program, physical therapy, and increased activity. Her diagnoses remained unchanged. Her work restrictions were

2 Copies of Dr. Bollenbacher's office notes were furnished to Respondent and its carrier.

lessened to the extent the weight was increased from 10 lbs. to 25 lbs. Petitioner was advised to return in four weeks. In a Medical Treatment Report/Employee Injury/Illness Treatment Report Dr. Bollenbacher listed Petitioner's diagnosis as "impingement resolving/repetitive injury." The doctor ordered physical therapy. (PX 2)(AX 4 - PX 1, Amended; PX 3, Amended)

At Respondent's request, Petitioner underwent an examination pursuant to Section 12 on May 23, 2013, with Dr. Lawrence Li. Thereafter, Dr. Li issued a written report based upon his examination and review of certain medical records (Dr. Bollenbacher's). He agreed with Petitioner's diagnosis of adhesive capsulitis. He further opined that the treatment provided by Dr. Bollenbacher was reasonable and necessary for adhesive capsulitis. However, Dr. Li did not feel that Petitioner's adhesive capsulitis was related to the March 5, 2013 reported injury, stating that such a condition is most commonly found in females between the ages of forty and fifty. He also agreed with injections, physical therapy, anti-inflammatory medication, and use of a Medrol Dosepak to treat Petitioner. Dr. Li stated that the only restriction that Petitioner would have would be no over chest work. Finally, he felt she would be at maximum medical improvement within two months to one year. (R Group X 5)

On May 30, 2013, an initial evaluation was performed at Paris Community Hospital per Dr. Bollenbacher's recommendation for physical therapy. Paris Community Hospital Physical Therapy set up eleven physical therapy appointments to begin on June 4, 2013, and end on June 27, 2013. Petitioner was unable to receive physical therapy because Respondent's carrier denied treatment, and refused to authorize treatment. (PX 3)

Petitioner presented to Dr. John Rowe at the Family Medical Center on July 9, 2013 for a second opinion regarding her shoulder. Petitioner described her job with TRW and related that while performing those duties she began experiencing some intermittent activity-related pain which by March 5, 2013 became severe enough that she had limited range of motion and trouble undressing. Petitioner also reported neck pain but without any radiating pain to her extremity and no numbness or tingling. Despite being off work since March 13, 2013 Petitioner reported ongoing and persistent shoulder pain both posteriorly and superiorly. On examination Petitioner displayed some atrophy of her deltoid and there was some prominence and tenderness to palpation of her AC joint. Her biceps tendon and anterior joint line was also tender. Petitioner displayed positive impingement and Hawkins and O'Brien's testing was done with pain on apprehension and load and shift and relocation. The doctor reviewed Petitioner's previous MRI which he felt was of poor quality. Dr. Rowe felt Petitioner had evidence of AC joint arthritis, impingement and a questionable anterior labral Bankart lesion. The MRI was read by the Center's radiologist and noted to be consistent with impingement but there was no evidence of joint effusion, a biceps tendon problem, or a rotator cuff tear. Dr. Rowe further opined that Petitioner's condition was casually related to Petitioner's work-related activities "on the basis of acumulative repetitive trauma." Dr. Rowe based his opinion upon his understanding that the biomechanics of the shoulder and Petitioner's explanation of her work-related activities. He stated that Petitioner had not yet reached maximum medical improvement, and that he would consider her temporarily partially disabled. His restrictions consisted of lifting, pushing, pulling no more than five pounds with the upper extremity; avoiding climbing ladders; no work at or above shoulder level with left upper

extremity; and avoid forceful grasping, pushing, pulling, and torquing of left upper extremity; and avoid repetitive motions with her left shoulder. He further instructed Petitioner not to perform any work requiring reaching with left shoulder extremity at or above shoulder level with the arm fully extended. He recommended that an MRI arthrogram be performed. (PX4; PX 5)

Petitioner testified that her appointment with Dr. Rowe lasted approximately one hour.

Petitioner signed her Application for Adjustment of Claim on July 25, 2013. (AX 2)

By letter dated August 7, 2013 Petitioner was advised to report to the Edgar County Human Resources Center on August 8, 2013 at 6:00 a.m. where she would be provided light duty work Monday through Friday for forty hours/week. Petitioner was to be paid $9.25/hour. (PX 8)

An MRI arthrogram was performed on August 7, 2013. According to the Radiologist's report, Petitioner had a type II acromion, an intact rotator cuff, labrum, and biceps, and findings consistent with a history of a frozen joint. (RX 4)

Dr. Rowe next saw Petitioner on August 20, 2013. He reviewed the MRI arthrogram personally. Petitioner was continuing to complain of signficant activity limiting pain in her left shoulder, including being awakened from sleep, limited ability to ride with her husband on his motorcycle, and pain with dressing and lifting and reaching objects in front of her. It was his opinion that Petitioner had a tear of the middle glenohumeral ligament and avulsion of the anterior labrum with some tendinopathy of the supraspinatus tendon. Dr. Rowe noted in his office note that Petitioner was now greater than eight months of left shoulder pain with significant limitation of activities. Petitioner had tried multiple injections, had had a course of physical therapy, and continued to have significant pain. Based upon his interpretation of the MRI arthrogram, he felt Petitioner did have a labral tear. He recommended that she undergo surgery consisting of an arthroscopy of the left shoulder with repair of the labrum if indicated, subacromial decompression, distal clavicle excision, and biceps tenotomy versus repair depending upon findings. He continued to place work restrictions of no lifting greater than twenty pounds; no work at or above shoulder level; and is to do no repetitive pushing, pulling, or lifting of her upper extremity. At that point, he was requesting authorization to proceed with surgical intervention. (PX4; PX 5)

On September 16, 2013 Petitioner filed her Petition for Section 8(a) medical treatment (PX 6) and Section 19(b) Petition. (PX 7)

Following the MRI arthrogram, Dr. Li was requested to issue an addendum report. In his letter of October 8, 2013, Dr. Li noted that he had reviewed the Radiologist's Report from the arthrogram as well as Dr. Rowe's medical records. Dr. Li disagreed with Dr. Rowe's recommendation of arthroscopy of the left shoulder. Dr. Li agreed that the MR arthrogram confirmed a frozen shoulder. It was his opinion that there was no evidence of any pathology in Petitioner's shoulder that required surgery.

At the arbitration hearing Petitioner testified that Dr. Rowe has told her she needs surgery

and she would like to have surgery authorized. She continues to notice limited motion of her shoulder. Petitioner testified that she needs assistance with getting clothing items over her shoulder. Petitioner described constant pain in her shoulder and occasional popping. The pain medication makes her sleepy. Petitioner testified that she has a newborn granddaughter who weighs seven pounds and Petitioner is unable to hold her. Petitioner feels she lacks strength in her shoulder. Petitioner also testified to occasional right shoulder pain which she believes is due to overcompensating.

Petitioner testified she has been off work since March 6, 2013. On cross-examination she acknowledged that she didn't work from December 20, 2012 through January 3, 2013 due to a calf problem. When asked about her history to Dr. Li in which she stated she began noticing problems in her shoulder in January of 2013, Petitioner explained it was probably the very end of January. She also testified that she spent some time on the "Work to Loan" program ("WOLP") while on restricted duty. Petitioner would supervise mentally challenged adults while they engaged in day to day activities. Petitioner usually stood while supervising so that she didn't have to use her left arm. During that time Petitioner acknowledged that she received weekly checks but the amount she received would be dependent upon the number of hours she worked at the program.

Petitioner testified that the Case Management Nurse was present at the IME but when Petitioner requested that the nurse attend and take part in the IME, the nurse refused. Petitioner testified that Dr. Li spent approximately three to five minutes with her. According to Petitioner, Dr. Li asked her questions about her employment but he did not weigh her, measure her, take her blood pressure, or use a stethoscope to take her heart beat. The only physical part of the examination was to have her hold her arms out in front of her, and she was asked if she could push down on his hand.

On further cross-examination Petitioner acknowledged that she worked for TRW in October of 2012 and that prior to that she did home health care. Petitioner's hobbies include walking, crocheting, and her kids (they play baseball, football, and basketball); however, she hasn't crocheted in some time and when she did, she did so wiith her right hand and not her left hand. Petitioner is right hand dominant.

The Arbitrator concludes:

1. Accident (Issue C). Petitioner sustained an accident on March 5, 2013 arising out of and in the course of her employment with Respondent. Petitioner's testimony was credible and her job description unrebutted. As such, she showed that her job required her to perform cumulative repetitive duties. Petitioner had no prior shoulder problems and there was no evidence presented to show any pre-existing trauma or disability in Petitioner's left shoulder. March 5, 2013 is a viable manifestation date. While Petitioner's symptoms and complaints may have begun earlier, it is on that date that Petitioner discussed with her doctor her belief that her complaints were associated with her work duties for Respondent.

2. Causal Connection (Issue F). Petitioner's current condition of ill-being in her left

shoulder is causally connected to her March 5, 2013 accident. This is based upon a chain of events and the opinion of Dr. Rowe whose opinion is deemed more credible and persuasive than that of Dr. Li. Petitioner's description of her job duties as an assembler was unrebutted and demonstrated that her job required her to perform cumulative repetitive duties. There was no history of pre-existing trauma, disability, or previous problems relating to her left shoulder. Petitioner's testimony, the medical records, and the opinion provided by Dr. Rowe support a determination of ongoing causation. The Arbitrator also concludes that Dr. Rowe's opinion is more credible than that of Dr. Li, and it is supported by the record. While Dr. Li did not believe Petitioner's shoulder condition was related to the March 5, 2013 reported injury he did not provide any explanation for his opinion and nothing in his reports suggests he had a clear, complete, and thorough understanding of Petitioner's job. The significance of this deficiency is further magnified by the fact Dr. Li also believed Petitioner should be restricted from above chest level work activities and Petitioner testified that portion of her job did, in fact, require at or above eye level work with her hands and arms which would constitute above the chest work. Additionally, Dr. Li appears to have misinterpreted Dr. Rowe's surgical recommendation as Dr. Li believed there were certain specific procedures Dr. Rowe was planning on performing beyond that of the arthroscopy. To the contrary, Dr. Rowe's intent is to perform an arthroscopy and at that time, and based upon his findings, proceed with additional procedures if appropriate based upon the findings. Indeed, he may do nothing more than the arthroscopy if the findings warrant nothing further being performed. Finally, the Arbitrator notes that Dr. Li did not review all of Petitioner's treating medical records.

3. Prospective Medical Care (Issue K). Based upon the Arbitrator's causation determination and the persuasive and credible testimony of Dr. Rowe, the Arbitrator concludes that Petitioner is entitled to prospective medical care in the form of an arthroscopy of the left shoulder with repair of the labrum if indicated, subacromial decompression, distal clavicle excision, and biceps tenotomy versus repair depending upon his findings.

4. Temporary Benefits (Issue L). Petitioner testified she has been off work since March 6, 2013 except for when she participated in the "WOLP." The parties stipulated that Petitioner has received $3,513.44 in temporary total disability benefits (TTD) and $633.71 in temporary partial disability benefits (TPD). (AX 1, 5) However, the stipulations of the parties (AX 1 and AX 5) contain some inconsistencies regarding the period of TTD. AX 1 alleges two periods of time with a short break in TTD (May of 2013) during which time Petitioner received TPD. AX 5 is silent as to any period of TPD being claimed and reflects a stipulation that Petitioner is entitled to TTD from March 6, 2013 through November 25, 2013. Respondent's dispute with regard to TTD and TPD has been based upon liability and not the periods of time. Accordingly, the Arbitrator is going to give greater weight to the stipulation of the parties found in AX 5 as it was based upon the attorneys having further time to review the issue as they had requested and, in accord with her liability determination above, awards Petitioner temporary total disability benefits (TTD) from March 6, 2013 through November 25, 2013, a period of 37 6/7 weeks based upon AX 5. Respondent is entitled to a credit for the TTD it has paid. Based upon this same stipulation there appears to be no claim for TPD at this time.

****

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

John Ortiz,
Petitioner,

vs. No. 12 WC 17509

Hard Rock Concrete Cutters,
Respondent.

14IWCC1015

DECISION AND OPINION ON REVIEW

A Petition for Review having been timely filed by Petitioner and notice given to all parties, the Commission, after considering the issues of accident, causal connection, temporary total disability, medical expenses, prospective medical treatment, and Respondent's credit for prior payments, and being advised of the facts and law, modifies the amount of credit awarded to Respondent for prior payments and otherwise affirms and adopts Arbitrator Flores' Section 19(b) Decision. A copy of the Arbitrator's Decision is attached hereto and made a part hereof. The Commission further remands this case to the Arbitrator for further proceedings for a determination of a further amount of temporary total compensation or of compensation for permanent disability, if any, pursuant to *Thomas v. Industrial Comm'n*, 78 Ill. 2d 277, 399 N.E.2d 1322, 35 Ill. Dec. 794 (1980).

Petitioner, a 40 year old concrete cutter employed by Respondent for over seven years, was injured on April 23, 2012 while using a core drill to make holes in concrete. He bent to vacuum slurry from the floor and raised up under a pipe that protruded 14" from the wall and struck him between his neck and left shoulder. Petitioner alleged injury to his cervical and lumbar spine. Respondent accepted the cervical injury, but denied that Petitioner's lumbar complaints were related to his April 23, 2012 work accident. Petitioner filed a Section 19(b) Petition, seeking authorization for cervical injections and treatment for his lumbar complaints. Respondent's Section 12 examiner, Dr. Zelby, opined that Petitioner was at maximum medical improvement with regard to his cervical injury by December 5, 2012 and found that his lumbar condition was not work-related. Respondent terminated all benefits based upon Dr. Zelby's opinions.

14IWCC1015

Prior to the Section 19(b) hearing on June 21, 2013, the parties filed a Request for Hearing, stipulating that Respondent was entitled to a credit of $35,166.04 for temporary total disability payments and an advancement toward permanency which it had paid prior to hearing. In her September 3, 2013 Decision, Arbitrator Flores found Respondent was entitled to a total credit of $36,166.04. Respondent timely filed a Section 19(f) Petition to Correct Clerical Errors, requesting several changes for perceived clerical mistakes in the Decision. Arbitrator Flores denied the Petition in its entirety, and Petitioner filed this appeal to the Commission.

After reviewing the entire record, including Respondent's Section 19(f) Petition, the Commission finds that the Arbitrator's calculation of credit for pre-hearing payments was erroneous and contrary to the parties' pre-hearing stipulation. Therefore, the Commission corrects the Arbitrator's award of credit for pre-hearing payments by reducing the amount credited to Respondent to $35,166.04 and otherwise adopts and affirms the Arbitrator's Decision.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Arbitrator's Decision, filed on September 3, 2013, is modified with respect to Respondent's credit for pre-hearing payments. Respondent shall receive credit for $35,166.04 for pre-hearing temporary total disability payments of $29,599.80 and $5,566.24 paid as an advance against permanency.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the reasonable and necessary medical bills of ATI, as documented in PX8, at the fee schedule rate, pursuant to Sections 8(a) and 8.2 of the Act. Petitioner's claim for the outstanding medical bills of Dr. Gireesan is denied.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay to Petitioner the sum of $810.95 per week for a period of 32.29 weeks, commencing April 24, 2012 through December 5, 2012, that being the period of temporary total incapacity for work under Section 8(b) of the Act.

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

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

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

14IWCC1015

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $30,000.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in the Circuit Court.

DATED: NOV 24 2014

Daniel R. Donohoo

o-09/09/14
drd/dak
68

Charles J. DeVriendt

Ruth W. White

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

ORTIZ, JOHN
Employee/Petitioner

Case# **12WC017509**

14IWCC1015

HARD ROCK CONCRETE CUTTERS
Employer/Respondent

On 9/3/2013, 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 0.06% 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:

0009 ANESI OZMON RODIN NOVAK KOHEN
JOHN M POPELKA
161 N CLARK ST 21ST FL
CHICAGO, IL 60601

1832 ALHOLM MONAHAN KLAUKE ET AL
STACEY E HILL
221 N LASALLE ST SUITE 450
CHICAGO, IL 60601

STATE OF ILLINOIS)
)SS.
COUNTY OF COOK)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b) & 8(a)

John Ortiz
Employee/Petitioner

v.

Hard Rock Concrete Cutters
Employer/Respondent

Case # 12 WC 17509

Consolidated cases: N/A

14IWCC1015

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Barbara N. Flores**, Arbitrator of the Commission, in the city of **Chicago**, on **June 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 **TTD overpayment and credit, prospective medical care**

FINDINGS

On the date of accident, **April 23, 2012**, Respondent *was* operating under and subject to the provisions of the Act.

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

On this date, Petitioner ***did not*** sustain an accident resulting in a low back injury that arose out of and in the course of employment as explained *infra*.

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

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

In the year preceding the injury, Petitioner earned **$63,254.40**; the average weekly wage was **$1,216.43**.

On the date of accident, Petitioner was **40** years of age, ***single*** with **1** dependent child.

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

Respondent shall be given a credit of **$29,599.80** for TTD, **$0** for TPD, **$0** for maintenance, and **$5,566.24** for other benefits (i.e., permanent partial disability advance payment), for a total credit of **$36,166.04** as agreed by the parties. *See* AX1 & Arbitration Hearing Transcript at 161-162.

Respondent is entitled to a credit of **$0** under Section 8(j) of the Act. *See* AX1.

ORDER

As explained in the Arbitration Decision Addendum, Petitioner failed to establish that he sustained a compensable low back injury as a result of the accident on April 23, 2012 and he further failed to establish a causal connection between any claimed current condition of ill being and his injury at work on April 23, 2012.

Temporary Total Disability

Respondent shall pay Petitioner temporary total disability benefits of $810.95/week for 32 & 2/7th weeks, commencing April 24, 2012 through December 5, 2012, as provided in Section 8(b) of the Act. Respondent shall pay Petitioner the temporary total disability benefits that have accrued from April 24, 2012 through June 21, 2013, and shall pay the remainder of the award, if any, in weekly payments. Respondent shall be given a credit of $29,599.80 for temporary total disability benefits that have been paid.

Medical Benefits

As explained in the Arbitration Decision Addendum, Respondent shall pay reasonable and necessary medical bills of ATI as provided in Sections 8(a) and 8.2 of the Act. Petitioner's claim for the outstanding medical bills of Dr. Gireesan is denied.

Prospective Medical Care

As explained in the Arbitration Decision Addendum, Petitioner failed to establish causal connection between his claimed current condition of ill being and accident at work. Thus, Petitioner's claim for prospective medical care is denied.

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

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

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

Signature of Arbitrator

August 30, 2013
Date

ICArbDec19(b)

SEP 3 - 2013

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b) & 8(a)

John Ortiz
Employee/Petitioner

v.

Hard Rock Concrete Cutters
Employer/Respondent

Case # 12 WC 17509

Consolidated cases: N/A

14IWCC1015

FINDINGS OF FACT

The issues in dispute include accident regarding Petitioner's claimed low back condition, causal connection regarding all of Petitioner's claimed current conditions, Respondent's liability for payment of certain medical bills, a period of temporary total disability, Respondent's entitlement to credit under Section 8(j) of the Act, and Petitioner's entitlement to the recommended cervical epidural injections. Arbitrator's Exhibit[1] ("AX") 1. The parties have stipulated to all other issues. AX1.

Background

Petitioner testified that he was employed by Respondent as a concrete cutter on April 23, 2012 and for approximately 7 ½ years. Tr. 10-11. He was also a Laborers' Union member of Local 76. Tr. 11, 15. As a concrete cutter, his duties included using a core drill to drill holes through concrete to allow for placement of pipes, etc., and using a roto hammer. Tr. 11, 14. Petitioner testified that core drilling required a lot of lifting and he would carry approximately 40-50 pounds of equipment at a time and 300 pounds total. Tr. 13. Core drilling also required him to stand and stand on a ladder. Tr. 13. A core drill weighs approximately 150 pounds without the blade or bit and he would have to mount it either on the floor or on the wall depending on what he was drilling. Tr. 14. Petitioner testified that he would drill anywhere from 15 to 45 minutes depending on the material that he was drilling. *Id.* Occasionally, Petitioner testified that he also helped others using a wall saw to cut window and door openings and using a slab saw, which is a flooring machine used to cut trench for plumbing and electrical. Tr. 12.

April 23, 2012

On April 23, 2012, Petitioner testified that he was core drilling toward the end of the day and he called the office to let them know that he would not be able to finish. Tr. 16. He testified that he was told to complete the job because there was another job for him the following day. *Id.* Petitioner testified that he bent down to vacuum the concrete and water slurry and "stood up kind of fast." *Id.* He testified that there was a "pipe sticking out of the wall about twelve inches [and about 4-5 feet up off the ground]. It had a shut-off valve on the top of it, and I struck my back and neck. And I fell forward knocking my [safety] glasses off and my hard hat." Tr. 16-17.

[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. Joint exhibits are denominated "JX." Exhibits attached to depositions will be further denominated with "(Dep. Exh. _)." The Arbitration Hearing Transcript is denominated as "Tr." with corresponding page numbers.

Petitioner testified that he was hit so hard that he felt like something fell off the ceiling and hit him and that he did not know what hit him when he fell forward. Tr. 17. He was on the ground for approximately 5-10 minutes trying to pull himself together and he slowly crawled to his equipment cart where he sat for another 5-10 minutes. Tr. 17-18. Petitioner testified that he felt light-headed and started feeling pain in his left shoulder. Tr. 18. He started to drill again, but felt his shoulder stiffen up and could barely lift his arm above shoulder level. *Id.* Petitioner testified that he reported the injury, but was asked if he could finish the job and did so. Tr. 18-19. He testified that he then went and completed paperwork at the steel mill and drove to the clinic on-site. Tr. 19-20. The steel mill provided transportation to the local hospital, St. Catherine's in East Chicago Indiana. Tr. 21-22.

Petitioner testified that he had never injured his left shoulder or neck before April 23, 2012, and that he has never before filed a workers' compensation claim. Tr. 20-21. He was injured while working for Respondent injuring a finger on his left hand sometime in October of 2011 and injured while working for a prior employer when he fell off of a ladder once. Tr. 20-21, 61.

On cross-examination, Petitioner testified that he did not recall being involved in a motor vehicle accident on May 6, 1998 or filing a claim with State Farm. Tr. 61-62. Petitioner further denied having a history of low back pain. Tr. 62.

Medical Treatment

The medical records reflect that Petitioner went to the St. Catherine Hospital emergency room on April 23, 2012. PX1. Petitioner reported that "he was working and bent over and when he stood up he hot [sic] his upper back just below neck to the steel pipe. Pt said he is having pain to affected area and feels neck is stiffening." *Id.*, at 4. A nurse noted that Petitioner "hit L shoulder mid upper back on pipe after getting up from bending down. No obvious injury noted. Onset 1430." *Id.* He also reported that "he was vacuuming in the 84 inch hot strip area of the mill when he bent over and as he stood up he hit his upper back on a steel pipe just below his neck." *Id.*, at 5. Petitioner underwent x-rays of the cervical spine, thoracic spine, and left shoulder, which were normal. *Id.*, at 14; Tr. 24. He was diagnosed with a back contusion, cervicalgia, and sprains and strains of joints and adjacent muscles and discharged with instructions to see his personal physician. PX1; Tr. 23-24. Petitioner did not report any low back complaints. PX1. Petitioner testified that he also took a drug test. Tr. 23; PX1 at 10.

Petitioner testified that on April 27, 2012 Dr. Plunkett was not in, so he saw Dr. Johansson. Tr. 24. The medical records reflect that Petitioner saw Dr. Plunkett and reported that he "backed up into a pipe at work about four days ago complaints of pain over the posterior medial aspect of his left chest between the spine and the shoulder and I can't really see anything there. He complains of some vague numbness in both hands. He's been able to do everything else. It did not sound like a dangerous mechanism. He doesn't have any complaints in his legs. He liked to see a workman's comp.. He has a name of somebody and so I've given a referral to that." PX2 at 5-6, 8. On examination, Petitioner had no tenderness over the spine, no bruising, ability to lift his arms, normal gait, and normal strength. *Id.* Petitioner did not report any low back complaints. *Id.* Dr. Plunkett placed Petitioner off work from April 24, 2012 through April 28, 2012 and until further evaluation by a specialist. *Id.* On cross-examination, Petitioner testified that he has not worked at all since his last day of work with Respondent. Tr. 62.

On April 30, 2012, Petitioner saw Dr. Gireesan reporting pain in the left upper back after an injury at work on April 23, 2012. JX3 (Dep. Exh. 2 at 5-6); Tr. 24. Petitioner denied headaches and, other than decreased range

of cervical motion, Petitioner's examination was normal. *Id.* Dr. Gireesan diagnosed Petitioner with traumatic myofascial syndrome of the left upper back and neck area, ordered physical therapy, and placed Petitioner off work since he could not drive a car and felt pain with standing. *Id.* Petitioner did not report any low back pain or symptoms. *Id.*; JX3 at 8-11.

A May 2, 2012 physical therapy note reflects that Petitioner had a chief complaint of bilateral cervicothoracic pain and bilateral upper extremity numbness and tingling which began on April 23, 2012 after being struck by a pole when standing up at work. PX4 at 102. Petitioner underwent Physical therapy at ATI from May 2, 2012 through October 4, 2012. PX4; Tr. 25. Petitioner testified that he noticed more pain during physical therapy, but it was explained to him that they had to do what they were doing to help Petitioner feel better. Tr. 25-26.

On May 24, 2012, Petitioner returned to Dr. Gireesan reporting headaches on the left side every other day that worsened with driving. JX3 (Dep. Exh. 2 at 7-8); Tr. 26. Other than decreased range of cervical motion, Petitioner's examination was normal. *Id.* Dr. Gireesan added a diagnosis of displacement of the intevertebral disc, site unspecified, without myelopathy with pain in the neck and both upper extremities, ordered a cervical spine MRI and continued physical therapy. *Id.* Petitioner did not report any low back pain or symptoms. *Id.*; JX3 at 11-12.

On May 29, 2012, Petitioner underwent the recommended cervical MRI and saw Dr. Gireesan reporting severe pain and increased headaches with driving. JX3 (Dep. Exh. 2 at 9-10, 15-16 & Dep. Exh. 3); Tr. 26. Dr. Gireesan maintained Petitioner's diagnoses and indicated that "[w]e will wait for the radiologist's report for definitive interpretation." *Id.* Dr. Gireesan kept Petitioner off work, prescribed more physical therapy, and refilled Petitioner's Norco, Naprelan, Ambien and Lioderm prescriptions. *Id.* Petitioner did not report any low back pain or symptoms. *Id.*; JX3 at 12-19.

The interpreting radiologist's cervical MRI report notes the following: (1) degenerative changes of the cervical spine most pronounced at C5-C6 where there is a shallow right paracentral/foraminal disc protrusion associated with mild right neural foraminal stenosis and no significant spinal canal stenosis at any level; and (2) nonspecific symmetric prominence of the lingual and palatine tonsils that may be reactive. JX3 (Dep. Exh. 2 at 15-16).

A June 3, 2012 physical therapy note reflects that Petitioner "had an incident of LBP, however, this has mostly dissipated." PX4 at 122.

On June 12, 2012, Dr. Gireesan reviewed cervical MRI, reported difficulty sleeping due to pain. JX3 (Dep. Exh. 2 at 11-13); Tr. 26. Petitioner continued to complain of pain, headaches and radiating pain into the left arm, but he reported improvement with physical therapy. *Id.* Dr. Gireesan kept Petitioner off work and ordered continued physical therapy. *Id.* Petitioner did not report any low back pain or symptoms. *Id.*; JX3 at 19-21.

On June 19, 2012, Petitioner reported difficulty sleeping, numbness in his fingers that increased in therapy, pain in the left neck with radiation to the left upper extremity, and headaches. JX3 (Dep. Exh. 2 at 14-16). Dr. Gireesan kept Petitioner off work and ordered continued physical therapy. *Id.* Petitioner did not report any low back pain or symptoms. *Id.*

A physical therapy note dated June 21, 2012 reflects that Petitioner reported "[increased] LBP since weekend Pt reports not doing anything unusual, stood for a while over the weekend[.]" PX4 at 137(*emphasis* added).

Under "Tolerance to TX" the physical therapist noted that Petitioner reported worsened pain after physical therapy. *Id.*

On June 26, 2012, Petitioner reported pain in the interscapular area and root of the neck, but gaining significant range of motion in the neck, "*pain in the lower back area last week. John informs me the therapist was working on his back when something triggered the pain in the back area.* John reports 40% improvement in his condition." JX3 (Dep. Exh. 2 at 17-18) (*emphasis* added). Dr. Gireesan updated Petitioner's diagnoses to include a back sprain, kept Petitioner off work and ordered continued physical therapy. *Id.* Petitioner did not report any low back pain or symptoms. *Id.*; JX3 at 21-22. Dr. Gireesan ordered physical therapy on June 28, 2012 for the cervical spine and "mechanical LBP/Strain[.]" PX4 at 95-96.

On July 10, 2012, Petitioner reported a burning pain in the neck on the left side, no radiation to the hands or arm, increased pain with lifting weights at physical therapy, and low back pain. JX3 (Dep. Exh. 2 at 19-22); JX3 at 22-24; Tr. 28-30. Dr. Gireesan performed trigger point injections which Petitioner testified that provided him with relief for a couple of days. *Id.* Dr. Gireesan discontinued physical therapy for one to two weeks, kept Petitioner off work, and maintained his prior diagnoses. *Id.*

A week later on July 16, 2012, Petitioner reported continued neck and low back pain but less burning in the left shoulder since the last trigger point injection and a 50% improvement in terms of neck pain relief with physical therapy and the injections. JX3 (Dep. Exh. 2 at 21-22); JX3 at 24-25; Tr. 27. Dr. Gireesan administered additional trigger point injections, ordered continued physical therapy to be followed by a work conditioning program, and kept Petitioner off work. *Id.*

On July 25, 2012, Petitioner returned to Dr. Plunkett noting that he had followed up with an orthopedic surgeon Dr. Gireesan and that he had undergone physical therapy with some continued discomfort in his chest, back, and neck. PX2 at 7. Petitioner reported some anxiety and vague headaches. *Id.* Dr. Plunkett also noted that Petitioner's blood pressure was borderline elevated and that "[t]here is a great component of stress and anxiety here. *Not sure what all his time off from work he is doing for him* [sic]." *Id* (*emphasis* added).

On August 20, 2012, Petitioner reported 40% improvement in his condition, neck pain that waxed and waned with days and activities although physical therapy seemed to help him, and worsened pain when he was not doing physical therapy. JX3 (Dep. Exh. 2 at 23-26); JX3 at 25-26; Tr. 30. Dr. Gireesan updated Petitioner stenosis to displacement of intervertebral disc, site unspecified, without myelopathy and recommended cervical epidural steroid injections to be performed at a pain clinic. *Id.* He ordered continued physical therapy and kept Petitioner off work. *Id.* Petitioner did not report any low back pain or symptoms. *Id.*

First Section 12 Examination – Dr. Zelby

Petitioner underwent an independent medical evaluation with Dr. Zelby at Respondent's request on September 24, 2012. RX5 (Dep. Exh. 2); Tr. 31. Dr. Zelby submitted to a deposition on May 15, 2013. RX5. Petitioner testified the appointment lasted no more than 10 minutes. Tr. 31.

Petitioner provided a history in which he reported that he was bent over vacuuming concrete slurry and hit his upper back on a pipe when standing up. RX5 & RX5 (Dep. Exh. 2). For the first time, Petitioner reported also hitting his head on the pipe. *Id.* He reported that he felt dizzy after he started to work again, so he sought medical treatment. *Id.* Petitioner reported that he had a severe headache, dizziness, neck pain and pain in the left shoulder blade with difficulty abducting his shoulder on the following day. *Id.* He also had numbness in his

left arm from the elbow down to his fingertips and continued to have this symptom in the mornings at the time of the IME. *Id.* Petitioner also reported a past medical history of hypertension and a fractured femur after a motor vehicle accident in 1985. *Id.*

On the date of the exam, Petitioner continued to complain of neck pain and pain between his shoulder blades. *Id.* He also reported headaches 2-3 times per week, difficulty sleeping, exacerbated symptoms by turning or moving too quickly, and pain at a level of 9/10 on the date of examination. *Id.* However, Dr. Zelby noted that Petitioner rested and moved comfortably, with no pain behaviors to suggest this was an accurate representation of his pain. *Id.* Petitioner also reported that he was on a new medication for hypertension and Dr. Zelby noted he had high blood pressure and told Petitioner to talk to his primary care physician about this right away. *Id.*

On examination, Petitioner was 216 pounds and 6'2" tall. *Id.* His neurological examination was normal for speech, cognition, CN 2-12, cerebellar, Romberg, and additional neurologic testing. *Id.* His cervical examination revealed tenderness with palpation to the lower cervical and upper thoracic regions in the midline, even with non-physiologic light tough. *Id.*

Dr. Zelby explained that he palpates the spine to see if there is a reproducible spasm. *Id.* Superficial light touch is touching so light that it would not be strong enough to result in any painful stimuli, and Petitioner reported this touching to be severely painful. *Id.* His cervical range of motion was limited. Spurling's maneuver was positive centrally with non-physiologic pressure. *Id.* Dr. Zelby explained that Spurling's test is axial loading the spine to look for fractures and that Petitioner reported severe neck pain while Dr. Zelby was lightly touching his head. *Id.* Hoffman's, squatting, straight leg raising, toe walking, heel walking, and Patrick's maneuver were negative bilaterally. *Id.* Dr. Zelby explained that Hoffman's test looks for pressure on the spinal chord. Straight leg raising looks for nerve irritation or potential problems in the lumbar spine. *Id.* Motor examination was normal: this exam included gait, posture, spasm and strength, and chord. *Id.* Squatting, toe walking and heel walking all test strength and coordination. *Id.* Posture is observed for scoliosis. *Id.* Spasm may be present and suggest a muscular process. *Id.* Sensory examination revealed diminished sensation in the entire left upper extremity but was otherwise normal. *Id.* Sensory exam tests the nervous system. *Id.* Reflex exam was normal except Petitioner had inconsistent behavioral responses which were positive for pain on superficial light tough, pain on simulation and non-anatomic sensory changes. *Id.* Measurements of the extremities revealed no atrophy and pulses were normal which meant there were no vascular issues. *Id.* Tinel's, Phalen's, and Adsons tests, which test nerves in the arms and first rib and brachial plexus, were negative bilaterally. *Id.*

Dr. Zelby reviewed Petitioner's MRI films and noted that they showed mild degenerative changes throughout the cervical spine with disc space heights well preserved. *Id.* At C2-3, there was a minuscule bulging disc. *Id.* At C3-4, there was a miniscule bulging disc and slight left uncovertebral joint hypertrophy without stenosis. *Id.* At C4-5, there was a broad-based bulging disc that minimally abutted the ventral thecal sac. *Id.* There was no stenosis. *Id.* At C5-6, there was a broad-based right paracentral disc/osteophyte complex, with mild effacement of the central CSF to the right, and mild right lateral recess foraminal stenosis. *Id.* At C6-7, there was a mild broad-based bulging disc, with minimal effacement of the central CSF. *Id.* There was no stenosis. *Id.* At C7-T1, there was a broad-based bulging disc and modest left uncovertebral joint hypertrophy, with trace left formaminal stenosis. *Id.*

Dr. Zelby noted that these degenerative changes were all mild, and easily age appropriate for Petitioner. *Id.* In laymen's terms, the MRI showed "mild aging of the spine with some bone spurs, consistent with someone in his early 40s. There are no acute or post-traumatic abnormalities." *Id.*

Ultimately, Dr. Zelby diagnosed Petitioner with cervical spondylosis and a cervical strain. *Id.* Dr. Zelby noted that Petitioner had never reported hitting his head and falling forward in any of the other medical records. *Id.* He agreed with Dr. Gireesan's diagnosis of traumatic myositis, which is essentially a soft tissue muscular contusion, but opined that Petitioner's injury resulted in no other infirmity to the spine or nervous system. *Id.* He also noted that Petitioner's MRI showed mild cervical spondylosis with degenerative changes, but no acute abnormalities and a predominant finding at C5-6 on the right, which had nothing to do with Petitioner's constellation of symptoms on the left. *Id.* He opined that the radiographic abnormality was not caused, aggravated or even made symptomatic as a consequence of the work injury. *Id.*

Dr. Zelby also noted that Petitioner had non-radicular left upper extremity complaints, with occasional and less severe non-radicular right upper extremity complaints and that cervical epidural steroid injections would be of no benefit since his symptoms did not correlate to his MRI findings. *Id.* Dr. Zelby explained that cervical steroid injections, "in the right circumstances are intended to relieve inflammation and pain associated with the nerves." *Id.*

With the exception of obvious non-anatomic sensory changes, Petitioner was neurologically normal. *Id.* When questioned about the non-anatomic sensory changes, Dr. Zelby explained, "Mr. Ortiz described loss of sensation in the entire left upper extremity. There's really no condition, irrespective of cause, that could affect the brain or spinal cord that could result in that kind of neurologic abnormality. There is no anatomic basis for the reported loss of sensory function." *Id.* Dr. Zelby opined that Petitioner's injury was a thoracic muscular contusion as well as perhaps a mild cervical strain and noted that Petitioner's persistent subjective complaints were out of proportion to his objective findings, particularly with the amount of treatment he had already received. *Id.*

Dr. Zelby recommended 3-4 weeks of work conditioning/hardening and indicated that Petitioner would then be at maximum medical improvement. *Id.* He released Petitioner back to work in the light-to-medium physical demand level indicating that Petitioner could return to work full duty after completing work hardening. *Id.* Dr. Zelby opined that only six weeks of physical therapy was reasonable and that Petitioner's medical treatment had been prolonged and protracted given the objective information about Petitioner's condition. *Id.*

Continued Medical Treatment

On September 25, 2012, Petitioner reported increased pain in his neck with radiation into both upper extremities that increased while watching television. JX3 (Dep. Exh. 2 at 27-28); JX3 at 26. Petitioner also reported 40% improvement in his condition and Dr. Gireesan continued to epidural injections. *Id.* Dr. Gireesan kept Petitioner off work and indicated that he would wait to see Dr. Zelby's recommendations. *Id.* Petitioner did not report any low back pain or symptoms. *Id.*

Petitioner testified that he completed physical therapy on October 4, 2012. Tr. 31; PX4.

On October 30, 2012, Petitioner reported continued left sided neck pain that worsened with activity, completing physical therapy, continued headaches, having his blood pressure under control, and pain in both elbows especially when he put pressure on them. JX3 (Dep. Exh. 2 at 29-30); JX3 at 26-27. Dr. Gireesan kept Petitioner off work and ordered work hardening and a functional capacity evaluation in light of Dr. Zelby's recommendation. *Id.* Petitioner did not report any low back pain or symptoms. *Id.*

Petitioner underwent work hardening at ATI from November 18, 2012 through December 5, 2012. Tr. 32; PX4. Petitioner testified that his pain increased and, as the days went on, work hardening was harder so that he could barely do anything they were asking him to do toward the end. Tr. 33-34.

Functional Capacity Evaluation

On December 6, 2012, Petitioner underwent a functional capacity evaluation ("FCE") at ATI. PX4 at 8-16; Tr. 34-35. The physical therapist indicated that the results were valid, although the report contained Petitioner's pain reports and pain behaviors in addition to objective data collected to determine the validity of testing. *Id.*

On cross-examination, Petitioner testified about certain tests performed during the FCE. He reported low back and neck pain during heel-toe walk testing and testified that it was a sharp pain. Tr. 54. During gait testing, Petitioner reported that he could not walk too far before he needed to sit down and sat during most breaks; he testified that he did so because his low back started acting up. Tr. 54-55. During stairs testing, Petitioner reported or demonstrated his head forward, holding onto the handrails, and slow labored steps alternating his foot with each step while ascending and descending, and reporting "my lower back is killing me." Tr. 55-56. Petitioner completed 22 of 50 steps terminating it with a report/behavior of "pain in my neck and my back from trying to hold myself up." Tr. 55-56. Petitioner testified that this was true and every time he went up he felt a pulling strain on his neck and that is when he had [pain in the] lower back. Tr. 56.

During standing tolerance testing, Petitioner reported or demonstrated his head forward, feet close and parallel to one another, and asked "[y]eah, can we move it? It hurts my neck to look down" at 5 minutes, he shifted his feet in place at 6 minutes, he moved his weight from side to side at 10 minutes, he reported "[i]t is really starting to bother my neck" at 15 minutes, he demonstrated a facial grimace and reported "[i]t is really starting to bother me from holding my hands up" at 16 minutes, he sat down at 21 minutes and reported "[t]here was a lot of pain in between my shoulder blades" at the termination of testing. Tr. 57-58. Petitioner testified that this was accurate. Tr. 58.

Petitioner testified[2] that his ability to heel-toe walk as identified in the FCE does not generally represent his abilities on every day since his accident because "[l]ike I said before, every day is different. From one day to the next day is different. I could be in more pain on one day and less the next day, but something will aggravated." Tr. 58-59. He testified that it was a bad day on the date of his FCE. Tr. 59. He added that he did not believe that he could do more on a good day "... Because I have tried to do things, and once I do them, the pain is just increasing. And it shuts me down for the rest of the day, maybe three, four days." Tr. 59-60.

On redirect examination, Petitioner reiterated that the way he felt on the day of the FCE is different from every other day. Tr. 64.

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[2] The Arbitrator notes that Petitioner's counsel made an objection just prior to the eventually re-phrased question posed by Respondent's counsel in the following exchange: "[Petitioner's counsel]: I object to the question as being unduly vague and too far-reaching. She's asking for every single day from the date of the accident to that date? That's not an appropriate form of the question. [Respondent's counsel]: I could go day by day. [Petitioner's counsel]: if you think that's going to help you, I think that's how you would have to do it. He can't answer for every day with one answer, and he probably doesn't recall, your Honor. The Arbitrator: Counsel, speaking objections are unnecessary. Sustained." Tr. 58.

Continued Medical Treatment

On December 10, 2012, Petitioner returned to Dr. Gireesan reporting "*[p]ain in the interscapular area, low back since it work related injury* [sic,]" completing physical therapy and work conditioning, and undergoing a functional capacity evaluation. JX3 (Dep. Exh. 2 at 31-32) (*emphasis* added); JX3 at 28-30; Tr. 35. Dr. Gireesan noted that Petitioner was still severely restricted in his activities, he had not seen any change in his condition, and he believed that a new MRI was appropriate to see if there was any interval change. *Id.* Petitioner did not report any low back pain or symptoms. *Id.*

Petitioner underwent the recommended MRI on December 17, 2012 at Northwestern Memorial Hospital. JX3 (Dep. Exh. 2 at 43-44); Tr. 35. The interpreting radiologist noted mild degenerative changes in the cervical spine without evidence of high grade neural foraminal or spinal canal stenosis and a 6 x 8 mm hyper intense T2 signal lesion at the midline floor of the mouth/anterior tongue base compatible with a thyroglossal duct cyst. *Id.*

Petitioner also saw Dr. Gireesan on December 17, 2012, reporting pain in the neck with radiation to the upper extremities. JX3 (Dep. Exh. 2 at 33-34); Tr. 35-36. Dr. Gireesan reviewed Petitioner's MRI noting a bulging disc at C6-C7 with no significant compression on the spinal cord. *Id.* He kept Petitioner off work, continued to recommend cervical epidural injections, and indicated that he awaited the FCE report to steer toward a vocational training program. *Id.* Petitioner did not report any low back pain or symptoms. *Id.*

Petitioner testified that he last received temporary total disability benefits through January 9, 2013 as indicated in a letter from Respondent. Tr. 36-38; PX5.

On March 15, 2013, Petitioner returned to Dr. Gireesan reporting pressure at the base of the neck, pain with sudden neck movements, radiating pain into the interscapular area on both sides, and inability to carry objects for too long. JX3 (Dep. Exh. 2 at 35-36); JX3 at 30-32; Tr. 38-39. Dr. Gireesan had not yet seen the FCE report on this date. *Id.* He reviewed Petitioner's December 17, 2012 MRI again indicating that it showed a bulging disc at C5-C6 and C6-C7. *Id.* Dr. Gireesan also noted the following:

> [Petitioner] wants to try cervical epidural steroid injections. *I informed [Petitioner] that the findings we have on the MRI are rather subtle. I do not see the extruded disc impinging on the spinal cord or the nerve roots. I also informed [Petitioner] that surgery by way of fusion is a big operation and that I would not recommend this until he has exhausted all the other options.* Id., (*emphasis* added).

Dr. Gireesan did not recommend or mention surgery in any of Petitioner's records other than in this progress note. JX3 (Dep. Exh. 2). Petitioner did not report any low back pain or symptoms. *Id.*

Second Section 12 Examination – Dr. Zelby

Petitioner submitted to a second independent medical evaluation with Dr. Zelby at Respondent's request on April 3, 2013. RX5 & RX5 (Dep. Exh. 3); Tr. 39. Petitioner testified the appointment lasted no more than 5 minutes. Tr. 39. On cross-examination, Petitioner testified that he experienced increased pain because he did not take his medication and due to bumps in the road and bouncing around while driving to the examination. Tr. 48-51.

On the date of his second evaluation, Petitioner reported that he had been in work conditioning for four weeks, but his symptoms increased during the second week so his pace of work conditioning was decreased. *Id.* He reported increased pain and stiffness in his neck, extending into both trapezius regions and the pain tingling and extending circumferentially into both upper extremities down to the tips of the fingers. *Id.* Petitioner also reported that he had all of the same pain in his neck, arms, and hands but also felt weakness in his hands. *Id.* His pain level was 8/10 improved from 9/10 earlier that morning. *Id.* Petitioner reported that he felt his symptoms were exacerbated by moving quickly, lifting, bending and fixed postures and that nothing gave him relief although he was taking pain medication and muscle relaxers. *Id.*

On examination, Dr. Zelby noted tenderness to palpation of the lower cervical and upper trapezius regions in the midline; even with non-physiologic light touch. *Id.* However, pressure in the same areas with testing of upper extremity strength elicited no pain. *Id.* The rest of the physical examination remained essentially the same as during Petitioner's first independent medical evaluation exam. *Id.*

Dr. Zelby reviewed Petitioner's December 17, 2012 MRI and noted that the study was unchanged since the last MRI. *Id.* He also reviewed additional medical records, work conditioning reports and Petitioner's FCE. *Id.*

Dr. Zelby noted that, despite Petitioner's complaints, his neurological examination was essentially normal and his MRI revealed mild degenerative changes without neural impingement. *Id.* Dr. Zelby again noted Petitioner's subjective complaints stating that "[h]is ongoing subjective complaints, their reported severity and their reported persistence cannot be explained by the objective medical evidence, and these complaints are completely inconsistent with the natural history of his objective medical condition." *Id.* Dr. Zelby also indicated that while Petitioner's FCE was described as valid, it made no sense in the context of the objective medical evidence and underlying medication condition stating that "[t]here is no medical evidence to suggest that Mr. Ortiz could not safely return to all of his usual vocational and avocational activities without restrictions." *Id.* At his deposition, Dr. Zelby testified that Petitioner's heart rate remained steady throughout the FCE testing and noted that this finding was suggestive that the test results were not an accurate representation of Petitioner's maximum abilities because maximum exertion should increase the heart rate as should the pain levels that Petitioner reported at the time of the FCE. *Id.*

On cross examination, Dr. Zelby admitted that pain cannot be measured and that he looks to see if the findings on the diagnostic studies correlate with the symptoms described. *Id.* He also testified that objective medical evidence would not be enough for him to prescribe epidural steroid injections because there would need to be corresponding pain complaints to support such an order. *Id.* He also acknowledged that the physical examinations in both of his reports were very similar, but explained that this was because Petitioner had essentially a normal physical examination on both occasions. *Id.* He also testified that he took Petitioner's word regarding his complaints and that is why he recommended work conditioning after the first examination. *Id.* Dr. Zelby also admitted that, hypothetically, if a disc is impinging on the thecal sac, an epidural injection would potentially help resolve symptoms arising from that condition. *Id.* He also explained that trigger point injections are intended to address a knot in the muscle that has point tenderness and is intended to relax the area and that a bulging disc is not caused by trauma but rather by degeneration and that a protrusion could be caused by trauma, but there were no protrusions identifiable in Petitioner's MRIs. *Id.*

Ultimately, Dr. Zelby felt Petitioner had reached maximum medical improvement in December of 2012 at the latest and could return to work after the some work hardening because Petitioner had no condition to explain his symptoms as it related to the spine – nothing in the nervous system, muscles, nerves joints or bones connected to the spine. *Id.* He also opined that Petitioner was not a candidate for cervical epidural injections because he

did not have a medical condition which would be treated with these injections and found that he required no additional medical treatment regardless of the cause. *Id.*

Continued Medical Treatment

On April 10, 2013, Dr. Gireesan, reviewed functional capacity evaluation test results, continued to recommend cervical epidural injections. On April 10, 2013, Petitioner reported pain in the neck with radiation to both shoulders, worsened pain if he did anything excessive and significantly diminished endurance, and being released per the functional capacity evaluation to sedentary to light duty work. JX3 (Dep. Exh. 2 at 38-39); JX3 at 38-39; Tr. 39-40. Dr. Gireesan released Petitioner to work in the sedentary-light capacity, continued to recommend cervical epidural steroid injections, and noted that he reviewed Dr. Zelby's most recent IME report. *Id.*

Correspondence

On April 19, 2013, Petitioner received a certified letter from Respondent dated April 6, 2013 addressed to PO Box 59334, but Petitioner testified that he address is PO Box 25627. PX7; Tr. 41. The letter directed Petitioner to return to work on April 12, 2013, which had already passed by the time he received a letter. Tr. 41-42. The letter also directed Petitioner to call Respondent by April 10, 2013 at 11:00 a.m. Tr. 42. Petitioner notified his attorney and forwarded the letter to him via e-mail. Tr. 42-43.

On cross-examination, Petitioner testified that he received his temporary total disability checks previously at PO Box 59334 in Chicago. Tr. 60-61. He acknowledged that he currently physically resides at 4726 N. Winchester, that he indicated his residence at 528 N. Francisco Ave. when he filed his application for adjustment of claim, and that at some point in time he also resided at 3526 W. Armitage Ave. Tr. 60. On redirect examination, Petitioner testified that he also received temporary total disability checks at PO Box 25627. Tr. 64-65.

Continued Medical Treatment

Petitioner returned to Dr. Gireesan on May 9, 2013 reporting continued neck pain with radiation to the middle back, pain down the medial aspect of both forearms, attempting to play ball with his kids and change the spark plugs in his truck with increased pain, and difficulty sleeping due to pain. PX6; Tr. 43. Dr. Gireesan continued to recommend epidural steroid injections and noted Petitioner "*is unable to his work as a concrete cutter. Him.*" PX6 (*emphasis* added). Petitioner did not report any low back pain or symptoms. *Id.*

Deposition Testimony of Dr. Gireesan

Respondent took the deposition of Dr. Gireesan, who admitted to meeting Petitioner's attorney prior to the deposition although further information was not garnered about the meeting. JX3.

Dr. Gireesan testified that on April 30, 2012, Petitioner did not report hitting his head, he denied headaches, and there was no mention of dizziness. *Id.* He testified that it was his understanding that Petitioner hit the pipe with the upper portion of his back in the area between his neck and the shoulder on the left side. *Id.* Throughout Petitioner's treatment, Dr. Gireesan acknowledged that he did not document any grimacing during cervical range of motion testing, pain with palpation, Spurling's maneuver, Hoffman's maneuver, or Waddell's signs (which he indicated that he did not know what Waddell's signs were). *Id.* Dr. Gireesan also testified that

Petitioner had full strength in his extremities and intact vibratory sensation. *Id.* he also testified that, while Petitioner had always complained of pain in both shoulders, it may have not been documented in his written records and he acknowledged that certain pain diagrams referenced throughout the deposition were not contained in his certified records. *Id.*

Dr. Gireesan also admitted that in reviewing Petitioner's MRI, he relied on the radiologist for a definite interpretation. *Id.* He also reviewed Petitioner's MRI at the deposition and noted that it revealed a minor bulging disk at the C6-7 level which he clarified was actually at C5-6. *Id.*

Dr. Gireesan testified that he reviewed Petitioner's functional capacity evaluation and admitted that, although the FCE indicated that he only demonstrated the ability to lift up to 8 or 14 pounds, Petitioner could carry up to 20 pounds in groceries and the like as, "[t]hey are not big weights anyway." *Id.* Furthermore, Dr. Gireesan testified that the FCE "is a rough guideline, you know, I would say sedentary to light, you know, where he could function." *Id.* He believed Petitioner could function at the light physical demand level even though the functional capacity evaluation placed him at the sedentary physical demand level. *Id.*

On cross examination, Dr. Gireesan testified that normally he does not document grimacing in his medical records and that he recalled Petitioner grimacing and displaying pain behavior during his examinations, but that he did not document this because he "what I mainly focus on, do they have any neurological deficit in terms of weakness or sensory changes in gait. Those are the major areas that we focus on." *Id.* Dr. Gireesan testified that Spurling's and Hoffman's maneuvers only test for large protrusions putting pressure on the spinal chord. *Id.*

Dr. Gireesan testified that on April 30, 2012, he diagnosed Petitioner with traumatic myositis because early on after someone gets hurt and they have no major structural problems, they treat it like a soft tissue injury and then after six weeks, on May 29, 2012, he ordered an MRI which found a right paracentral foraminal disc protrusion associated with mild neuroforaminal stenosis. *Id.* He testified that this finding would typically produce pain in the shoulder and extremities, but that the MRI did not match Petitioner's complaints because those included pain in both extremities and the protrusion was only on the right side. *Id.* Notwithstanding, Dr. Gireesan opined that the degeneration existed before the accident, but the accident caused it to be symptomatic. *Id.*

Dr. Gireesan testified that, in late June, Petitioner began complaining of low back pain and "I told [Petitioner] that was probably not, you know, related to the work because he got hit on the top… And so I said get therapy and move on with it." *Id.* Dr. Gireesan also testified that Petitioner was no longer complaining of radiation into his arms and hands and that he reported a 40% improvement by July 10, 2012; however, Petitioner reported worsened pain with increased weights at physical therapy so he administered a trigger point injection, which he testified that is intended to address soft tissue pain. *Id.* Dr. Gireesan also testified that Petitioner's pain was reportedly worsening when he was not in therapy, prompting him to recommended cervical epidural steroid injections, which are intended to address the disc protrusion and "deep" pain. *Id.*

Dr. Gireesan disagreed with Dr. Zelby's opinion that epidural steroid injections were not necessary because he only saw Petitioner on one occasion, although Dr. Gireesan agreed that Petitioner did not have any neurological deficits. *Id.* He further disagreed with Dr. Zelby and testified that an epidural injection is not an invasive procedure and perhaps it could enhance Petitioner's function; Petitioner had muscular complaints that seemed to have resolved, but he still had complaints so maybe epidural injections could help. *Id.*

Dr. Gireesan also testified that the FCE was a valid study which placed Petitioner at the sedentary-light capacity and that there was no way for him to know if the injections would be helpful unless they tried them. *Id.* Ultimately, Dr. Gireesan again testified that Petitioner's cervical condition was aggravated by the work injury, that he could not work full duty, and that his condition was temporary. *Id.* He testified that Petitioner's low back was not something that he injured in the accident at work. *Id.*

Additional Information

Regarding his current condition, Petitioner testified that he feels a stinging sensation in the middle of his neck, burning, sharp pain, numbness in both arms which occurs mainly while he is sleeping and occurs occasionally during the day, back spasms, and sharp pains shooting from the base of his neck down between his shoulder blades. Tr. 43-45. Petitioner also testified that he experiences unspecified symptoms in his low back mainly while going up and down stairs and after sitting for too long. Tr. 45. Petitioner testified that he takes Norco and Flexeril. Tr. 45-46.

Petitioner testified that to the best of his knowledge Petitioner's group Exhibit 8 contains outstanding medical bills from Dr. Gireesan and ATI. Tr. 46-47. He also testified that he wishes to undergo the recommended cervical epidural injections recommended by Dr. Gireesan. Tr. 47.

Brad Bacon

Respondent called Brad Bacon ("Mr. Bacon") as a witness. Tr. 67-68. He is a project manager for Respondent and has been so employed for approximately 8 years before which he was employed as a pastor. Tr. 68. Mr. Bacon testified that April 23, 2012 was a Monday and he was working as the project manager on a job when he received a call from the office about Petitioner. Tr. 69-70. Mr. Bacon testified about a series of conversations between himself and others.

During the first phone call, Mr. Bacon testified that the office told him that Petitioner was having difficulty completing his job and did not know if he could get it done on that date. Tr. 70. Mr. Bacon then received a call from Petitioner that he was hurt and testified that his concern was no longer whether the job was going to be finished but for Petitioner's well-being. Tr. 70. Mr. Bacon called Mr. Dvoratchek, Respondent's owner, and asked him if he wanted Mr. Bacon to go over and see how Petitioner was and what was happening, to which Mr. Dvoratchek responded affirmatively. Tr. 70.

Mr. Bacon then called Petitioner and was on his way from the job site to the first aid center at the steel mill at which time he asked Petitioner some questions including whether Petitioner had been in contact with Randy (Respondent's contact at the steel mill). Tr. 71. Petitioner responded affirmatively stating that Randy told him where to go and Mr. Bacon indicated that he would call Randy and have Randy come get Petitioner so that Petitioner could follow Randy to the first aid place. Tr. 71. Later on, Petitioner called Mr. Bacon back indicating that they were taking him from the first aid place to the hospital and Mr. Bacon told Petitioner that he would meet Petitioner at the hospital. Tr. 71.

Mr. Bacon arrived at the hospital and sat with Petitioner where he was being examined and had a conversation during which he asked Petitioner how the accident happened and where he was injured. Tr. 72. Mr. Bacon testified that Petitioner gestured to the back side of the right shoulder and neck area. Tr. 72. Mr. Bacon asked Petitioner whether he had on his hardhat and safety glasses and whether Petitioner hit his head, which Petitioner denied saying "[n]o, no, no[.]" Tr. 72-73. He also testified that he spent approximately an hour with Petitioner

at the hospital after which a nurse came in and told Petitioner that she would give him a pain medication prescription for him to take after his drug test. Tr. 77-78. Mr. Bacon asked Petitioner whether he felt okay to drive from the hospital in East Chicago, Indiana to Maywood[, Illinois] to get the drug test and Petitioner responded "[n]ope, I'm fine. I'll be good to drive." Tr. 78.

James Dvoratchek

Respondent called James Dvoratchek ("Mr. Dvoratchek") as a witness. Tr. 81-82. He is Respondent's owner and president. Tr. 82. Mr. Dvoratchek testified that he first became aware of Petitioner's injury on April 23, 2012 and that he tried to get "background from the people who had talked with him, and then I contacted Brad Bacon and requested that he go down to the job site and/or hospital to make sure [Petitioner] was okay because I was concerned as to his well-being." Tr. 83.

Mr. Dvoratchek testified that he spoke with Petitioner that evening and asked him how he was under the circumstances to which Petitioner responded that his shoulder and back was a little bit sore. Tr. 83. He spoke with Petitioner about the mechanism of injury and Petitioner reported that while he stood up there was a valve sticking out of the wall that hit him in his back. Tr. 83-84, 115-116. He testified that he asked Petitioner whether "it hit [Petitioner's] neck" or head, to which Petitioner responded "no." Tr. 84-85. Mr. Dvoratchek also testified that he asked Petitioner where he was hit on the back and that Petitioner told him that it was near his shoulder blade. Tr. 84. On cross-examination, Mr. Dvoratchek acknowledged that Mr. Bacon testified that the conversation between Mr. Dvoratchek and Petitioner involved Petitioner providing a brief "[y]eah, yeah" answers; however, the Arbitrator notes that Petitioner's counsel objected to this line of questioning during Mr. Bacon's testimony and the focus of Mr. Bacon's testimony changed. Tr. 74, 116-117.

Mr. Dvoratchek spoke with Petitioner the following day. Tr. 85-86. He called Petitioner because he received a call from the Advanced Occupational Clinic where Petitioner had the drug testing the night before and indicated that Petitioner did not seek additional medical treatment there. *Id.* Mr. Dvoratchek testified that Petitioner told him that he was going to see his own doctor and he asked Petitioner to inform him about his progress. Tr. 86-87.

Mr. Dvoratchek called Petitioner on the Monday of the following week, payday, to know Petitioner's status, but he did not hear back from Petitioner. Tr. 87.

At some point thereafter, Mr. Dvoratchek spoke with Petitioner at which time Petitioner said he saw his doctor on Friday and that the doctor told Petitioner that he had whiplash or something. Tr. 87-88, 122-124. Petitioner told Mr. Dvoratchek that he did not have a neck brace and that he was restricted from working for four weeks and, as a result, Mr. Dvoratchek told Petitioner that he would need to pick up the truck from him because they were busy at that time of year. *Id.* Petitioner told Mr. Dvoratchek that he could not drive, so he arranged to have two employees go to Petitioner's home and pick up the truck and gas credit card with instructions to leave the phone with Petitioner. Tr. 89. The employees returned with the truck, Petitioner's tools, the gas credit card, and phone. *Id.*

Mr. Dvoratchek tried to contact Petitioner again at his home phone number asking to speak with him about the accident and left him several messages, but never received a return call. Tr. 92-94. On July 18, 2012, Mr. Dvoratchek called Petitioner again because he'd received a request for employment verification around that time and he was trying to find out Petitioner status because he understood Petitioner was going to be off work for four weeks as of April and had no progress reports are updated work releases since that time. Tr. 94.

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On July 17, 2012, Mr. Dvoratchek sent Petitioner a letter to Petitioner at 6528 N. Francisco Ave. asking for an update regarding his work restrictions, indicating that Respondent was willing to accommodate Petitioner in a modified duty position if he had restrictions, and inquiring about in employment verification request that Mr. Dvoratchek received via facsimile. Tr. 95-100; RX1(a) & RX1(b). The letter was sent to Petitioner and delivery was attempted, but returned to Mr. Dvoratchek "attempted, not known." *Id.* Petitioner did not contact Mr. Dvoratchek after July 18, 2012. Tr. 100.

On September 13, 2012 and April 6, 2013, Mr. Dvoratchek called Petitioner at his home and left a message to call him back; Petitioner did not return his calls. Tr. 100-102. Mr. Dvoratchek also sent Petitioner a letter on April 5, 2013 that was dated April 6, 2013 to 3256 W. Armitage Ave. offering Petitioner modified duty work and asking Petitioner to get in contact with him. Tr. 103-106, 138-141; RX2(a) & RX2(b). The letter was sent via U.S. Express mail and delivered on April 6, 2013. *Id.* Mr. Dvoratchek also sent a copy of this letter to Petitioner at the PO Box 59334 address via U.S. Express mail which was delivered on April 6, 2013. Tr. 106-109; RX3(a) & RX3(b). Mr. Dvoratchek testified that he sent Petitioner the April of 2013 letter offering Petitioner work up to and including sedentary desk work as a result of a conversation with someone at his workers compensation insurance carrier who helped him put the letter together. Tr. 132-134, 137-138.

Mr. Dvoratchek called Petitioner again on April 10, 2013 at the number listed by Petitioner in the employee phone list and left a message. Tr. 110-111. Petitioner did not return Mr. Dvoratchek's call. *Id.* as of the date of trial, Mr. Dvoratchek testified that he did not have sedentary desk work available for Petitioner. Tr. 115.

Nebojsa Gilgorevic

Respondent called Nebojsa Gilgorevic ("Mr. Gilgorevic") as a witness. Tr. 147. Mr. Gilgorevic is a private investigator hired on April 3, 2013 to do an investigation of Petitioner. *Id.* Mr. Gilgorevic testified that he began his investigation at approximately 11:00 a.m. at a medical appointment that Petitioner had scheduled and identified Petitioner in the doctor's office when he observed Petitioner enter the waiting room and check in with the receptionist who stated Petitioner's name. Tr. 148, 152-153. Mr. Gilgorevic provided video surveillance footage of Petitioner. RX9.

The Arbitrator reviewed the video which reflects Petitioner walking and moving his neck in no apparent discomfort on various occasions. He also entered an automobile in no apparent discomfort and turned his head limitedly in no apparent discomfort.

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ISSUES AND CONCLUSIONS

The Arbitrator hereby incorporates by reference the Findings of Fact delineated above and the Arbitrator's and parties' exhibits are made a part of the Commission's file. After reviewing the evidence and due deliberation, the Arbitrator finds on the issues presented at trial as follows:

In support of the Arbitrator's decision relating to Issue (C), whether an accident occurred that arose out of and in the course of Petitioner's employment by Respondent, the Arbitrator finds the following:

The parties do not dispute whether Petitioner sustained an accident to the neck on April 23, 2012, but Respondent disputes whether Petitioner sustained a compensable injury to the low back. The Arbitrator finds that Petitioner did not sustain an accident resulting in an injury to the low back that arose out of and in the course of his employment with Respondent as claimed. In so concluding, the Arbitrator does not find Petitioner to be credible. Petitioner's testimony at trial differed significantly from the mechanism of injury that he reported to medical providers, his reports about low back pain began months after his injury at work, and Petitioner's low back pain complaints to Dr. Gireesan and during physical therapy are inconsistent.

At trial, Petitioner reported that he struck his upper back and neck on April 23, 2012. He testified that he crawled back to sit down and collect himself twice before calling for assistance and being instructed to finish his job despite a purportedly severe injury which he did. The emergency room records note that Petitioner had no outward evidence of any injury to the neck or upper back area, which is corroborated by Dr. Plunkett's records during a visit days thereafter.

Then Petitioner came under the care of Dr. Gireesan through an unknown referral. His records reflect that Petitioner had somewhat limited range of motion in the neck, but essentially otherwise normal examinations throughout the remainder of his treatment with the exception of Petitioner's continuing and inconsistent pain complaints in the neck, shoulders, bilateral arms, forearms, hands, and low back. The first reference in the records to any low back pain is in a June 3, 2012 physical therapy note that Petitioner "had an incident of LBP, however, this has mostly dissipated." PX4 at 122. A physical therapy note dated June 21, 2012 reflects that Petitioner reported "*[increased] LBP since weekend Pt reports not doing anything unusual, stood for a while over the weekend[.]*" PX4 at 137 (*emphasis* added). Under "Tolerance to TX" the physical therapist noted that Petitioner reported worsened pain after physical therapy. *Id.* On June 26, 2012, Dr. Gireesan noted Petitioner's report of "*pain in the lower back area last week. John informs me the therapist was working on his back when something triggered the pain in the back area.*" JX3 (Dep. Exh. 2 at 17-18) (*emphasis* added).

Additionally, Petitioner testified on cross examination about the low back pain complaints that he made during his FCE, including a report that his low back was "killing" him and demonstrating slow, labored steps and ceased performing testing activities due to reported low back pain. However, the Arbitrator does not find Petitioner's testimony regarding his low back pain at any point to be credible whatsoever.

Even Dr. Gireesan admitted that Petitioner's claimed low back condition was not related to his injury at work on April 23, 2012 and he testified that when Petitioner began complaining of low back pain "[he] told [Petitioner] that was probably not, you know, related to the work because he got hit on the top… And so I said get therapy and move on with it." Notwithstanding Dr. Gireesan's admissions, Petitioner did not report any low back injury or symptoms for months after his accident, he reported them occasionally to Dr. Gireesan and physical therapists, and, when he did report low back pain, it was related to activities outside of work. Indeed, Petitioner testified that he has not worked since April 23, 2012 and even Petitioner's report of low back pain to Dr.

Gireesan stemming from activities in physical therapy is contradicted by the physical therapy records which reflect Petitioner's reports of low back pain stemming from nothing unusual while at home over a weekend. Moreover, while the surveillance video of Petitioner is limited to one day and not shocking in terms of his activities while being filmed, it reinforces the demeanor representative of a claimant whose subjective complaints are either wholly unfounded by objective medical evidence or overstated, at best.

Based on all of the foregoing, the Arbitrator finds that Petitioner failed to establish by a preponderance of credible evidence that he sustained a compensable injury to the low back at work on April 23, 2012. Thus, all other issues related to the claimed low back condition are rendered moot, and all benefits and compensation related to the claimed low back condition is denied.

In support of the Arbitrator's decision relating to Issue (F), whether the Petitioner's current condition of ill-being is causally related to the injury, the Arbitrator finds the following:

The parties dispute whether Petitioner's claimed low back condition and neck condition are causally related to the accident at work on April 23, 2012. As explained in the accident analysis above, the Arbitrator finds that Petitioner failed to establish that he sustained a compensable low back injury at work and that Petitioner's testimony is not credible and further finds that Petitioner's claimed continued cervical spine condition is not causally related to his injury at work on April 23, 2012 beyond what is indicated by Dr. Zelby in his last Section 12 report dated April 3, 2013. In so concluding, the Arbitrator again finds that Petitioner's testimony is not credible. Moreover, his treating physician, Dr. Gireesan, relied almost exclusively on Petitioner's subjective complaints which are inconsistent with objective medical evidence in making his treatment recommendations and rendering his causation opinions. The Arbitrator assigns little weight to Dr. Gireesan's opinions in light of the record as a whole.

Indeed, Dr. Gireesan acknowledged during his deposition that Petitioner's MRIs revealed mild symptoms and he even amended his findings regarding the location of Petitioner's disc protrusion while reviewing the MRI during the deposition. He also admitted that Petitioner's right paracentral disc protrusion should produce symptoms on the right, not on the left as reported by Petitioner. This admission corroborates Dr. Zelby's review of Petitioner's subjective reports and objective medical evidence as reflected in his Section 12 reports; he also indicated that Petitioner's predominant finding was at C5-6 on the right, which had nothing to do with his left-sided symptoms. Notwithstanding, Dr. Gireesan testified that he administered trigger point injections for Petitioner's reported muscular complaints, which seemed to have resolved, and further recommended cervical epidural injections because they could help Petitioner's subjective complaints despite acknowledging that Petitioner had no neurological deficits. The Arbitrator does not find Dr. Gireesan's causation opinions or recommendations for treatment to be appropriate in light of these admissions and considering the medical evidence—the majority of which resulted in recommended treatment arising from Petitioner's subjectively reported, inconsistent and contradictory pain complaints.

Given this record, the Arbitrator finds the opinions of Respondent's Section 12 examiner, Dr. Zelby, to be persuasive. Dr. Zelby noted that Petitioner's persistent subjective complaints were out of proportion to his objective findings and objective findings noted by Dr. Gireesan; particularly given the amount of treatment Petitioner had already received and the inconsistencies between Petitioner's subjective reports and objective medical evidence. For example, he explained, "Mr. Ortiz described loss of sensation in the entire left upper extremity. There's really no condition, irrespective of cause, that could affect the brain or spinal cord that could result in that kind of neurologic abnormality. There is no anatomic basis for the reported loss of sensory function." Dr. Zelby also noted several inconsistencies between Petitioner's reported symptomatology at the

time of his functional capacity evaluation and his abilities or physical condition on that date. Ultimately, Dr. Zelby opined that Petitioner's injury was a thoracic muscular contusion as well as perhaps a mild cervical strain, which the Arbitrator finds to be persuasive diagnoses based on reliable objective medical evidence when viewing Petitioner's emergency room records, the records of Dr. Plunkett, and the objective medical evidence contained in Dr. Gireesan's records.

Finally, the Arbitrator finds that Petitioner's credibility is further brought into question by additional inconsistencies and contradictions. First, Petitioner's testimony at trial incredibly expounds on the details of his injury adding additional body parts, conditions, and pain complaints that are not corroborated by the medical records. Petitioner did not report any injury to the head to his supervisor or Respondent's owner, emergency room personnel, Dr. Plunkett, or even Dr. Gireesan. The first time that he mentioned any head injury was when he saw Dr. Zelby six months after his accident at which point his medical records already reflected Petitioner's denial of any loss of consciousness, dizziness, head injury, swelling or edema of any kind. Even Dr. Gireesan's records are devoid of a report of falling to the ground on the date of accident, or noting any bruising or lacerations consistent with the type of severe neck—and head, low back, etc.—injury that incrementally increased, but was nonetheless inconsistently reported, as time went on. Second, Petitioner complained of increased weight and high blood pressure at trial, but there is no credible evidence or any medical opinion that Petitioner's increased weight or blood pressure are secondary conditions related to his accident at work. Third, in addition to observing Petitioner at trial, the Arbitrator notes that the surveillance video taken of Petitioner on the date of his last independent medical evaluation is not shocking in and of itself, but it diminishes Petitioner's testimony at trial that he was experiencing a "bad" day with high pain levels when he is filmed walking and getting into and out of a vehicle and turning his head with absolutely no identifiable pain behavior in line with the severe pain reported by Petitioner. In light of the record as a whole, Petitioner's testimony is simply not credible.

Based on all of the foregoing, the Arbitrator finds no credible evidence to support a causal connection finding between Petitioner's claimed continued symptomatology in the neck and his accident at work beyond Dr. Zelby's last Section 12 report and finds that Petitioner failed to establish a causal connection between any claimed current condition of ill being and his work accident on April 23, 2012.

In support of the Arbitrator's decision relating to Issue (J), whether the medical services that were provided to Petitioner were reasonable and necessary, and whether Respondent has paid all appropriate charges for all reasonable and necessary medical services, the Arbitrator finds the following:

As explained above, Petitioner failed to establish a causal connection between any claimed current condition of ill-being and his accident at work on April 23, 2013 beyond that opined by Dr. Zelby in his last Section 12 report dated April 3, 2013. Petitioner claims that Respondent is liable for certain outstanding medical bills from Dr. Gireesan for treatment in 2013 and from ATI for physical therapy from November 2012 through January of 2013. The Arbitrator finds that the bills from ATI were reasonable and necessary, but not those of Dr. Gireesan. Thus, the outstanding medical bills from ATI are awarded pursuant to the Act and Dr. Gireesan's outstanding medical bills from 2013 are denied.

In support of the Arbitrator's decision relating to Issues (K) and (O), Petitioner's entitlement to prospective medical care, the Arbitrator finds the following:

As explained in detail above, Petitioner has failed to establish a causal connection between any claimed current condition of ill being and his work injury. Thus, his claim for prospective medical care is denied.

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In support of the Arbitrator's decision relating to Issues (L), (N) and (O), Petitioner's entitlement to temporary total disability benefits, temporary total disability benefits overpayment and credit, the Arbitrator finds the following:

The parties stipulated that Petitioner is entitled to temporary total disability benefits through September 24, 2012. AX1. Thus, such benefits are awarded. The Arbitrator further awards temporary total disability benefits through December 5, 2012, when Petitioner completed work conditioning in accordance with the opinions rendered by Dr. Zelby that Petitioner reached maximum medical improvement. Thus, Petitioner's claim for temporary total disability benefits after December 5, 2012 is denied. Respondent shall be given a credit of $29,599.80 for temporary total disability benefits that have been paid.

In support of the Arbitrator's decision relating to Issue (M), whether penalties or fees should be imposed upon Respondent, the Arbitrator finds the following:

Given the facts presented in this case, and after considering the parties' motion and response, the Arbitrator finds that Respondent had a reasonable dispute as to whether Petitioner sustained a compensable injury to any body part other than the neck and whether Petitioner's claimed continued condition of ill being in the neck was causally related to his accident at work as alleged. Respondent repeatedly required Petitioner to submit to Section 12 examinations and the record reflects that Petitioner avoided contact with Respondent while residing at one of several residential addresses and receiving mail at two PO box addresses. Respondent's conduct was not unreasonable, vexatious and/or in bad faith. Thus, Petitioner's claim for penalties and fees under Sections 19(k), 19(l) or 16 of the Act is denied.

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Elizabeth McKinley,

Petitioner,

vs.

14IWCC1007
NO: 10 WC 43687

Metro Staff,

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, permanent partial disability, penalties/fees, and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed August 12, 2013, is hereby affirmed and adopted.

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

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

DATED: NOV 24 2014
CJD:yl
o 11/12/14
49

Charles J. DeVriendt

Daniel R. Donohoo

Ruth W. White

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

McKINLEY, ELIZABETH
Employee/Petitioner

Case# **10WC043687**

METRO STAFF
Employer/Respondent

14IWCC1007

On 8/12/2013, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

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

BART DURHAM & ASSOC LTD
400 N SCHMIDT RD
SUITE 200
BOLINGBROOK, IL 60440

0766 HENNESSY & ROACH PC
JASON D KOLECKE
140 S DEARBORN 7TH FL
CHICAGO, IL 60603

STATE OF ILLINOIS)
)SS.
COUNTY OF MCHENRY)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

14IWCC1007

ELIZABETH MCKINLEY
Employee/Petitioner

v.

Case # **10** WC **43687**

METRO STAFF
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 Erbacci**, Arbitrator of the Commission, in the city of **Woodstock**, on **June 6, 2013**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

14IWCC1007

FINDINGS

On **October 28, 2010**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

On this date, Petitioner ***did 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 **$15,305.16**; the average weekly wage was **$294.33**.

On the date of accident, Petitioner was **31** years of age, ***single*** with **4** dependent children.

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

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

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

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

ORDER

The Petitioner's claim for compensation is denied.

No benefits are awarded herein.

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

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

Arbitrator Anthony C. Erbacci

August 1, 2013
Date

AUG 12 2013

14IWCC1007

FACTS:

On October 28, 2010, the Petitioner was employed by the Respondent, a temporary agency, and she was performing the duties of an assembly line worker at the Weber Grill assembly plant in Huntley, IL. The Petitioner's work duties at this location consisted of working in various positions assembling grills. The various physical duties the Petitioner performed included putting together card board boxes, putting grill parts into boxes, and other necessary tasks to complete the assembly of a grill. The Petitioner testified that during her eight hour shift, from 6:00am to 2:00pm, she never performed the same task for more than two hours continuously. At least every two hours if not sooner, she would be rotated to a different work position on the assembly line.

The Petitioner testified that on October 28, 2010, her supervisor assigned her to a position she had never worked before. She testified that this position required her to lift pieces of grill frames out of a bin and then place the pieces into a box on the assembly line. The Petitioner described the pieces as "heavy" and she testified that she was required to do this job in a "confined space". The Petitioner testified that she started her shift at 6:00 am and that at about 11:00 am she began to notice that her back began to stiffen and get "tense". She testified that she continued working and completed her regular eight hour shift and then went home. The Petitioner testified that she did not report her back stiffness to her supervisor or anyone else before she left to go home and that she did not seek any medical treatment that day.

The Petitioner testified that her back stiffness increased while she was at home and that when she awoke the next day, which was a Saturday, her back was "hurting a lot". She testified that she stayed home hoping the pain would subside, but it did not go away. The Petitioner testified she did not seek any medical treatment on that day.

The Petitioner testified that on Sunday, which was Halloween, she had difficulty walking due to back pain. She testified that she started to go trick or treating with her children, but the pain increased to the point she was unable to participate in the activity and had to go home and lay down. The Petitioner did not seek treatment on this day either.

On Monday, November 1, 2010, the Petitioner returned to work and began her shift at 6:00am. The Petitioner testified that she mentioned her back pain to one of the Respondent's managers and she testified that she was assigned to a different job. She testified that she worked for about 15 minutes and then had to stop. She testified that she informed a supervisor of her condition and was sent to the nurse's station. The Petitioner testified that she was then sent to Physicians Immediate Care and was driven there by one of the Respondent's employees.

At Physicians Immediate Care, a history was taken and a physical exam was performed, along with x-rays of the thoracic spine. The history noted indicates that the Petitioner developed left sided mid back pain on October 28, 2010, as a result of putting five to ten pound grill grates in a box for about an hour. The physical exam revealed normal back

range of motion, no lumbosacral lordosis, and no spinal kyphosis or scoliosis. Abnormal findings included tenderness of the left thoracic paravertebral musculature and pain with lateral rotation. The Petitioner rated her pain at 5 out of 10. X-rays of the thoracic spine were found to be normal. The diagnosis at that time was a lumbar strain. The Petitioner was provided pain medication and work restrictions consisting of no lifting greater than 10lbs from floor to waist and no lifting greater than 5lbs from waist to shoulder.

The Petitioner testified that she provided these restrictions to her employer, but was never contacted about returning to work. Monique Edwards testified that these restrictions would have been within the Petitioner's everyday job activities and thus there would be no reason to have to make any accommodation in order for the Petitioner to be physically able to return to work. The Petitioner testified that after November 1, 2010 she never returned to work for the Respondent nor did she ever attempted to.

The Petitioner returned to Physicians Immediate Care on November 8, 2010. The record indicates that the Petitioner reported some improvement in her back pain which she rated at 3 out of 10. She denied any radiation into the upper or lower extremities and the physical findings remained the same as the prior visit. The diagnosis was improving thoracic strain. The Petitioner was provided medication and her restrictions were lessened to no lifting greater then 10lbs floor to waist and no lifting greater than 15lbs waist to floor. The Petitioner was instructed to follow up in one week.

The Petitioner testified that instead of returning to Physicians Immediate Care, she sought alternative care with a chiropractor, Daniel Horn, at Advanced Medical and Wellness Center. The Petitioner treated with this facility for the first time on November 8, 2010, the same day as her visit with Physicians Immediate Care. The Petitioner provided a history of developing pain in the left mid back as a result of lifting parts at work on October 28, 2010 and she rated her pain at 3-5 out of 10. She reported no weakness, but reported that she did have radiation on the left side near the rib cage. The records from that initial visit do not indicate that any work restrictions were prescribed.

The Petitioner returned to Advanced Medical on November 10, 2010. The records from that visit indicate that the Petitioner reported that her pain had increased to 7 out of 10 and that she had developed weakness in the left and right arm. It was recommended that the Petitioner undergo chiropractic manipulations and physical therapy at the same time, five times per week for the first week. No work restrictions were provided at the time of this visit.

The recommended treatment program began on November 12, 2010. On November 15, 2010 the Petitioner reported that her pain had decreased to 3 out of 10. The Petitioner was provided with work restrictions for the first time after this visit. These restrictions consisted of no lifting greater than 10lbs, no standing more then 4-6 hours, no sitting more than 4-6 hours, no repetitive hand motions with the left hand more then 3-4 hours. She was also to avoid repetitive bending, carrying, overhead reaching, twisting, pulling. These restrictions were in effect until November 29, 2010.

The records from Advanced Medical and Wellness indicate that the Petitioner's pain rating had decreased to 1-2 out of 10 by November 22, 2010. On November 23, 2010, the pain rating was 1 out of 10, with the same finding on November 24, 2010 and November 29, 2010. On December 1, 2010, the Petitioner provided a pain rating of 1 out of 10. She was offered an EMG test, but she declined. She was recommended to continue with the chiropractor's plan of treatment. No work restrictions were provided to the Petitioner at the time of his examination. During her treatment visit on December 3, 2010 the Petitioner reported no pain, only stiffness. The Petitioner also reported no pain on December 7th, 8th, and the 10th. On December 14, 2010 the Petitioner provided a pain rating of 0-1 out of 10 and she reported that the frequency was only 2 times per week with no weakness or radiation. It was recommended that the Petitioner continue with chiropractic treatment and physical therapy for an additional four weeks. No written work restrictions were provided.

From December 14 2010 through January 11, 2011, the Petitioner attended therapy twelve times and missed treatment six times. The records demonstrate that, when the Petitioner did attend therapy, her pain rating was never above 2 and she often reported no pain. During this time no written work restrictions were provided. On January 11, 2011, the Petitioner reported pain of 1-2 out of 10, with a frequency of once to twice a week. It was recommended that the Petitioner continue with a supervised exercise program three times per week for four weeks and therapy was continued through January 20, 2011.

At the request of the Respondent, the Petitioner was seen by Dr. Babak Lami, an orthopedic spine surgeon, on January 26, 2011. At the time of this visit the Petitioner provided a history of taking 5lbs pieces of a grill and turning and putting them in a box on October 28, 2010. She indicated she was performing this task in a limited space. The Petitioner told Dr. Lami that she did not feel pain until October 31, 2010. The Petitioner reported that her initial pain was 9 out of 10 but that she did not feel any pain at the time of the visit. Dr. Lami performed a physical exam, which he indicated was completely normal, and he also reviewed the Petitioner's treatment records from Physicians Immediate Care and Advanced Medical and Wellness Center. Subsequent to Dr. Lami's physical exam and review of the treatment records, he provided an opinion that no accident had occurred on October 28, 2010, whether acute or repetitive and that the extensive chiropractic treatment the Petitioner received was excessive and unnecessary. Dr. Lami opined that the Petitioner was capable of working in a full duty capacity and no further treatment was needed.

On January 27, 2011 the Petitioner returned to Chiropractor Daniel Horn. It was noted that the Petitioner rated her pain at 1 out of 10 and reported that she experienced pain at the end of the day once to twice a week. No work restrictions were provided at the time of this exam. Subsequent this visit, the Petitioner did not participate in any additional therapy and she was released from care on February 8, 2011. The chiropractor placed her at maximum medical improvement at this time with no restrictions.

The Petitioner testified that she has not sought or received any treatment for her back since February 8, 2011, and that she was released to return to work without any restrictions at that time. The Petitioner testified that her back feels "better" and she "is doing fine". She

further testified that she currently has no symptoms or problems with her back. The Petitioner testified that she started another job in March of 2011 and that she is currently a full time student.

On cross examination, the Petitioner again testified that her pain began on October 28, 2010. She testified that the new assignment she was given required her to lift metal grates that weighed one pound each and that she was required to lift twenty of those grates at a time. When it was pointed out that October 28, 2010 was a Thursday, the Petitioner testified that "It happened on a Friday" and she then indicated that it must have happened on the 29th. The Petitioner also acknowledged that the restrictions imposed on her by Physicians Immediate Care were not job prohibitive as her normal job was within those restrictions.

The Respondent presented the testimony of Monique Edwards, an 18 year employee of the Respondent. Ms. Edwards described the various jobs performed by the Respondent's employees at the Weber Grill assembly plant including the job performed by the Petitioner. Ms. Edwards acknowledged that the Respondent did receive a copy of the initial work restrictions placed on the Petitioner by Physicians Immediate Care but she testified that the Petitioner's regular job requirements were within those restrictions. The Arbitrator notes that Ms. Edwards' testimony regarding the assembly line jobs at the Weber Grill assembly plant contradicted the Petitioner's testimony as to the nature of the line and the physical activities involved in working on the line.

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:

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 that the Petitioner failed to meet that burden here. Specifically, the Arbitrator finds that the Petitioner failed to prove that an accident arising out of and in the course of her employment with the Respondent occurred on October 28, 2010.

Initially, the Arbitrator notes that the mere onset of symptoms while working does not, in itself constitute an "accident" as contemplated by the Act. The Petitioner testified that she began to notice stiffness in her back while she was working on October 28, 2010. She did not testify to an acute onset of pain while lifting a specific object or performing a specific task. While she testified that she was repetitively lifting heavy objects in a confined space, that testimony was not supported by the credible evidence in the record. The Petitioner's own testimony and the testimony of the Respondent's witness demonstrate that the Petitioner exaggerated the weight of the objects she was required to lift and that the Petitioner rotated between positions on the assembly line every two hours.

Additionally, the Petitioner's testimony as to the date of her alleged accident was inconsistent with the credible evidence. The Petitioner testified that her back symptoms

commenced while she was working on October 28, 2010 and all of the histories provided by the Petitioner to her medical providers indicated that her onset of back symptoms started on October 28, 2010. On cross examination however, the Petitioner testified that her symptoms must have started on October 29, 2010 because "it happened on a Friday". The Arbitrator notes that October 28, 2010 was a Thursday.

Finally, the Petitioner's testimony as to the onset and progression of her back complaints is suspect. The Petitioner testified that her symptoms began early in her shift on a Friday. (She initially testified that they started on October 28, 2010 which was a Thursday.) She did not report her symptoms to anyone on the day they commenced and she continued to work her entire shift that day. She testified that her symptoms increased while she was at home over the weekend, to the point that she had difficulty walking and she was unable to continue trick or treating with her children on Sunday. The Petitioner testified that she reported her back pain when she arrived at work on Monday, November 1, 2010 and that she was given a different work assignment. She testified that she was only able to perform that work for fifteen minutes before she had to stop due to her pain. On cross examination however, the Petitioner acknowledged that she "may have worked most of the day" on that Monday.

The Arbitrator notes that an alleged injury on a Friday with no report of that alleged injury until the following Monday, after a holiday weekend, is sufficient, in itself, to cause some suspicion. Further, the Arbitrator finds it difficult to believe that had the Petitioner's pain increased over the entire weekend to the point that she had difficulty walking and had to stop her Halloween trick or treating with the children as she testified, she would wait until after she had "worked most of the day" on Monday before she sought medical treatment for her complaints. The totality of the Petitioner's testimony and the evidence presented causes the Arbitrator to doubt the reliability of the Petitioner's testimony.

Based upon the foregoing, and having considered the totality of the evidence adduced at hearing, the Arbitrator finds that the Petitioner failed to prove that an accident occurred which arose out of and in the course of the Petitioner's employment with the Respondent on October 28, 2010.

Having found that the Petitioner failed to prove that an accident occurred which arose out of and in the course of the Petitioner's employment with the Respondent, determination of the remaining disputed issues is moot. The Petitioner's claim for compensation is denied and no benefits, penalties or attorney's fees are awarded herein.

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

Carolyn Coffman,

Petitioner,

14IWCC1008

vs.

NO: 13 WC 22608

Memorial Medical Center,

Respondent.

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed May 6, 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.

14IWCC1008

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: NOV 2 4 2014

Charles J. DeVriendt

Ruth W. White

Daniel R. Donohoo

DJD/gaf
O: 11/5/14
45

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

COFFMAN, CAROLYN
Employee/Petitioner

Case# **13WC022608**

14IWCC1008

MEMORIAL MEDICAL CENTER
Employer/Respondent

On 5/6/2014, 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 0.45% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

2427 KANOSKI BRESNEY
THOMAS R EWICK
2730 S MacARTHUR BLVD
SPRINGFIELD, IL 62704

0490 SORLING NORTHRUP HANNA ET AL
GARY A BROWN
1 N OLD STATE CAPITOL PLZ #20
SPRINGFIELD, IL 62701

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 **14IWCC100**

CAROLYN COFFMAN,
Employee/Petitioner

v.

MEMORIAL MEDICAL CENTER,
Employer/Respondent

Case # **13** WC **22608**

Consolidated cases: _____

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Maureen Pulia**, Arbitrator of the Commission, in the city of **Springfield**, on **4/16/14**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☐ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☐ What was the date of the accident?
E. ☐ Was timely notice of the accident given to Respondent?
F. ☒ Is Petitioner's current condition of ill-being causally related to the injury?
G. ☐ What were Petitioner's earnings?
H. ☐ What was Petitioner's age at the time of the accident?
I. ☐ What was Petitioner's marital status at the time of the accident?
J. ☒ Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. ☒ 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 14IWCC1008

On **10/5/10**, 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 **$27,878.24**; the average weekly wage was **$536.12**.

On the date of accident, Petitioner was **60** years of age, ***single*** with **no** dependent children.

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

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

Respondent shall be given a credit of **$00.00** for TTD, **$00.00** for TPD, **$00.00** for maintenance, and **$00.00** for other benefits, for a total credit of **$00.00**.

Respondent is entitled to a credit of **$34,386.00** under Section 8(j) of the Act.

ORDER

Respondent shall pay Petitioner temporary total disability benefits of $357.41/week for 8-4/7 weeks, commencing 11/29/12 through 1/27/13, as provided in Section 8(b) of the Act.

Respondent shall pay reasonable and necessary medical services for petitioner's left knee from 10/5/10 through 1/27/13, as provided in Sections 8(a) and 8.2 of the Act, as well as petitioner's out of pocket expenses for these reasonable and necessary medical services.

Respondent shall be given a credit of $34,386.00 for medical benefits that have been paid, and Respondent shall hold petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act.

Respondent shall pay Petitioner permanent partial disability benefits of $321.67/week for 75.25 weeks, because the injuries sustained caused the 35% loss of the petitioner's left leg, as provided in Section 8(e) of the Act.

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

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

Signature of Arbitrator

4/30/14
Date

ICArbDec p. 2

MAY - 6 2014

THE ARBITRATOR HEREBY MAKES THE FOLLOWING FINDINGS OF FACT:

Petitioner, a 60 year old operating room scheduler/secretary sustained an accidental injury to her left knee that arose out of and in the course of her employment by respondent on 10/5/10. On the date of accident petitioner had worked for respondent for about 5 years. Her duties included scheduling surgeries in advance for doctors' offices. Her job is primarily sedentary in nature. Prior to 10/5/10 petitioner had been diagnosed with arthritis in both knees. At times petitioner would have pain in her knees, but had no trouble walking and did not have a limp.

Petitioner testified that she did not undergo any specific treatment for her knees prior to 10/5/10. When she would see her doctor for other reasons she may tell the doctor about her arthritis symptoms that included some pain and swelling in her hips, knees and neck. Petitioner never had any physical therapy for her left knee, an MRI of her left knee, aquatic therapy for her left knee, buckling of her left knee, or any workers' compensation cases for her left knee prior to 10/5/10.

On cross-examination petitioner testified that her primary care physician from 1990 was Dr. Hale. She stated that in 1995 she discussed her overall arthritis with Dr. Hale and he prescribed Mobic. Prior to then petitioner was taking Naprosyn and Aleve for her arthritis in her shoulder and other joints. At one point after 1995 petitioner saw Dr. Ramsey who prescribed Celebrex. Petitioner tried this medication but stated that it did not help.

On 10/5/10 petitioner was working in the main operating room, which was in the cellar of the main hospital, in the Baylis Building. As she was coming out of the locker room, which had a tight hinge on the door, she had opened the door and with the door open, stopped to see if anyone was coming down the hall before she fully exited the doorway. As she was standing in the doorway and looking to make sure the hallway was clear, the door closed fast and hit her in the back and hips with her left knee planted. Petitioner was pushed forward by the force of the door. Petitioner's left knee twisted, she heard a loud pop, and her left knee buckled. Petitioner had immediate pain in her left knee.

Petitioner reported the accident to her supervisor Sandy Flattery following the injury. She did not seek immediate treatment that day, thinking that it might feel better the next day. A few days later petitioner completed an accident report, and was sent for treatment by respondent. The Event Information petitioner entered was "door on locker room closes excessively hard - It pushed me out and I twisted my knee-I get really bad pain that goes up and down my leg from my knee. Usually I can get it to let me walk after a few minutes- I

do not want to follow.." Corrective Actions Taken were identified as "Engineering contacted. Informed that door closure required repair and immediately accomplished."

On 10/11/10 petitioner was sent by respondent to Midwest Occupational Health Associates (MOHA). Petitioner gave a consistent history of the accident. Petitioner complained of left knee swelling, and worsening pain after sitting for prolonged periods of time. She denied any buckling, but reported weakness in the left knee. She denied any prior injuries to her left knee or any previous problems with her left knee. Petitioner was seen by the nurse practitioner. Following an examination, the nurse practitioner diagnosed a left knee strain and ordered x-rays of petitioner's left knee. Petitioner was given a prescription for Tramadol and was instructed to continue taking Mobic. She was released to full duty work.

X-rays of the left knee were performed on 10/13/10. The impression was mild to early moderate tricompartmental osteoarthritis. Following the x-rays petitioner followed up at MOHA on 10/18/10 without any improvement, and was maybe even a little worse. Petitioner was prescribed physical therapy and underwent a 2-3 week course of physical therapy. She continued to work full duty.

On 11/10/10 petitioner returned to MOHA and reported no improvement of her left knee. She reported that the physical therapy had helped her calf and Achilles tendon, but not her knee. An MRI of the left knee was ordered. This was performed on 11/19/10. The impression was a radial tear of the posterior horn of the medial meniscus with peripheral extrusion of the body of the medial meniscus; marked osteoarthritis in the medial and patellofemoral compartments; knee effusion with an associated popliteal cyst, and loose bodies within a popliteal cyst; and mild patellar tendinopathy.

On 11/30/10 petitioner returned to MOHA. She stated that her left knee was a little better, and then on 11/22/10 it popped and has felt a little better since then. She rated her pain at a 5/10. She stated that she was taking Mobic, but not Tramadol. She reported that her left knee hurts worse at night. Petitioner asked for a referral to Dr. Borowiecki, who she had already showed the results of the MRI. She requested this referral because she had worked with him in the operating room and he had been recommended by others in the operating room. Petitioner was continued on regular duty. Physical therapy was suspended.

On 12/2/10 petitioner presented to Dr. Borowiecki for an evaluation of her left knee. Following an examination and record review, Dr. Borowiecki's impression was degenerative arthritis in the knee with medial meniscal tear that could be associated with the petitioner's injury on 10/5/10. Dr. Borowiecki assessed left knee joint pain, localized osteoarthritis of the left knee, and an acute medial meniscus tear. He told petitioner that sh had two problems: preexisting osteoarthritis of the left knee and a superimposed injury on this as a result of the

twisting injury she described. Dr. Borowiecki was of the opinion that the meniscal tear may potentially be a result of the injury on 10/5/10, but he could not opine. Dr. Borowiecki injected petitioner's left knee with corticosteroid. Petitioner testified that this injection provided some relief for a while.

On 12/7/10 petitioner returned to MOHA. She reported that Dr. Borowiecki gave her an injection into the left knee and her knee felt about 60% improved. She rated her pain at a 3/10. Petitioner was continued on regular work and given a refill of her Ultram.

On 1/13/11 petitioner returned to Dr. Borowiecki. Petitioner reported that she was 80% improved. Dr. Borowiecki recommended continued observation. He was hesitant to recommend an arthroscopy because he did not believe it would give her complete relief.

On 1/26/11 petitioner followed-up at MOHA. She reported that overall she was doing a lot better. She stated that she was 80% improved. Petitioner reported that she was not taking any medications for her left knee. An examination of the left knee revealed no edema, a probable Baker's cyst located at the posterior knee, tenderness at the posterior knee area with palpation, good flexion and extension, and crepitus. Petitioner was continued on regular duty work.

On 3/10/11 petitioner returned to Dr. Borowiecki. Dr. Borowiecki performed a repeat injection into petitioner's left knee due to recurring symptoms. Petitioner was released on an as needed basis.

While petitioner was treating with Dr. Borowiecki, she was also following up at MOHA. On 3/15/11 petitioner returned to MOHA and reported that she was doing great. She rated her pain level at 1/10. She stated that she had a cortisone injection on 3/10/11 and felt great. Petitioner reported a little stiffness up to the posterior aspect of the left knee on occasion to a minor degree. She stated that she was doing regular work without difficulty. She noted that she was taking no medications specifically for her left knee. Petitioner was continued on full duty work, and was released from care by MOHA on an as needed basis.

On 5/9/11 petitioner returned to MOHA due to increased pain in her left knee for a week. She stated that her job requires her to be up and down a lot more at work. She stated that she did not know if this irritated her left knee. Petitioner denied any new injuries. She rated her pain at a 6/10.

On 5/12/11 petitioner returned to Dr. Borowiecki. Petitioner reported that the relief she had from the last injection only lasted about a month before it started to wear off. Petitioner complained of quite a bit of discomfort. She reported that the temporary relief she received following the injection on 3/10/11 had worn off. Dr. Borowiecki was of the opinion that the MRI showed pretty advanced arthritis of the left knee with

narrowing of the joint spaces, and marginal osteophyte formation. He also noted that the MRI showed a degenerative complex-type tear over the posterior horn of the medial meniscus, and the patellofemoral compartment showed severe degenerative changes. Dr. Borowiecki gave petitioner a few options. One was to proceed with viscosupplementation with Hyalgan, a 3-injection series. Two, would be to consider an arthroscopy. Since he could not address any of the arthritic findings at all during this surgery, his suspicion was that petitioner would not get dramatic symptom relief from an arthroscopy, and if she did it would be short lived. A third option was a total knee arthroplasty. Petitioner did not want surgery unless absolutely necessary, and selected the injections.

On 5/20/11 petitioner followed-up at MOHA. Nurse practitioner Bowers was of the opinion that Dr. Borowiecki noted that most of petitioner's symptoms were probably due to her arthritis, and recommended a series of three Hyalgan injections. He also discussed a total knee arthroscopy. Petitioner indicated that she wanted to undergo the recommended injections. She stated that she has been on her feet a bit more while working and this could be the cause of her increased pain in her left knee. She reported pain and stiffness in the morning when she wakes up, and pain when getting out of a chair. Bowers noted that they were waiting for approval of the injections from respondent and she was to continue working regular duty.

On 5/26/11 petitioner presented to Dr. Clem at MOHA. She noted that she had undergone 2 injections. She noted that they were trying to decide if her symptoms were related to the meniscal problem or the arthritis. Dr. Clem examined petitioner and recommended a course of aqua therapy. Petitioner was released to full duty work.

From 6/1/11-6/23/11 petitioner underwent a course of aqua therapy. She testified that the therapy would help her on the days she had therapy and for a little while after.

On 6/9/11 petitioner followed-up with Bowers at MOHA. She reported that the Aleve helps more than the Mobic. She also stated that the aqua therapy was helping. She rated her pain level at a 4/10. She denied any locking, buckling, or giving out of the knee. Petitioner was continued in aqua therapy and instructed to continue to take Aleve. She was continued on regular duty work.

On 6/23/11 petitioner returned to MOHA and was examined by Bowers. It was noted that petitioner had not had much improvement with any medications they had tried. Petitioner continued to complain of increased pain at work with getting up and down on a frequent basis. She reported that her knee was better overall with the aqua therapy. She stated that she was no longer interested in surgery at that time. Petitioner stated that the Hyalgan injections were denied by respondent. Petitioner was examined and assessed with a left knee strain on

top of chronic arthritis. Petitioner stated that she had no follow-ups scheduled with Dr. Borowiecki. She was given one more week of aqua therapy and again released on an as needed basis.

On 7/20/11 petitioner returned to MOHA and was seen by Bowers. Petitioner reported a fall secondary to her left knee buckling. She stated that the fall occurred when she was going up stairs at home. She stated that her knee was bent and was on the upper step, and as she pushed up on the leg, her left knee buckled and gave out on her causing her to fall. Petitioner was concerned that her left knee was worsening. Petitioner complained of persistent symptoms. Her symptoms were in the medial and posterior aspects of her left knee. She stated that her left knee felt like it was going to give out on her since the injury, but this was the first time it happened. Bowers felt it was appropriate for petitioner to see if there were any other options for her besides surgery. A consultation was set up with Dr. Wolters. Petitioner was released to full duty work.

On 7/26/11 petitioner presented to Dr. Wolters for a second opinion. Dr. Wolters reviewed the diagnostic tests and performed an examination. He was of the opinion that petitioner would not be a candidate for a knee arthroscopic debridement, since he did not believe it would result in any relief of her pain. He recommended Hyalgan injections. He believed these could delay her need for a total knee arthroplasty. He was of the opinion that petitioner would need a knee replacement sometime in the near future.

On 7/27/11 respondent decided that they would not authorize this treatment and stopped petitioner's workers' compensation benefits on 7/27/11. Petitioner testified that respondent informed her that they would only pay for an arthroscopy.

On 8/12/11 petitioner returned to MOHA and was examined by Bowers. Bowers noted that Dr. Wolters was not recommending surgery at that time. She noted that he did recommend the Hyalgan injections. Petitioner stated that she would put these injections through her personal insurance since workers' compensation had already denied them. Petitioner also stated that she began taking Osteo Bi-flex 2 weeks ago and it was helping. She stated that her pain was localized to the medial and posterior aspects. She also stated that she was doing exercises in the pool that she learned in aqua therapy. Petitioner was instructed to continue with her home exercise program. Petitioner was released on an as needed basis and released to full duty work.

Dr. Wolters performed a series of 3 Hyalgan injections on 8/25/11, 9/1/11 and 9/9/11. Petitioner testified that the injections helped for a little while, but then her pain would return.

In August of 2011 petitioner had a unrelated small heart attack. Petitioner treated for this condition and had a stent implanted. Following this unrelated procedure, petitioner was told that she could not undergo any surgical procedures for a year.

On 9/23/11 petitioner followed-up with Dr. Wolters. Petitioner reported that the Hyalgan injections were not working. She requested other treatment. Petitioner stated that she could not take anti-inflammatories due to her heart condition. Petitioner stated that she could not walk due to the sharp pain in the medial aspect of her knee. Due to petitioner's cardiac stent, Dr. Wolters recommended conservative treatment for her left knee until cleared by the cardiologist. Dr. Wolters injected petitioner's left knee.

On 2/1/12, 2/24/12 and 3/2/12 petitioner underwent another course of 3 Hyalgan injections. On 5/14/12 petitioner underwent a cortisone injection to the left knee.

On 8/24/12 petitioner returned to Dr. Wolters wanting to talk about a total knee replacement. She also requested another injection. Dr. Wolters performed another injection to the left knee. Petitioner's left knee was really bothering her. She rated her pain at a 9/10. She stated that she could not walk more than a block without pain. She stated that she was taking Tramadol for her pain. She stated that she wanted to undergo a left knee replacement in the near future.

On 11/22/12 petitioner returned to Dr. Wolters. She stated that she was ready to proceed with the total arthroscopy. Dr. Wolters recommended that petitioner go ahead with the total left knee arthroplasty. On 11/29/12 petitioner underwent a full left knee replacement that was performed by Dr. Wolters. Her postoperative diagnosis was left knee degenerative joint disease. Petitioner was authorized off work by Dr. Wolters from 11/29/12 through 1/27/13. Respondent did not pay petitioner any temporary total disability benefits. Petitioner used her sick time when she was off, and her group carrier paid for the surgery and post-operative treatment. Petitioner also testified that she incurred some out of pocket expenses.

Petitioner underwent post operative physical therapy from 12/17/12 to 1/18/13. Petitioner testified that most of the pain in her left knee resolved after the surgery and post-operative treatment. She stated that she no longer experiences any stabbing pain in her left knee.

On 10/31/13 Dr. Wolters drafted a letter to petitioner's attorney, Ewick. Dr. Wolters opined that as a resul of the accident on 10/5/10 petitioner aggravated and caused an acute exacerbation of her preexisting osteoarthritis and it was inevitable that her osteoarthritis would advance to a symptomatic state. Dr. Wolters opined that the effusion was probably associated with the acute injury. He noted that it was difficult to tell

whether or not petitioner had an effusion or a radial tear of the posterior horn of the medial meniscus prior to the injury. He was of the opinion that many patients with osteoarthritis do develop tears within the medial meniscus, especially the posterior horn region. Dr. Wolters opined that the injury accelerated the arthritis that the petitioner demonstrated. He further opined that the meniscal tear may have been caused by the injury. He opined that petitioner's arthritis was so advanced that most likely the treatment of the meniscus would not deem her knee asymptomatic following any arthroscopic intervention. Dr. Wolters further opined that the left total knee arthroplasty was necessary because of the petitioner's preexisting condition of osteoarthritis. He was of the opinion that her symptoms did improve per the medical record with conservative treatments including cortisone injections as well as physical therapy, however, her advancing arthritis most likely caused the knee replacement that was performed. Dr. Wolters did not think the injury caused any future limitations. He believed her arthritis had just advanced to the point where she needed an arthroplasty. He believed that ongoing symptoms were unlikely given the fact that her arthritis had been removed, as well as her meniscus tear.

On 11/22/13 petitioner last followed up with Dr. Wolters. Petitioner stated that she was doing very well. She reported very little pain in her left knee. She reported occasional catching of her kneecap. Dr. Wolters recommended that petitioner continue with her home exercise program. Petitioner testified that she still performs the home exercises recommended by Dr. Wolters. Dr. Wolters placed petitioner at maximum medical improvement (MMI) on 11/23/13 and told her to follow-up in a couple of years.

On 3/21/14 the evidence deposition of Dr. Wolters, an orthopedic surgeon, was taken on behalf of the petitioner. Dr. Wolters opined that when someone hears a pop in their knee it can be related to an ACL or MCL tear and consistent with an acute trauma. Dr. Wolters opined that a person who had the same findings as those demonstrated on petitioner's left knee MRI could be completely asymptomatic, and a twisting type injury can make these findings symptomatic. Dr. Wolters opined that it is certainly possible that the radial tear of the posterior horn of the medial meniscus occurred during the injury. He also noted that these types of tears are very common in patients petitioner's age with osteoarthritis. He stated that he recommended Hyalgan injections to control the pain that was most likely related to the osteoarthritis and delay the knee replacement given her relatively young age.

Dr. Wolters opined that petitioner exacerbated her existing osteoarthritis in her left knee as a result of the injury on 10/5/10. He further opined that as a result of the injury petitioner may have sustained effusion, swelling, and a tear of the posterior horn of the meniscus. Dr. Wolters opined that the accident petitioner described and he reviewed in the medical records, may have advanced petitioner's need for a total knee

arthroscopy. He based this opinion on the fact that petitioner had more pain after her injury that did not completely go away, and the fact that petitioner was asymptomatic prior to the injury.

Currently, petitioner is still working the same job she was working on 10/5/10. She reported that when she is sitting at work her left knee gets stiff sometimes, and it is hard for her to get up. Petitioner testified that her job is a sedentary job, and she sits most of the time. Petitioner is working the same hours she did before the injury. Petitioner can sit up to 3-4 hours at a time. She reported that she does get up and walk around a little bit during her shift. Petitioner testified that although there are stairs at work she chooses to use the elevator because she does not trust her left knee on the stairs. Petitioner is currently 63 years old. Petitioner stated that her future earning capacity has not been diminished by the injury since she is still working the same job, for the same amount of hours, at the same hourly rate.

Petitioner testified that her left knee is numb, and gets stiff at least once a day. Petitioner does not take any pain medications for her left knee. When petitioner performs activities around the house, she has trouble vacuuming as it causes her pain in her left knee. Petitioner stated that she only goes downstairs when she has to do laundry 3-4 times a week. Petitioner is careful on the steps so that her knee does not buckle. Petitioner testified that she cannot walk the dog very far, and has to rest her left knee because it hurts. Petitioner was of the opinion that the surgery improved her left knee. Petitioner testified that x-rays taken of both knees prior the accident showed arthritic changes in both knees that were similar.

F. IS PETITIONER'S CURRENT CONDITION OF ILL-BEING CAUSALLY RELATED TO THE INJURY?

The threshold issue in this case is whether or not petitioner's current condition of ill-being as it relates to her left knee is causally related to the injury she sustained on 10/5/10. The only causal connection opinions offered with respect to petitioner's left knee and the accident on 10/5/10 were those of Dr. Borowiecki and Dr. Wolters.

It is unrebutted that prior to the injury on 10/5/10 petitioner had preexisting arthritis in her joints, including her knees. Petitioner was taking Mobic for her arthritis before the accident date, but had had no specific treatment related to her left knee. Prior to the injury, when petitioner would see her doctor for other unrelated issues she may mention the arthritis in her joints. Prior to the injury, petitioner never had any physic therapy for her left knee, an MRI for her left knee, buckling of her left knee, surgery recommendation for her left knee, or restrictions related to her left knee. Until 10/5/10 petitioner was able to work her sedentary job without any restrictions.

Following the unrebutted accident on 10/5/10 petitioner reported immediate pain in her left knee for which she sought treatment within a few days following the accident. Petitioner treated at MOHA at the directive of respondent. Petitioner reported swelling, pain, and some weakness in her left knee. X-rays of the left knee on 10/13/10 only showed mild to early moderate tricompartmental osteoarthritis.

When petitioner's pain did not improve, she underwent an MRI of the left knee that revealed a radial tear of the posterior horn of the medial meniscus with peripheral extrusion of the body of the meniscus; marked osteoarthritis in the medial and patellofemoral compartments; knee effusion with an associated popliteal cyst, with loose bodies within a popliteal cyst; and mild patellar tendinopathy.

On 12/2/10 Dr. Borowiecki evaluated petitioner and his impression was degenerative arthritis in the knee with medial meniscal tear that could be associated with the petitioner's injury on 10/5/10. Dr. Borowiecki was of the opinion that petitioner had preexisting osteoarthritis of the left knee with a superimposed injury on this as a result of the injury on 10/5/10.

Petitioner underwent conservative treatment at MOHA and with Dr. Borowiecki and Dr. Wolters that included a course of physical therapy, aqua therapy, cortisone injections and Hyalgan injections over the next year or so, all of which would result in immediate relief, sometimes up to 80-90%, that would then gradually wear off to the point where petitioner had significant pain. In 7/20/11 petitioner's left knee actually buckled on her when she was walking up the stairs of her home.

In May of 2011 and July of 2011 both Dr. Borowiecki, and Dr. Wolters, respectively, were of the opinion that petitioner would not be a candidate for a knee arthroscopy because it would not address the osteoarthritis and give lasting relief. Hyalgan injections were recommended in order to buy petitioner time until she would need a total knee arthroscopy. Petitioner underwent two series of Hyalgan injections, but eventually did not have any lasting relief.

Petitioner sustained an unrelated heart attack in August of 2011, had a stent implanted, and was told that she was unable to undergo any surgical procedures for a year.

In August of 2012 Dr. Wolters and petitioner discussed the option of total knee arthroscopy. Her pain at that time was a 9/10. By November 2012 petitioner's pain was constant and she was ready to undergo the total knee arthroscopy. This was performed on 11/29/12.

On 10/31/13 Dr. Wolters drafted a letter to petitioner's attorney in response to a letter he had sent. Dr. Wolters opined that as a result of the accident on 10/5/10 petitioner aggravated and caused an acute

exacerbation of her preexisting osteoarthritis and it was inevitable that her osteoarthritis would advance to a symptomatic state. Dr. Wolters opined that the injury accelerated the arthritis that the petitioner demonstrated, and that the meniscal tear may have been caused by the injury. He also opined that petitioner's arthritis was so advanced that most likely the treatment of the meniscus would not deem her knee asymptomatic following any arthroscopic intervention. Dr. Wolters opined that the left total knee arthroplasty was necessary because of the petitioner's preexisting condition of osteoarthritis. He was of the opinion that her symptoms did improve per the medical record with conservative treatments including cortisone injections as well as physical therapy, however, her advancing arthritis most likely caused the knee replacement that was performed. He believed her arthritis had just advanced to the point where she needed an arthroplasty.

In his deposition Dr. Wolters, clarified some of the opinions stated in his letter dated 10/31/13. Dr. Wolters opined that when someone hears a pop in their knee it can be related to an ACL or MCL tear and consistent with an acute trauma, and for that reason believed the tear of the medial meniscus was related to the injury on 10/5/10. Dr. Wolters opined that even if the tear was present before the injury it was asymptomatic, and a twisting type injury can make these findings symptomatic. Dr. Wolters opined that it is certainly possible that the radial tear of the posterior horn of the medial meniscus occurred during the injury.

Dr. Wolters opined that petitioner exacerbated her existing osteoarthritis in her left knee as a result of the injury on 10/5/10. Dr. Wolters opined that the accident petitioner described and he reviewed in the medical records, may have advanced petitioner's need for a total knee arthroscopy. He based this opinion on the fact that petitioner had more pain after her injury that did not completely go away, and the fact that petitioner was asymptomatic prior to the injury.

Based on the above, as well as the credible evidence, the arbitrator adopts the findings of both Dr. Borowiecki and Dr. Wolters and finds although the petitioner had osteoarthritis, and a possible tear of the medial meniscus prior to the injury, and some day would most likely need a total knee arthroplasty as a result of her osteoarthritis, the injury on 10/5/10 exacerbated her existing osteoarthritis, possibly caused the tear of the medial meniscus, and took a relatively asymptomatic left knee and made it acutely symptomatic. Despite extensive measures of conservative treatment following the injury, these modes of treatment never resulted in long lasting improvement of petitioner's knee condition, thus causing a left total knee arthroscopy sooner than Dr. Wolters opined petitioner would probably have needed the procedure. Both Dr. Borowiecki and Dr. Wolters both opined that a simple arthroscopic procedure would not have alleviated petitioner's symptoms, and for that reason opined that a left total knee arthroscopy. Following the left total knee arthroscopy petitioner's

left knee condition improved significantly. Respondent did not have a doctor examine petitioner or perform a record review, and offer any causal connection opinion.

Based on the above, the arbitrator finds the petitioner's current condition of ill-being as it relates to her left knee is causally related to the injury on 10/5/10. The arbitrator finds the injury of 10/5/10 aggravated the petitioner's preexisting osteoarthritis in petitioner's left knee, and either aggravated or caused the medial meniscus tear, thus requiring the left total knee arthroscopy sooner than she would have needed it without the injury. The arbitrator also finds it significant that the x-rays of the left knee performed on 10/13/10, performed only 8 days after the injury, only showed mild to early moderate tricompartmental osteoarthritis, and there existed no opinion at that time that petitioner was a candidate for a total knee arthroscopy.

J. WERE THE MEDICAL SERVICES THAT WERE PROVIDED TO PETITIONER REASONABLE AND NECESSARY? HAS RESPONDENT PAID ALL APPROPRIATE CHARGES FOR ALL REASONABLE AND NECESSARY MEDICAL SERVICES?

The Arbitrator adopts her findings of fact and conclusions of law contained above with respect to the issue of causal connection and incorporates them herein by this reference.

The petitioner is claiming that all medical services provided to petitioner for her left knee including the left total knee arthroscopy were reasonable and necessary to cure or relieve petitioner from the effects of the injury on 10/5/10. Respondent claims the left total knee arthroscopy is not causally related to the injury 10/5/10, but rather to her preexisting osteoarthritis.

Having found the petitioner's left total knee arthroscopy was causally related to the injury petitioner sustained on 10/5/10, the arbitrator finds all treatment petitioner received for her left knee from 10/5/10 until 11/23/11 was reasonable and necessary to cure or relieve petitioner from the effects of the injury she sustained on 10/5/10.

The arbitrator finds the respondent shall pay all reasonable and necessary medical services for petitioners left knee from 10/5/10 through 11/23/13 pursuant to Sections 8(a) and 8.2 of the Act.

Respondent shall be given a credit of $34,386.00 for medical benefits that have been paid, and Respondent shall hold petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act.

K. WHAT TEMPORARY BENEFITS ARE IN DISPUTE?

The Arbitrator adopts her findings of fact and conclusions of law contained above with respect to the issue of causal connection and incorporates them herein by this reference.

The petitioner claims she was temporarily totally disabled from 11/29/12 through 1/27/13. Respondent claims it is not liable for this period of temporary total disability because petitioner's total knee arthroscopy is not causally related to the injury on 10/5/10.

Having found the petitioner's total knee replacement is causally related to the injury on 10/5/10, and Dr. Wolters had authorized petitioner off work from 11/29/12 through 1/27/13 following her total knee arthroscopy and post-operative treatment until she was released to full duty work, the arbitrator finds the petitioner was temporarily totally disabled from 11/29/12 through 1/27/13 a period of 8-4/7 weeks.

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

The Arbitrator adopts her findings of fact and conclusions of law contained above with respect to the issue of causal connection and incorporates them herein by this reference.

As a result of the injury on 10/5/10 petitioner underwent extensive conservative treatment that consisted of physical therapy, aqua therapy, cortisone injections, Hyalgan injections and a left total knee arthroscopy. Following post-operative treatment petitioner was released to full duty work without restrictions on 11/23/13. At her last visit with Dr. Wolters on 11/23/13 petitioner stated that she was doing very well. She reported very little pain in her left knee. She reported occasional catching of her kneecap. Dr. Wolters recommended that petitioner continue with her home exercise program. Petitioner testified that she still performs the home exercises recommended by Dr. Wolters. Dr. Wolters placed petitioner at maximum medical improvement (MMI) on 11/23/13 and told her to follow-up in a couple of years.

Currently, petitioner is still working the same job she was working on 10/5/10. She reported that when she is sitting at work her left knee gets stiff sometimes, and it is hard for her to get up. Petitioner testified that her job is a sedentary job, and she sits most of the time. Petitioner is working the same hours she did before the injury. Petitioner can sit up to 3-4 hours at a time. She reported that she does get up and walk around a little bit during her shift. Petitioner testified that although there are stairs at work she chooses to use the elevator because she does not trust her left knee on the stairs. Petitioner is currently 63 years old. Petitioner stated that her future earning capacity has not been diminished by the injury since she is still working the same job, for the same amount of hours, at the same hourly rate.

Petitioner testified that her left knee is numb, and gets stiff at least once a day. Petitioner does not take any pain medications for her left knee. When petitioner performs activities around the house, she has trouble vacuuming as it causes her pain in her left knee. Petitioner stated that she only goes downstairs when she has t

do laundry 3-4 times a week. Petitioner is careful on the steps so that her knee does not buckle. Petitioner testified that she cannot walk the dog very far, and has to rest her left knee because it hurts.

Based on the above, as well as the credible evidence, the arbitrator finds the petitioner sustained a 35% loss of use of the left leg pursuant to Section 8(e) of the Act.

STATE OF ILLINOIS)
) SS.
COUNTY OF WILL)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Lawrence Sullivan,

Petitioner,

14IWCC1009

vs.

NO: 13 WC 31878

Premier Transportation,

Respondent.

DECISION AND OPINION ON REVIEW

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

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

14IWCC1009

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

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

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $50,000.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: NOV 2 4 2014

Charles J. DeVriendt

Daniel R. Donohoo

CJD/gaf
O: 10/22/14
49

Dissent

I respectfully dissent from the majority opinion. I would have found that Petitioner failed to sustain his burden of proving either accident or causal connection to an alleged current condition of ill-being of his right knee. Therefore, I would have reversed the Decision of the Arbitrator and denied compensation.

Petitioner testified he fell out of his truck while backing out of it at the end of his shift at around 12:30 pm on August 7, 2013. He testified he injured both knees. He landed on his knees and possibly twisted his right knee in the process. He stayed on the ground for 15 to 20 minutes before being able to get up. Surveillance video in the lot taken at 12:41 pm on the date of the alleged accident showed Petitioner walking without limp or any apparent difficulty. Petitioner continued to work for another two weeks. The left knee condition resolved but the right knee condition did not. The right knee appeared to be getting better initially but then was getting worse.

Petitioner also testified on August 23, 2013, he told his general manager that his knee was getting worse. He informed Petitioner to write up a report, took a photograph of Petitioner's knee, and advised him to seek medical attention. On that date an examination showed no joint effusion, minimal ecchymosis, and some tissue swelling. A knee contusion was diagnosed. Petitioner had physical therapy and an injection, but his complaints increased. An MRI was

14IWCC1009

performed, which Petitioner's treating doctor and Respondent's section 12 medical examiner, interpreted as essentially normal. In addition Respondent's medical examiner noted a normal physical examination, found symptom magnification, and concluded there were no objective findings to support Petitioner's significant subjective complaints.

I do not believe Petitioner sustained his burden of proving accident or causation. His testimony that he could not get off the ground for 15 to 20 minutes due to extreme pain is inconsistent with the video taken within 10 minutes of the alleged accident. In addition, Petitioner's continuing to work and his failure to file an accident report or seek medical treatment for two weeks after the accident militate against any causal connection between the alleged accident and any current condition of ill being of Petitioner's right knee. Finally, the lack of objective findings to support Petitioner's significant subjective complaints puts his credibility in doubt.

For the reasons noted above I would have reversed the Decision of the Arbitrator and denied compensation. Accordingly, I respectfully dissent from the majority opinion.

Ruth W. White

Ruth W. White

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

14IWCC1009

SULLIVAN, LAWRENCE
Employee/Petitioner

Case# **13WC031878**

PREMIER TRANSPORTION
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:

0059 BAUM RUFFOLO & MARZAL LTD
RICHARD W BRAUN
33 N LASALLE ST SUITE 1710
CHICAGO, IL 60602

2965 KEEFE CAMPBELL BIERY & ASSOC
SHAWN R BIERY
118 N CLINTON ST SUITE 300
CHICAGO, IL 60661

STATE OF ILLINOIS)
)SS.
COUNTY OF WILL)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

14IWCC1009

LAWRENCE SULLIVAN
Employee/Petitioner

v.

PREMIER TRANSPORTATION
Employer/Respondent

Case # 13 WC 31878

Consolidated cases: _____

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **FALCIONI**, Arbitrator of the Commission, in the city of **New Lenox**, on **11/20/2013**. 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 **FUTURE MEDICAL TREATMENT**

14IWCC1009

FINDINGS

On **8/7/2013**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$57,500.04**; the average weekly wage was **$1,105.77**.

On the date of accident, Petitioner was **56** years of age, ***single*** with **2** dependent children.

Necessary medical services ***have not*** been provided by the Respondent.

To date, **$0.00** has been paid by the Respondent for T.T.D. and/or maintenance benefits.

ORDER

- **THE RESPONDENT SHALL PAY THE PETITIONER TEMPORARY TOTAL DISABILITY BENEFITS OF $780.00/WEEK FOR 12-5/7 WEEKS, FROM 8/23/2013 THROUGH 11/20/2013, WHICH IS THE PERIOD OF TEMPORARY TOTAL DISABILITY FOR WHICH COMPENSATION IS PAYABLE.**
- **THE RESPONDENT SHALL PAY THE FURTHER SUM OF $11,214.45 FOR NECESSARY MEDICAL SERVICES, AS PROVIDED IN SECTION 8(A) OF THE ACT.**
- **THE RESPONDENT IS ORDERED UNDER SECTION 8(A) TO AUTHORIZE PRESCRIBED RIGHT KNEE SURGERY AS FURTHER SET FORTH HEREIN.**
- **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 ATTORNEY'S FEES, AS PROVIDED IN SECTION 16 OF THE ACT.**

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

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

Signature of Arbitrator

December 3, 2013
Date

DEC 20 2013

STATE OF ILLINOIS)
) SS
COUNTY OF WILL)

14IWCC1009

BEFORE THE WORKERS' COMPENSATION COMMISSION
IN THE STATE OF ILLINOIS

Lawrence SULLIVAN, Petitioner,	)	
vs.	)	No. 13 WC 31878
PREMIER TRANSPORTATION, Respondent.	)	

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19B

An Application for Adjustment of Claim was filed on this matter and Notice of Hearing was mailed to each party. The matter was heard by the Honorable Robert Falcioni, Arbitrator of the Illinois Workers' Compensation Commission, in the City of New Lenox on November 20, 2013. The issues in dispute included whether Petitioner suffered an accident which arose out of and in the course of Petitioner's employment by Respondent, whether Petitioner provided Notice of the alleged accident, whether Petitioner's current condition of ill-being was causally related to the injury, medical and TTD liability and prospective medical treatment of Dr. Chudik.

THE ARBITRATOR MAKES THE FOLLOWING FINDINGS OF FACT

Petitioner testified to his name, address and employment with Respondent as a truck driver which began approximately two and a half years prior. Petitioner testified he had a special license for driving which was a CDL 8 and that he drove semi/tractor trailer trucks for Premier. Petitioner testified he had been a truck driver in some capacity for approximately 38 years.

Petitioner testified he reported to work at approximately 430 a.m. on August 7, 2013 and at the close of his shift, while turning backward and exiting his truck cab, he slipped and fell out of the truck striking both knees on the steps. Petitioner testified the cab was approximately 4-5 feet from the ground with the steps starting about a foot from the floor.

Petitioner testified he was removing his log, cooler and lunch from the cab while exiting and he grabbed for the handle when falling however he caught the seatbelt which extended and didn't slow his fall.

Petitioner testified he felt pain in both knees and sat on the ground for several minutes until the immediate pain subsided and he then moved his items to his vehicle.

Petitioner testified he finished his work and continued working for the next several weeks. Petitioner testified on the day of the August 7 accident, he noted his fall to Lilly in the facility because the supervisor was at lunch. Petitioner testified he continued to work until August 23, 2013 and was limping off and on but attempted to work through it. Petitioner testified he had pain mostly in the right knee and while he had initially also struck his left knee, it cleared up. Petitioner testified he didn't believe he had injured any other parts of his body.

Petitioner testified he had mentioned his injury to several other people and he recalled specifically telling Bruce Johnson at the August 17 safety meeting after Mr. Johnson asked him why he was limping. Petitioner testified he also told a corporate safety person and an individual named Heath at that time. Petitioner testified he explained the fall from the truck in detail after being questioned at that time.

Petitioner testified he was still in pain at that time and he was sent to the company clinic. Petitioner testified Bruce Johnson had suggested he present to the MD at Medworks and Petitioner also noted he was asked to create a written statement and noted a photo was taken of his knee as well.

Petitioner testified he did attend a visit at Medworks and they performed an x-ray as well as prescribing medication for the pain. Petitioner testified he was also provided a knee brace and on a second visit was prescribed crutches and an MRI was to be performed.

Petitioner testified he used a cane and agreed that the cane wasn't prescribed, only crutches—however he had switched to the cane after difficulty navigating with the crutches.

Petitioner testified he underwent therapy as well as having the MRI. Petitioner testified he underwent therapy at ATI through November 16. Petitioner testified he was also referred to a specialist, Dr Chudik and upon exam he provided Dr. Chudik with his history of falling from the truck and striking his knee. Petitioner testified he underwent exam and also had an injection in the knee which provided approximately 4 days relief. Petitioner testified Dr. Chudik then recommended arthroscopic surgery.

Petitioner testified to multiple notes which were marked as exhibit 6 to confirm that they were various work restriction notes. Petitioner testified he was taken off work however he asked for light duty to be able to return to some work. Petitioner testified he had provided the work status to Bruce Johnson and was advised that light duty was not available unless signed off by corporate. Petitioner testified light duty wasn't offered.

Petitioner testified he had received no benefits except a prescription card which he had used once and then had it cancelled. Petitioner testified he had received no monetary benefits.

Petitioner testified to multiple medical bills which were marked as exhibit 7 and confirmed he didn't believe any of the bills had been paid. Petitioner also testified to receiving a TENS unit and testified to a document noted as exhibit 8 which was a letter in regard to that unit. Petitioner testified he had not yet received a bill for the TENS unit.

Petitioner testified he had never suffered a prior injury to his knees and further testified that his knee was getting worse without treatment with increase pain and increased difficulty walking, standing and with stairs.

On cross exam, Petitioner testified there were no witnesses to his accident as far as he knew. Petitioner testified he also was able to walk without a limp at times and individuals may have seen him both limping or not limping at times.

Petitioner testified he presented for an exam with Dr. Walsh at the request of the insurance company. Petitioner testified he believed he gave Dr. Walsh a complete history. Petitioner testified Dr. Walsh didn't review the MRI disc in his presence.

Petitioner also testified to job logs being offered as Respondent Exhibit 2 and confirmed he didn't personally fill out the logs although he believed they may have been the logs completed by security. Petitioner agreed that there was no accident noted on any of the logs which were for dates from August 7 through August 23, 2013.

Petitioner testified he also agreed that security cameras were present at the facility and that the video evidence being submitted as Respondent Exhibit #3 did appear to be accurate video from the facility.

Petitioner further testified he had no specific ability to confirm the wage payments listed in the document marked as Respondent Exhibit #4 were not accurate. Petitioner testified at some point the drivers had been placed on salary in questioning regarding potential mileage additions to wages.

On re-direct, Petitioner testified he was paid a flat rate of $225 per day and worked Saturdays for 6 day weeks at least from November to February. Petitioner further testified that Dr. Walsh had spent ten to fifteen minutes with him in exam.

The parties entered multiple exhibits. Petitioner offered Petitioner Exhibit 1—Medworks records; Petitioner Exhibit No. 2—ATI records; Petitioner Exhibit No. 3—Midwest Open MRI records; Petitioner Exhibit No. 4—Hinsdale Orthopedic records; Petitioner Exhibit No. 5—records of Dr. Steve Chudik; Petitioner Exhibit No. 6—work status notes; Petitioner Exhibit No. 7—medical expense statements and Petitioner Exhibit No. 8—TENS unit confirmation letter.
Respondent offered Respondent Exhibit No. 1—October 27, 2013 record of Dr. Kevin Walsh; Respondent No. 2—trailer activity logs from August 7-23, 2013; Respondent

Exhibit No.3—video footage of security cameras and Respondent Exhibit No. 4—wage statement.

THE ARBITRATOR MAKES THE FOLLOWING CONCLUSIONS OF LAW

Longstanding Illinois law mandates a claimant must show that the injury is due to a cause connected to the employment to establish it arose out of employment. *Elliot v. Industrial Commission*, 153 Ill. App. 3d 238, 242 (1987). The burden of proof is on a claimant to establish the elements of his right to compensation, and unless the evidence considered in its entirety supports a finding that the injury resulted from a cause connected with the employment, there is no right to recover. *Board of Trustees v. Industrial Commission*, 44 Ill. 2d 214 (1969).

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

The Arbitrator notes Petitioner confirmed in his testimony that he suffered some accident on August 7, 2013 and his testimony was consistent with the medical records. It is noted the video evidence doesn't appear to show any significant deficits and that the trailer logs do not indicate any reporting of an accident. However, Petitioner's testimony supports a finding that an accident did occur which arose out of and in the course or Petitioner's employment with Respondent.

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

The Arbitrator finds that there is no evidence to rebut the allegations of Petitioner in his testimony that he reported some accident occurring on August 7, 2013 with the 45 day time frame necessary to comply with the Workers' Compensation Act of Illinois and his testimony was consistent with the initial medical. In that regard, Petitioner's testimony supports a finding that Notice of an accident occurring on August 7, 2013 was provided to Respondent.

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

The Arbitrator finds that while an accident did occur which arose out of and in the course or Petitioner's employment with Respondent, the evidence presented at hearing with regard to medical evidence is extremely probative.

It is initially noted that the competing opinions of Dr. Chudik and Dr. Walsh for the basis for the disputes with regard to causal connection. Dr. Chudik diagnosed osteochondral injury of the lateral femoral condyle and provided an injection while noting surgery was an

option if not improved. After Dr. Chudik reviewed the MRI, he recommended a right knee diagnostic arthroscopy. Dr. Chudik does not appear to have provided an opinion of causation within a reasonable degree of medical and surgical certainty

Dr. Walsh noted objectively normal physical exam as well as normal MRI and noted the symptoms were disproportionate to the objective findings along with an element of symptom magnification. Dr. Walsh stated that at best that Petitioner suffered a contusion.

After Petitioner's accidental injury on August 7, 2013, he credibly testified and it is unrebutted and supported by the medical records that Petitioner suffered pain, swelling and limping with his right knee. He was given crutches, but uses a cane instead to assist in walking.

The medical records support that after trying to work for 2 weeks, he sought medical attention and has continued to treat for his injury since August 23, 2013. He treated with Medworks from August 23, 2013 to October 17, 2013. Medworks ordered an MRI of his right knee, which was performed on September 17, 2013. He started physical therapy with ATI on September 24, 2013 and continues in therapy to the present. He saw Dr. Steven Chudik on two occasions 10/30/13 and 11/11/13 and Dr. Chudik has prescribed right knee surgery.

As *International Harvester v. Industrial Commission*, 93 Ill. 2d 59, 442 N.E. 908, 66 Ill. Dec. 347 (1982) states;

> *A chain of events which demonstrates previous condition of good health, accident, and subsequent injury resulting in disability may be sufficient circumstantial evidence to prove a causal nexus between accident and employee's injury.*

In the present case the Arbitrator notes that there has been no evidence presented of a pre existing condition with respect to Petitioner's right knee, that Dr. Walsh agreed that Petitioner had sustained at least a sprain to the right knee, that the initial medical records indicate that Petitioner still had ecchymosis two weeks after the accident, the consistent nature of the complaints and the positive findings on the MRI in concluding that there is in fact a causal connection between Petitioner's current condition of ill being and the accident alleged herein.

G. What were Petitioner's earnings?

Petitioner testified he was paid a flat rate of $225 per day and worked Saturdays for 6 day weeks at least from November to February. However Petitioner also testified that he didn't

have any recollection of his wages with regard to verifying or denying the wage payments listed in the wage statement.

Reviewing the record and evidence considered in its entirety, the wage statement entered as Respondent Exhibit No. 4 is the best evidence of wages and supports an average weekly wage rate of $1,105.77. The Arbitrator so finds.

J. Were 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 Petitioner treated at Medworks, the company clinic in Joliet, Illinois, ATI in Bolingbrook for physical therapy and with the orthopaedic specialist, Dr. Steven Chudik at Hinsdale Orthopaedics in Westmont, Illinois.

The Arbitrator finds the following changes of these three facilities, reasonable and necessary to cure and relieve the effects of Petitioner's work injury to his right knee.

The Arbitrator finds these three charges related to Petitioner's work injury at Premier Transportation, which arose out of and in the course of his employment.

These charges are:

1.	ATI	$ 9,363.95
2.	Medworks	$ 856.50
3.	Hinsdale	$ 994.00
	TOTAL	$11,214.45

The arbitrator awards these medical bills and orders Respondent to pay these bills according to the Illinois Workers' Compensation fee schedule outlined in Section 8.2 of the Act.

K. Is Petitioner entitled to any prospective medical care?

Petitioner has undergone consistent extensive conservative care to date without any cure or relief for his right knee condition, which Dr. Chudik describes as an osteochondral injury to the lateral femoral condyle.

Conservative care at Medworks in the form of bracing, crutches and testing has not been effective in relieving Petitioner's condition. Physical therapy at ATI in Bolingbrook hasn ot provided relief either. A knee injection by Dr. Chudik to Petitioner's right knee only provided brief temporary relief.

Finally, on November 11, 2013, Dr. Chudik recommended and prescribed a right knee diagnostic arthroscopy with possible microfracture of the LFC of the right knee. (Pet. Exh. #4 & #5) The Respondent, Premier Transportation has not authorize the prescribed right knee surgery and since the Arbitrator finds said treatment reasonable, related and necessary the Arbitrator orders Premier Transportation to authorize and pay for the surgery and the subsequent follow up care as prescribed by Dr. Chudlik.

L. What temporary benefits are in dispute? TTD

Petitioner stopped working on August 23, 2013, the same day he went to the company clinic, Medworks in Joliet. Medworks treated him from August 23, 2013 until October 17, 2013. (Pet. Exh. #1) He was released to light duty or restricted work on several occasions, but the employer, Premier Transportation never tendered light work or restricted work for Petitioner.

When Petitioner started treating with Dr. Steven Chudik at Hinsdale Orthopaedics, he was prescribed no work, given documents to that effect and prescribed surgery for his right knee.

Based on the record as a whole , the Arbitrator finds that the Petitioner temporarily totally disabled from. from August 23, 2013 to the date of hearing November 20, 2013 or 12-5/7 weeks at a rate of $737.18 per week.

Respondent shall have credit for all amounts 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 of _____% shall accrue from the date listed below to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

STATE OF ILLINOIS)
) SS.
COUNTY OF)
JEFFERSON

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

George Engleby,

Petitioner,

vs.

NO: 09 WC 15433

14IWCC1010

Western Express,

Respondent.

REMAND

Timely Petition for Review having been filed by the Respondent herein and notice given to all parties, the Commission remands this matter back to the Arbitrator with instructions that he prepare a written decision with findings of fact and conclusions of law.

This matter proceeded to trial before the Arbitrator on November 8, 2013 under 19(b). The issues in dispute were causal connection, both prospective and incurred medical and temporary total disability. The parties went on to prepare a four volume transcript of those trial proceedings.

At the time of trial both attorneys advised the Arbitrator that they are not requiring a written decision containing findings of fact and his conclusions of law. They agreed to this, even though they offered four volumes of medical records and took depositions in this case.

Respondent reviewed the Arbitrator's decision which did not contain findings of fact or conclusions of law.

14IWCC1010

The Commission finds that without the Arbitrator's findings of fact or conclusions of law it is unable to properly review the Arbitrator's decision. Therefore, the Commission remands this matter back to the Arbitrator and instructs him to issue a full decision containing findings of fact and conclusions of law.

DATED: NOV 24 2014

Charles J. DeVriendt

Daniel R. Donohoo

Ruth W. White

HSF
O: 9/24/14
049

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)	☐ Reverse	☐ Second Injury Fund (§8(e)18)
WILLIAMSON		☐ PTD/Fatal denied
	☒ Modify up	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

CHRISTOPHER HURST,

Petitioner,

14IWCC1011

vs.

NO: 11 WC 24720

RUSTY'S HOME 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 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.

1. Petitioner performed general maintenance outside of Respondent's lumber yard, delivered materials to customers and unloaded trucks.

2. While walking inside on November 12, 2010, Petitioner was struck with a forklift tire on his foot and fell to the ground. The forklift then ran over his right shin.

3. Petitioner was admitted to Carbondale Memorial Hospital and was diagnosed with a grade 1 open right tibia fracture, compartment syndrome and mild complex regional pain syndrome. He underwent emergency surgery. A steel rod was placed in his leg and was screwed in. He then treated there for 18 months, along with physical therapy and work hardening.

4. Petitioner last treated at Carbondale Memorial for this injury on September 9, 2013. He returned to work 7 months after surgery but realized he could not jump or run anymore, and walked with a limp.

14IWCC1011

5. Petitioner has undergone two subsequent surgeries to remove screws from his leg because they were irritating him. The steel rod in his leg remains.

6. Currently he has purple, black and blue foot discoloration most of the day. He does not play golf as much as he did prior to the accident, feels right leg pressure when he picks up heavy items and experiences occasional ankle swelling.

The Commission affirms the Arbitrator's rulings on the issues of accident, causal connection and the permanent partial disability award of a 2.5% loss of use of his right foot.

The Commission, however, modifies the Arbitrator's ruling on permanent partial disability benefits related to Petitioner's leg. The Commission views the evidence slightly different than does the Arbitrator, and finds that Petitioner suffered a 42.5% loss of use of his right leg.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $220.00 per week for a period of 91-3/8 weeks, as provided in §8(e) of the Act, for the reason that the injuries sustained caused the 42.5% loss of use of his right leg.

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

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

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $18,400.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: NOV 2 4 2014
O: 9/24/14
DLG/wde
45

David L. Gore

Mario Basurto

Stephen Mathis

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

HURST, CHRISTOPHER
Employee/Petitioner

Case# **11WC024720**

14IWCC1011

RUSTY'S HOME CENTER
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:

FOLEY & DENNY
JOHN D FOLEY
PO BOX 685
ANNA, IL 62906

0299 KEEFE & DePAULI PC
NEIL GIFFHORN
#2 EXECUTIVE DR
FAIRVIEW HTS, IL 62208

STATE OF ILLINOIS)
)SS.
COUNTY OF WILLIAMSON)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
NATURE AND EXTENT ONLY

14IWCC1011

CHRISTOPHER HURST
Employee/Petitioner

Case # 11 WC 24720

v.

Consolidated cases: None

RUSTY'S HOME CENTER
Employer/Respondent

The only disputed issue is the nature and extent of the injury. An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable Molly Dearing, Arbitrator of the Commission, in the city of Herrin, on November 14, 2013. By stipulation, the parties agree:

On the date of accident, **November 12, 2010**, Respondent was operating under and subject to the provisions of the Act.

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

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

Timely notice of this accident was given to Respondent.

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

In the year preceding the injury, Petitioner earned **$18,656.65**, and the average weekly wage was **$358.78**.

At the time of injury, Petitioner was **21** years of age, ***single*** with **0** dependent children.

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

Respondent shall be given a credit of $- for TTD, $- for TPD, $- for maintenance, and **$308.92** for other benefits, for a total credit of **$308.92 as an overpayment of TTD to be credited against PPD**.

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

ORDER

Respondent shall pay Petitioner the sum of $220.00/week for a further period of 84.8 weeks, as provided in Section 8(e)(11) and 8(e)(12) of the Act, because the injuries sustained caused 2.5% loss of use of the right foot and 37.5% loss of use of the right leg, less Respondent's credit of $308.92 for overpayment of temporary total disability benefits.

Respondent shall pay Petitioner compensation that has accrued from September 9, 2013 through November 14, 2013, and shall pay the remainder of the award, if any, in weekly payments.

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

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

Signature of Arbitrator

Date

DEC 10 2013

STATE OF ILLINOIS)
)SS.
COUNTY OF WILLIAMSON)

14IWCC1011

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
NATURE AND EXTENT ONLY

CHRISTOPHER HURST,
Employee/Petitioner

v. Case 11 WC 24720

RUSTY'S HOME CENTER,
Employer/Respondent.

MEMORANDUM OF DECISION OF ARBITRATOR

FINDINGS OF FACT

As of the date of the accident, Petitioner was twenty four years old and employed by Respondent, a lumber yard located in Anna, Illinois. At or near the time of his accident, Petitioner's job duties included delivering materials to customers, unloading materials from trucks onto forklifts, and general maintenance.

On November 12, 2010, Petitioner was struck by a forklift driven by another employee. He was immediately taken to Memorial Hospital of Carbondale, and on November 12, 2010, Dr. C. David Wood performed a right tibia intramedullary nailing, irrigation and debridement of a grade 1 open right tibia fracture, four compartment fasciotomies of the right leg, and measurement of intercompartmental tissue pressures to address a grade 1 open right tibia fracture and impending compartment syndrome. This surgery required the implantation of hardware into Petitioner's right leg. Petitioner was eventually released from the hospital on November 15, 2010. PX 1.

Petitioner followed up with Dr. Wood on November 18, 2010, at which time Petitioner was noted to be doing well post-surgery, and Dr. Wood ordered Petitioner to return the following day to the operating room for a fasciotomy wound closure. On November 19, Petitioner underwent irrigation and debridement of fasciotomy wounds or the right leg with delayed primary closure. PX 2.

On November 30, 2010, Petitioner was diagnosed with right leg painful hardware. Dr. Wood noted a 3 mm gap at the fracture site that he opined would benefit from dynamization of tibial nail. Petitioner underwent physical therapy. On December 17, 2010, Dr. Wood performed a dynamazation of the right leg tibial nail. Thereafter, Petitioner underwent Exogen bone stimulation therapy and Petitioner's physical therapy was put on hold. Dr. Wood released Petitioner to return to work without restrictions as of March 9, 2011. PX 2.

Following his return to work, Petitioner complained of pain and swelling in his leg and toes. Dr. Wood authorized Petitioner to work four hours per day, and then undergo work conditioning the remainder of the day. Petitioner underwent work hardening from March 15, 2011 through March 28, 2011. PX 2.

On March 29, Petitioner returned to Dr. Wood with complaints of more pain and discomfort from his last visit. He specifically complained of pain on the plantar aspect of his foot and around the interlocking bolts distally. Radiographs obtained that day demonstrated more callus formation than previously seen, specifically over the posterior aspect of the fractures and the region over the anterior aspect. Dr. Wood recommended physical therapy address his plantar fascia. He allowed him to return to full work days, but restricted him from working on Saturdays and Sundays, and reduced his work hardening down to three days per week. PX 2.

Petitioner returned to work hardening from April 4 through May 9, 2011, at which time he was discharged. Upon discharge, Petitioner was noted to have met all of his goals, and to be tolerating work hardening in conjunction with his work activities. The plantar fasciitis on his right foot had also improved, and a return to work full duty was recommended. PX 2.

On May 10, 2011, Petitioner presented to Dr. Wood. He was doing fairly well after returning to work full duty, but voiced concerns about remaining sensitivity in and around his open injury. Radiographs obtained on that date demonstrated bony consolidation across the tibia fracture interval, and intact hardware without evidence of complication. Dr. Wood noted that his area of sensitivity may improve with time, and would not limit him in anything he wanted to do. He indicated that Petitioner's leg would never be the same again, however, it should not limit him in his activities. In regard to the possibility of additional medical care, Dr. Wood contemplated the possibility of removing the interlocking bolts as they are somewhat palpable on Petitioner's medial distal leg. Petitioner was discharged from Dr. Wood's care as of that date. PX 2.

Petitioner returned to Dr. Wood on March 12, 2012 with complaints of swelling, discoloration, and numbness and tingling in his right lower extremity. He reported continued difficulties with the right leg due to shooting pain and dysesthesias down into his foot associated with coldness and discoloration. A physical examination revealed no significant swelling. Dr. Wood was able to see all the veins down into the right foot. The right foot was cold, a bit sweaty, and somewhat purple in color. Dr. Wood noted some hair formation but not anymore than on the contralateral side. Petitioner had good range of motion in the ankle and non specific dermatographia. He had excellent range of motion in the knee and well-healed incisions. The proximal screw was unremarkable, and the nail insertion area was benign on examination. His open wound area was sensitive to taping Tinel's type examination, and the two distal interlocking bolts were very prominent. Radiographs obtained demonstrated normal bony anatomy and intact hardware. Dr. Wood's attributed Petitioner's symptomatology to injury in his saphenous vein, and indicated that the interlocking bolts could contribute to that as they are within the zone of the saphenous nerve. Dr. Wood prescribed Lyrica, and recommended the removal of the distal interlocking bolts. PX 2.

Petitioner underwent a Section 12 examination with Dr. Gary Schmidt on June 4, 2012. Dr. Schmidt's impression was that Petitioner had no sequelae from a compartment syndrome of healed tibial fracture. There was no explanation for complaints of weakness, nerve pain, or reported worsening of symptoms. Dr. Schmidt noted inconsistencies on examination as well as no atrophy or significant objective findings. He had no treatment recommendations for Petitioner, other than he found the removal of the distal locking screws to be reasonable. Dr. Schmidt recommended Petitioner continue to work full duty without restrictions, and opined that after the screw removal, no further treatment would be required. PX 3.

On September 21, 2012, Petitioner underwent a removal of painful internal fixation hardware with Dr. Wood. Petitioner was taken off work for a period of time, and again released to return to full duty work on October 4, 2012. PX 2.

On November 15, 2012, Petitioner followed-up with Dr. Wood, who noted Petitioner's leg to be substantially better. Petitioner was no longer having any popping sensation after the bolts had been removed, he had full range of motion of both his ankle and knee, his wounds were well-healed without evidence of infection or complication, he had good strength on examination, but he ambulated with a minimal limp on the right side as compared to the left. Dr. Wood released him from care and placed at maximum medical improvement. PX 2.

Petitioner returned to Dr. Wood on September 9, 2013 with complaints of continual numbness and pain over the right lower leg. He did not complain of the plantar or dorsal foot areas, but reported occasional numbness in the lower leg when waking up. The physical examination revealed normal range of motion, good motor strength, and sensation was good as well. Dr. Wood noted that that skin color was normal, but noted that Petitioner "indicates that occasionally, especially when he has rested for a period of time, his foot has a tendency to get very red or purple in nature." Radiographs were reviewed and found to show good healing with no evidence of complications. Dr. Wood's impression was that Petitioner suffered from persistent complaints of the right lower extremity after an open fracture complicated by compartment syndrome, with mild elements of hyper sympathetic flow and a "very, very mild" complex regional pain syndrome. Dr. Wood indicated that he did not think Petitioner's condition would improve, but indicated that it would not worsen. He was again released from care. PX 2.

At Arbitration, Petitioner testified that upon his return to work, he noticed that everything was different. He was unable to run or jump. Instead, he limped. Petitioner is presently working for Respondent loading and unloading materials for customers, delivering materials, cleaning up the lumber yard, unloading semi-truck trailers, and stacking lumber. Petitioner testified that he is essentially doing the same duties post-accident as he was before same. His is able to do his job satisfactorily.

Presently, Petitioner does not take medication, but he believes he may need to return to the doctor again. He testified to a limited ability to golf because of the turning and twisting mechanisms required in his right leg, and limitations in playing basketball. Petitioner notices a constant limp in his gait, which causes a callus to form on his right great toe. He testified that his right foot becomes discolored on the inner part of his right foot. Petitioner is unable to jump off of objects, as doing so creates a shock-like sensation in his right leg. Picking up objects puts

pressure on his right leg, so he limits the amount of weight he lifts. Petitioner's right leg condition is affected when he is on his feet for long periods of time, and he can feel changes in the weather. Petitioner currently has one screw in his right knee and a steel rod that runs inside of his bone from his knee to his ankle.

CONCLUSIONS OF LAW

Based upon the foregoing and the record in its entirety, as a result of his accident of November 12, 2010, Petitioner sustained a grade 1 open right tibia fracture and compartment syndrome, the condition and residual symptoms for which were surgically treated in three procedures, as well as with a bone stimulator, physical therapy, and work hardening. Petitioner was also diagnosed with extremely mild complex regional pain syndrome following the development of persistent symptomatology in his right foot. He returned to work full duty for Respondent, and by his own testimony, is able to continue to work the same duties following his return to work. Petitioner does not take medication. Petitioner still has a metal rod in his right leg spanning from his knee to his ankle, and a remaining screw in his knee from his original surgery. He testified that he walks with a limp in his gait, which was noted by Dr. Wood in his treatment record of March 12, 2012, that Petitioner indicated causes a callus to form on his right great toe.

The Arbitrator, having had an opportunity to view Petitioner's right lower leg and foot, and compare the same to his left lower extremity, notes that Petitioner has two discolored scars, each approximately five inches in length, on his right lower leg. The Arbitrator was able to observe pink and purple discoloration on the inner part of Petitioner's right foot and a callus on Petitioner's right great toe, which are consistent with his testimony at Arbitration regarding the current condition of his right lower extremity.

The Arbitrator finds Petitioner to be a credible witness at trial, as his testimony appeared to be candid and forthcoming. Petitioner testified to subjective complaints from his right knee into his right foot and right toes, and limitations in same following his accident and treatment, which the Arbitrator finds to be reasonable in light of the condition he suffered and the treatment he received. Therefore, in light of the severity of Petitioner's injury, the treatment received for his condition, Petitioner's continued complaints and limitations, and Petitioner's young age, the Arbitrator finds that Petitioner sustained permanent partial disability to the extent of 2.5% of his right foot and 37.5% loss of use of his right leg under Sections 8(e)(11) and 8(e)(12). Respondent shall receive credit for an overpayment of temporary total disability benefits in the amount of $308.92 against the permanent partial disability benefits. Therefore, Respondent shall pay Petitioner the sum of $220.00 per week for a period of 84.8 weeks, representing 2.5% loss of use of the right foot and 37.5% loss of use of the right leg, less Respondent's credit of $308.92.

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 down	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Joan Anderson,

Petitioner,

14IWCC1012

vs.

NO: 11 WC 02786

Steak-N-Shake,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of accident, causal connection, temporary total disability, medical expenses, prospective medical care, and permanent partial disability and being advised of the facts and law, modifies temporary total disability 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 45 year old employee of Respondent, who described her job as waitress/trainer/manager. Petitioner began working for Respondent as a waitress in March 2004 and was promoted to trainer before she became manager. Petitioner testified she had worked since she was 15, always in the food industry. She had gone to beauty school and became a licensed beautician, but she always did something with her hands. On the date of accident, May 30, 2008, Petitioner testified that they were busy and she was trying to keep the dining room cleaned up. Petitioner stated she was bussing tables and carrying back bus tubs. Petitioner testified she was wiping off the table and she was in a hurry and she had wiped off the table and felt and heard a pop in her right hand. Petitioner stated that it was really loud and the pain was excruciating like she had never

felt before; it just shot up all the way across her hand. Petitioner testified that she had never experienced any type of pain in her right hand prior to that and she had never before then received any treatment with a doctor for that. Petitioner testified of no prior treatment for pain in any joints in her body prior to this accident.

- Petitioner testified she told the managers on duty (either Matt Boyer or Paul Shaffer - she did not recall exactly) of the accident and she went home. Petitioner testified she had also told Brooke Tucker (the general manager) and other managers. She believed that Ms. Tucker was off until that Monday and she stated that she had also advised Dan Roark the district manager, of the incident. Petitioner again indicated that she felt the pop in her right hand when she was wiping off a table (indicating some movement). Petitioner testified that she was in a hurry that day because they were busy. Petitioner stated that as she was wiping the table she felt and heard the pop in her hand around the thumb joint around her wrist and she felt excruciating pain. She again indicated they were busy "as all get out." Petitioner subsequently did seek medical treatment that afternoon, May 30, 2008. Petitioner went to Dr. Hoffman; she could not get in to see her doctor so she saw her spouse's doctor. Dr. Hoffman examined Petitioner and referred her to Dr. Triana, an orthopedic surgeon, about June 10-11, 2008. Petitioner saw Dr. Triana who ordered an MRI and examined Petitioner. Petitioner had the MRI and returned for a follow up with Dr. Triana; in the interim Petitioner had seen her family doctor, Debbie Hayes, whom Petitioner had been seeing for 20 years. Petitioner testified her doctor referred her to Dr. Williams, another orthopedic surgeon. Petitioner indicated she went to the other orthopedic doctor because Dr. Triana said the condition was out of his realm, out of his specialty and he was not comfortable with it. Petitioner testified that Dr. Triana stated that the condition was more complicated than what he felt comfortable with and he wanted Petitioner to see a hand specialist. Petitioner had first seen Dr. Williams in October 2009 and subsequently had surgery to the thumb area of her hand on November 13, 2009. Petitioner understood the surgery was to replace the thumb joint. Post surgery, Petitioner was placed in an Ace bandage and then into ma cast. She had treated with him until January 2010 and was released. Petitioner stated then the pain had increased and was a little bit worse, the surgery had not helped; it was bad. Petitioner indicated in November (November 2009, shortly after the surgery) she had gone to the emergency room. Petitioner indicated she had been letting the dog out (big black lab) and was not going fast enough for the dog. The dog hit the door and the door hit her hand. Petitioner stated that she was worried that she had messed it up and that was why she had gone to the emergency room; to get her hand checked out to be sure it was okay. Petitioner had been examined at the ER and released. Petitioner testified that the incident did increase the pain in her thumb for a little while. She indicated that the dog incident had made it a little bit worse but then it went back to her normal level of pain. Petitioner testified she did not go back for treatment for that particular incident.

- Petitioner testified in February 2010 she had a subsequent surgery. Petitioner stated at that time her body started to reject the joint and the pin that was holding the joint in actually came out through her hand. Petitioner testified she had gone back to Dr. Triana and the doctor said he had to take the joint back out because Petitioner's body was rejecting it. The replacement of the thumb joint had been done by Dr. Williams but she

had gone back to Dr. Triana to have him look at it when the pins were coming out. Petitioner indicated Dr. Triana went in and took the joint out and the hardware and put a spacer in. Petitioner indicated there was an abscess around the bone so the doctor wanted to test it to make sure it was okay and he went in again about a week later and put in another joint (around March 5-6, 2010). Post surgery, Petitioner was referred for physical therapy at Atrium at Methodist, and she went and had completed that. Petitioner testified her pain had gotten no better at all post surgery and the more she moved it, the more it hurt. Petitioner stated that it would cramp and she noted that it shrank, the muscle was gone, and it was disfigured. Petitioner had another surgery with Dr. Triana in late June 2010. Petitioner indicated that she understood that the scar was too wide and had deep tissue growing out of it and they had to go in and cut that off that tissue. Petitioner had further therapy after that surgery at Atrium at Methodist.

- Petitioner testified after that, Dr. Triana left town so she did not have a doctor and she had tried calling other orthopedic doctors. Petitioner stated that she had called Dr. Mitzelfelt; however, when he found out about the surgery Dr. Triana had performed, he refused to see her. Petitioner testified she tried to return to Dr. Williams but he also refused to see Petitioner as she had gone to Dr. Triana. She indicated she had tried every doctor in Peoria. Petitioner testified that she eventually found Dr. Rhode, from Rush in Chicago. Petitioner stated that Dr. Rhode would come down there every other week so she went to see him April 6, 2011 (Dr. Rhode deposition was noted). Petitioner believed she had seen Dr. Rhode about 10 times.

- Petitioner testified that she was still in pain and that was when the muscle atrophied even more and became more disfigured. Dr. Rhode wanted Petitioner to see Dr. Frederick at Rush as he is a hand specialist who deals with more complicated cases. Petitioner indicated they had been trying to make an appointment and get it approved through WC, but she did not see him as Respondent sent Petitioner to see Dr. Wysocki (for a §12 examination [IME], October 19, 2011) who was in the same group. After the IME she received a call from Dr. Frederick's nurse saying they could not see Petitioner. She indicated that was kind of the end of things. Petitioner had not seen any other doctors since. Petitioner testified that she understood her options for treatment was either leave it as is and deal with the pain, or have her thumb cut off and have her index finger moved there, but that did not guarantee the pain would go away. She indicated the Dr. could not say if it would be any better with that surgery. The other option was getting the joint fused so it looked normal, but again, that would not take the pain away. Petitioner indicated at her age (51) she did not care how her hand looked. She had been through 4 surgeries and had enough and they could not say further care would make it any better. Petitioner testified that it hurts all of the time; it is a dull ache all the time. Petitioner stated that if she bumps it or strains it, it will hurt and now her whole hand is starting to cramp up. Petitioner testified the doctor said her thumb was of no useful consequence and she agreed pretty much with that.

- Petitioner stated that she was taken off work when she initially saw Dr. Hoffman, May 30, 2008 and then Dr. Triana kind of went back and forth. Dr. Triana would sometimes say she could do one handed work (work left handed only) but that was about it.

Petitioner indicated that if she would be in more pain he would take her back off of work. Petitioner was terminated by Respondent on September 30, 2008. Petitioner did not work again until June 2011 because she had to. She indicated her teen son had committed suicide in their backyard and she needed money. Petitioner testified she had a neighbor who had a cleaning business and she offered Petitioner some things to take up Petitioner's time to get out of the house. Petitioner testified at that point Dr. Rhode had released Petitioner to one handed work and Petitioner worked for her neighbor (Linders Cleaners). Petitioner testified she worked one handed as more of a supervisor, she would dust occasionally with her left hand, but it was more supervisory. Petitioner no longer worked for them as the Linder's had moved to Iowa. Petitioner currently does work as she owns her own cleaning business with two employees. Petitioner sets the appointments and takes the checks and goes with the employees to make sure they are doing the job, and she talks to the customers to make sure they are happy. She is still released to only one hand work. Petitioner testified she does try sometimes to use her right hand; she had learned to adapt. Petitioner indicated you cannot get dressed with one hand and you cannot do a lot of things; you cannot tie your shoes with one hand; with no right thumb use she indicated she had learned to manipulate with getting dressed and cooking. She can use her fingertips but that is causes pain; she can lift with her fingertips as she does not have a choice. Petitioner stated that she does garden as her spouse will till and she tries to use her left hand. She may have to balance with her right hand, but nothing heavy. She indicated she can steady a pan with her hand when cooking an egg, but she cannot pick up the pan and move it. Petitioner testified her hand was atrophying, fading away from non-use. Petitioner stated that she takes Norco occasionally for the pain (prescribed by her primary doctor); however, she tries not to take it because it is addictive. Petitioner indicated that if she is in a lot of pain and cannot sleep it will dull the pain, but does not really take the pain away. Petitioner indicated she had taken it for so long that it only dulls the pain a little. Other than her primary doctor, she was not seeing any other doctors. Petitioner stated that she had been on short term and long term disability. Petitioner agreed there is an itemization of outstanding medical bills (PX17) and she indicated it was accurate and up to date. Petitioner had no plans of seeking additional medical care as there was nothing else they could do.

The Commission finds that there is no evidence Petitioner had any problems of significance with her right hand or thumb prior to this reported incident. The medical records support her ongoing complaints and symptoms since the date of accident throughout her treatment and is consistent with Petitioner's testimony. The surveillance video does not reveal anything to be contrary to Petitioner's testimony. Petitioner had some apparent pre-existing mild arthritic condition, but again there was no evidence of symptoms prior to this incident. The evidence and testimony appears consistent and supportive that Petitioner had sustained an accident May 30, 2008 and there is evidence in support of a causal relationship with the medical records noting her history of injury on the job similar to her testimony. There was a period from October 13, 2008 through June 29, 2009 where there is no evidenced treatment, which raises the issue of an ongoing causal connection given the approximate 8 month gap in treatment. Petitioner's complaints, symptoms and findings thereafter are still consistent with the 2008 treatment and then throughout the remainder of her treatment (through injections and the multiple surgeries) up to her testimony at

hearing. Petitioner clearly evidenced and the Arbitrator had the opportunity to view Petitioner's right hand and thumb to see the end result. While there is no explanation for the break in treatment, everything is still consistent and supportive of an ongoing causal connection to Petitioner's current condition of ill-being, despite Respondent's IME's (Dr. Wysocki) opinion that the incident did not cause or aggravate a pre-existing condition, given the treating medical records clearly reflecting the ongoing condition since the date of this incident. Petitioner's testimony is really unrebutted and the evidence and testimony does support a finding that Petitioner sustained an accident that arose out of and in the course of her employment with the evidence further supporting a causal connection (cause or aggravation of a pre-existing condition) to her current condition of ill-being. 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 of accident, as well as, affirms and adopts the Arbitrator's finding as to causal connection.

The Commission notes, regarding the issue of temporary total disability (TTD) that the Arbitrator found that Petitioner was entitled to an award of 152-3/7 weeks of temporary total disability benefits (6/11/08-1/18/10 & 2/15/10-6/9/11) at a rate of $442.31 per week under §8(b) of the Act ($67,420.68 total TTD). Respondent paid $-0- in TTD benefits and received a credit of $19,083.60 for Long & Short term disability paid to Petitioner. The Commission finds the first awarded period of TTD fully supported by the evidence presented by Petitioner. After the initial surgery and some recovery time, Petitioner was released from the care of Dr. Williams. Petitioner did remain symptomatic and Petitioner had evidenced post-operative complications and sought further care which required additional surgical procedures and, unfortunately complications, the final surgery being irrigation and debridement and wound closure June 24, 2010. The medical records indicated a three to six month recovery period post surgery. Given Petitioner's apparently poor recovery rate the Commission considers her recovery at six months, December 24, 2010 (as the assumed MMI date). At that point Petitioner's condition appeared to have stabilized/plateaued. Medical records are rather silent as to stating specifically her work status, but there is no evidence Petitioner had reached maximum medical improvement or that her condition had in any way stabilized prior to that point. It is also clear that Petitioner did not first see Dr. Rhode until April 6, 2011, when he then took Petitioner off of work, and it is not clearly evidenced what went on during that interim period. The appointments with Dr. Rhode give no indication of any real treatment which further supports the position that Petitioner's condition had by then stabilized. Given the documentation of the expected recovery period, and the gap in documented treatment, it is difficult to find Petitioner entitled to any lost time benefits with the start of seeing Dr. Rhode in April 2011 when then there was no clear treatment provided. Additionally, Dr. Rhode was also Petitioner's third choice of 'treaters'. The Commission, therefore, modifies the TTD award to find Petitioner proved entitlement to benefits June 11, 2008 through January 18, 2010 and February 15, 2010 through December 24, 2010 (128-6/7 weeks at $442.31 per week [total TTD=$56,994.80] with Respondent entitled to the disability credits totaling $19,083.60). The Commission finds the decision of the Arbitrator not totally contrary to the weight of the evidence and herein modifies the Arbitrator's finding as to total temporary disability as noted above.

14IWCC1012

The Commission further finds, with the above finding of accident and causal connection to Petitioner's condition of ill-being, that the medical records of her treatment consistent with the testimony. Accordingly the Commission finds that Petitioner met the burden of proving entitlement to the awarded benefits and affirms the award as is regarding medical expenses. The Commission finds Dr. Rhode as a third choice of medical providers and that there had been a significant gap in treatment before Petitioner even sought out his care. The Commission can find 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/prospective medical care.

The Commission, with the above finding of accident and causal connection to her condition of ill-being, finds regarding permanent partial disability (PPD), the medical records of Petitioner's treatment consistent with testimony and affirms the award as is to find Petitioner met the burden of proving entitlement to the awarded PPD benefits. The awarded PPD benefits are well supported with the evidence, especially given the multiple surgeries and post-operative complications. 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 Permanent partial disability.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed January 3, 2014, (other than the below noted TTD modification), is hereby affirmed and adopted.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $442.31 per week for a period of 128-6/7 weeks, that being the period of temporary total incapacity for work under §8(b) of the Act. Respondent entitled to a credit of $19,083.60 for short term and long term disability benefits paid to Petitioner.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $398.08 per week for a period of 112.75 weeks, as provided in §8(e)(9) of the Act, for the reason that the injuries sustained caused the 55% loss of use of Petitioner's right hand.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay all reasonable and necessary medical bills for services, with the exception of the medical bills from Dr. Blair Rhode, as provided in §8(a) and §8.2 of the Act, subject to the fee schedule. Respondent is not liable for medical bills incurred by Petitioner for the services of Dr. Rhode.

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

14IWCC1012

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: NOV 24 2014
o-9/24/14
DLG/jsf
45

David L. Gore

Stephen Mathis

Mario Basurto

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

ANDERSON, JOAN
Employee/Petitioner

Case# **11WC002786**

14IWCC1012

STEAK N SHAKE
Employer/Respondent

On 1/3/2014, 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 0.09% 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:

0192 CUSACK GILFILLAN & O'DAY
DANIEL P CUSACK
415 HAMILTON BLVD
PEORIA, IL 61602-1102

1832 ALHOLM MONAHAN KLAUKE ET AL
GEORGE F KLAUKE JR
221 N LASALLE ST SUITE 450
CHICAGO, IL 60601

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 14IWCC1012

JOAN ANDERSON
Employee/Petitioner

Case # 11 WC 02786

v.

Consolidated cases: ____

STEAK N SHAKE
Employer/Respondent

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable Molly Dearing, Arbitrator of the Commission, in the city of Peoria, on October 24, 2013 and October 29, 2013. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

14IWCC1012

On **May 30, 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 **$34,499.92**; the average weekly wage was **$663.46**.

On the date of accident, Petitioner was **45** years of age, ***single*** with **1** dependent children.

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

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

Respondent shall be given a credit of **$0.00** for TTD, **$0.00** for TPD, **$0.00** for maintenance, and **$19,083.60** for short term and long term disability benefits, for a total credit of **$19,083.60**.

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

ORDER

Respondent shall pay all reasonable and necessary medical services, with the exception of medical bills from Dr. Blair Rhode, as provided in Sections 8(a) and 8.2 of the Act, subject to the fee schedule. Respondent is not liable for medical bills incurred by Petitioner for the services of Dr. Rhode.

The parties stipulated that Respondent is entitled to a credit of $19,083.60 for short term and long term disability benefits paid to Petitioner. Respondent shall pay Petitioner temporary total disability benefits of $442.31 per week for a total period of 152 3/7 weeks, representing June 11, 2008 through January 18, 2010, and February 15, 2010 through June 9, 2011, less Respondent's credit of $19,083.60. Respondent shall pay Petitioner the temporary total disability benefits that have accrued from May 30, 2008 through October 29, 2013, and shall pay the remainder of the award, if any, in weekly payments.

Respondent shall pay Petitioner permanent partial disability benefits of $398.08/week for 112.75 weeks, because the injuries sustained caused the 55% loss of use of the right hand, as provided in Section 8(e) of the Act.

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

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

Signature of Arbitrator

December 19, 2013
Date

JAN 3 - 2014

STATE OF ILLINOIS)
)SS.
COUNTY OF PEORIA)

14IWCC1012

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

JOAN ANDERSON,
Employee/Petitioner

v. Case 11 WC 02786

STEAK N SHAKE,
Employer/Respondent.

MEMORANDUM OF DECISION OF ARBITRATOR

FINDINGS OF FACT

At the time of her accident, Petitioner was forty five years of age. She began working for Respondent in March 2004 as a waitress. Petitioner was then promoted to a trainer before becoming a manager. On May 30, 2008, Respondent's restaurant was busy. Petitioner was attempting to keep the dining room clean by bussing and cleaning tables. She was hurriedly wiping down a table when she felt a pop in her right thumb followed by excruciating pain shooting up through her hand. Petitioner immediately told the manager on duty, who, according to Petitioner, would have been Matt Boyer or Paul Shaffer. Petitioner testified that she also told Brooke Tucker, the General Manager, the following Monday, and Dan Roark, a district manager. Petitioner had never experienced pain in her right hand prior to the work incident, nor had she been treated by a physician for any right hand symptoms.

Because she could not get in to see her primary care provider, Petitioner presented to Dr. Daniel Hoffman, on May 30, 2008. Petitioner presented to Dr. Hoffman with symptoms of right hand swelling. Dr. Hoffman noted tenderness and swelling over the dorsal aspect of the right hand, and assessed Petitioner's condition as a soft tissue injury versus ganglionic cyst. Dr. Hoffman prescribed medication and referred her to Dr. Jeffrey Traina. PX 1.

Petitioner presented to Dr. Traina on June 11, 2008 complaining of a problem in her wrist. She reported that she was at work a week and a half prior when she was cleaning a table and had immediate pain in her hand. Petitioner reported to Dr. Traina "one episode of previous pain before in her hand but it has never been as severe as it was ten days ago." A physical examination revealed tenderness over the base of the second metacarpal, some localized swelling in the area, relatively little pain in her wrist, no swelling at the carpal joint, and a normal carpometacarpal joint. Dr. Traina's impression was edema with pain over the second metacarpal secondary to overuse. He ordered her off work, prescribed a wrist brace and anti-inflammatory medication, and ordered her to return in ten days. PX 2.

Petitioner returned to Dr. Traina on June 23, 2008, at which time she reported doing better, but still symptomatic. He ordered her to return in three weeks, and continued her off work status until that time. PX 2. Subsequently, Petitioner continued to treat with Dr. Traina, wherein Petitioner continued to experience symptomatology at the base of the second metacarpal of her right hand with little improvement utilizing the brace. Dr. Traina ordered an MRI. PX 2.

The MRI of July 24, 2008 revealed no acute abnormality within the base of the right second digit, mild thickening and findings suggestive of chronic injury to the first metacarpal joint, and mild degenerative changes of the first CMC and MTP. Following her MRI, Petitioner followed-up with Dr. Traina on July 28, at which time he ordered her to one-handed work only, prescribed therapy and anti-inflammatory medication.

Petitioner again saw Dr. Traina on August 12, 2008 with continued symptomatology and reported that she was unable to attend therapy as of yet due to a family emergency. He ordered her to continue use of the brace, and indicated if there was no improvement with same, then he would try a cortisone injection. PX 2. Continued modalities of treatment were attempted, including a thumb spica brace and a cortisone injection in the CMC joint with Celestone, all of which were unsuccessful in relieving her pain. Dr. Traina referred Petitioner to a hand surgeon. PX 2.

On June 15, 2008, Petitioner completed a Short Term Disability Claim Form, wherein she alleged that her disability was due to an illness. Dr. Traina completed the physician's portion of the disability form on June 20, 2008. In response to the question, "Is condition work related?" he checked the box "No". RX 3.

The Arbitrator finds no treatment records in evidence between Petitioner's treatment with Dr. Traina on October 13, 2008, and treatment with Dr. Hoffman on June 29, 2009, an approximately eight month gap in treatment.

Petitioner returned to Dr. Hoffman on June 29, 2009 with continued complaints of pain on the dorsal aspect of her right hand, which showed tenderness and swelling upon examination. Dr. Hoffman's impression was tendonitis or possible RSD. He ordered her to remain off work and advised her return to Dr. Traina for additional studies. PX 1.

Petitioner testified that in the meantime, she sought treatment with her primary care provider, Debbie Hays, a nurse practitioner, who referred her to Dr. James Williams. A singular treatment record from Debbie Hayes with a date of service of August 31, 2009 appears amongst the records of Dr. Williams.

On October 22, 2009, Petitioner presented to Dr. Williams at the Midwest Orthopaedic Center with complaints of right thumb basilar joint pain, which reportedly began in May while wiping up a table as a manger at Steak N Shake. After reviewing her MRI and radiographs, and performing a physical examination of her showing tenderness over the joint, Dr. Williams recommended a right thumb CMC joint arthroplasty as an outpatient procedure. Petitioner underwent that procedure on November 13, 2009 at Methodist Medical Center of Illinois. PX 4.

Seven days after surgery, on November 20, 2009, Petitioner presented to the Emergency Department at Methodist Medical Center of Illinois with a history of catching her thumb in a door, feeling a pop, and experiencing pain. Radiographs were taken, which showed surgical placement of K-wire across the carpometacarpal junction of the right wrist at the level of the trapezium and base of the second metacarpal. Petitioner was given pain medication and discharged. PX 5.

Post-operatively, Petitioner experienced pain with finger movement, which resolved. Dr. Williams noted that her post-operative radiographs looked fantastic. Petitioner underwent therapy, and was released to work without restrictions on December 1, 2009. At her final visit with Dr. Williams on January 18, 2010, Petitioner was experiencing some residual tenderness, which Dr. Williams thought would resolve, and she reported an inability to fully lay her thumb flat or hyperextend her thumb. Dr. Williams believed both limitations were due to the increased laxity at Petitioner's metacarpophalangeal joint. He indicated that both limitations could only be prevented by a complete fusion to that joint, but he did not recommend that procedure. Dr. Williams released her from his care on that date. PX 4.

On February 15, 2010, Petitioner returned to Dr. Traina, and reported no relief from the surgery performed by Dr. Williams. A physical examination revealed tenderness over the CMC joint with motion of the thumb, some swelling, no redness, heat or warmth, diffuse tenderness without apparent abnormality, and a well-healed incision. Dr. Traina's assessment was a questionable problem versus infection, for which he ordered radiographs to ascertain questionable fracture of the metacarpal and blood work. He applied a short-arm thumb spica and asked her to return in one week. RX 2.

Radiographs of the right hand obtained on February 15, 2010 revealed postoperative changes and a vertical fracture line extending along the shaft of the proximate first digit metacarpal. PX 8.

Petitioner returned to Dr. Traina on February 22 with complaints of feeling like the pin in her hand was coming out. Dr. Traina noted that radiographs confirmed showed the pin to be migrating, and a bone scan obtained on February 18, 2010 was abnormal and showed increased uptake, but did not reveal any fracture. RX 2, 9. Petitioner was having significant pain and some tinting of the skin. Dr. Traina recommended removing the pin and exploration of the CMC joint. RX 2.

On February 23, 2010, Petitioner presented to the Emergency Department at Methodist Medical Center of Illinois with complaints of a pin protruding out of her right wrist. She reported that she had difficulties with one of the pins coming out of her wrist following her surgery with Dr. Williams, and that Dr. Traina had scheduled her for surgery to remove the pin, but she indicated the pin seemed to be protruding farther than normal on this date. A physical examination revealed that the pin was not "through and through, but it is quite pronounced." Radiographs obtained showed a metallic pin tenting the skin. The Emergency Department personnel spoke with Dr. Traina, who recommended her wrist be splinted with a dressing, and Petitioner was discharged. PX 11.

On February 25, 2010, Dr. Traina performed a removal of carpometacarpal implant of the right thumb with irrigation and debridement and insertion of antibiotic cement spacer and removal of retaining pins. PX 2, PX 12. One week later, on March 4, 2010, Dr. Traina performed a carpometacarpal reconstruction of the right wrist at the first metacarpal with a graft jacket implant. PX 13. Post-operatively, she was placed in a thumb spica cast, but developed an open area with deep tissue coming out. Dr. Traina attempted to excise this in the office on June 18, 2010 without success secondary to discomfort. He scheduled her for surgery to further excise the tissue. On June 24, 2010, Dr. Trina performed a right thumb irrigation and debridement. Petitioner did well post-operatively with the aid of a thumb splint. PX 2.

Petitioner began therapy on July 19 and reported some relief from treatment. She was discharged from therapy on December 15, 2010. PX 15.

On August 4, 2010, Petitioner returned with complaints of a burning sensation in her hand, which Dr. Traina noted to be a relatively new finding. Petitioner had a significant contracture of the MCP joint. Petitioner was undergoing therapy, and Dr. Traina recommended continued aggressive therapy. She thereafter failed to present to her office visit of August 25, 2010. Dr. Traina noted on September 17, 2010 that physical therapy wanted to restart therapy, which Dr. Traina could not order until Petitioner re-presented to him. Dr. Traina was leaving the Peoria area and indicated she would need to find another orthopedic provider. PX 2.

Petitioner returned to Dr. Traina on October 23, 2010 and reported an inability to continue therapy due to the recent suicide of her son. She complained of pain over the CMC joint and weakness bilaterally. Dr. Traina restarted physical therapy, ordered pain medication, and referred her to Great Plains Orthopedics. PX 2.

After concluding treatment with Dr. Traina, Petitioner testified that she attempted to seek treatment with other doctors, such as Dr. Mitzelfelt of Pekin, and attempted to return for treatment with Dr. Williams, but both physicians declined to treat her because of her previous treatment with Dr. Traina. She stated that she "tried every doctor in Peoria", but without success. Eventually, she saw Dr. Rhode, who was referred to her by her attorney.

Petitioner presented to Dr. Rhode on April 6, 2011. His impression was that she suffered from a painful CMC graft jacket. Dr. Rhode believed this to be a "complicated condition that I believe requires a subspecialist in hand surgery." He recommended Petitioner follow-up with Dr. John Fernandez at Rush, and ordered her off work until she was evaluated by a hand specialist. PX 16.

Before Petitioner could secure an appointment with Dr. Fernandez, she was scheduled for a Section 12 examination with Dr. Wysocki at Rush Hospital. Due to the Section 12 examination, Dr. Fernandez's office would not see Petitioner because she had already seen another physician within the group. Dr. Rhode referred Petitioner to Dr. Mark Cohen, who refused to see her for similar reasons as Dr. Fernandez. Dr. Rhode then referred her to Dr. Oakey. PX 16.

On March 7, 2012, Petitioner presented to Dr. Rhode with no reported change in symptoms. He believed that she had plateaued secondary to her inability to gain access to

medical treatment. Dr. Rhode opined that Petitioner's right wrist would not improve and would likely worsen without further medical treatment. He stated that she had essentially lost all opposition and key pinch strength, and continued to experience debilitating pain at the first CMC joint. He recommended she take oral pain medication indefinitely and indicated she may benefit from steroid injections into the first CMC joint. PX 16.

On April 18, 2012, Petitioner followed-up with Dr. Rhode, who indicated that Petitioner's treatment options consisted of a revision fusion versus a foam amputation. Dr. Rhode ordered permanent restrictions on Petitioner of no use of the right upper extremity, and placed Petitioner at maximum medical improvement. PX 16.

Dr. Rhode testified by way of evidence deposition. Dr. Rhode felt that because Petitioner's case was a complex hand case, he did not want to "do something that I felt was outside the scope of my practice, which I felt this was, so I felt most appropriate to refer her to a subspecialist." PX 19, Pg. 10. He recommended Petitioner see Dr. John Fernandez at Rush Hospital, a hand specialist, but because Petitioner was scheduled for a Section 12 examination with one of Dr. Fernandez's partners, she was unable to see Dr. Fernandez. Even after Petitioner was unable to treat with Dr. Fernandez, Dr. Rhode did not want to surgically treat Petitioner because "[a]gain this is out of the scope of practice for what I do." PX 19, Pg. 11. Dr. Rhode then referred her to Dr. Mark Cohen, a hand specialist, who was unable to treat Petitioner for a similar reason. Dr. Rhode hoped that someone would do a fusion with bone graft on Petitioner, but stated "I would hope–and it's out of the scope of my practice. As I said before, I don't feel comfortable treating this patient surgically." PX 19, Pg. 13.

Dr. Rhode indicated that Petitioner has a painful "floppy finger" that could benefit with a higher level of function and a lower impairment and disability if the thumb was linked back to the wrist. If she were to undergo an amputation of the thumb, Dr. Rhode indicated that it would be devastating to her function in that wrist. Absent any surgery, Dr. Rhode did not anticipate Petitioner being able to resume using her right hand for work. With regard to causation, Dr. Rhode opined that Petitioner aggravated her pre-existing arthritis, causing her thumb to become symptomatic and precipitated surgery. In formulating his opinion, Dr. Rhode testified that he reviewed an MRI of July 24, 2008, a verbal history from Petitioner, radiographs obtained in his office, and a Section 12 examination report from Dr. Wysocki. He did not have the records of Dr. Hoffman, Dr. Traina or any other physicians. Dr. Rhode acknowledged that he did not treat Petitioner, other than having discussions with her regarding an injection and an assessment with a hand specialist. PX 19.

Petitioner was examined by Dr. Wysocki at the request of Respondent on October 19, 2011 pursuant to Section 12. Dr. Wysocki reviewed the treatment records of Dr. Hoffman, Deborah Hayes, Dr. Williams, and Dr. Traina as well as operative reports from Methodist Hospital. Dr. Wysocki also reviewed radiographs, the MRI and a bone scan. He performed a physical examination, performed radiographs in his office, and took a history from Petitioner. Petitioner described wiping down a table with a relatively sudden onset of pain in the right thumb. She did not recall having any problems in her hand prior to the May 30 incident, and at the time she saw Dr. Wysocki, she reported that her hand was essentially useless to her in that she did not use her right thumb whatsoever. The only way she utilized her hand was to perform

a small amount of pinching between any combination of the index through small fingers with no use of the thumb. Dr. Wysocki's assessment was right thumb pain, stiffness, and dysfunction stats post surgical treatment of CMC arthritis. Based on his review of records, the history obtained from Petitioner, and the physical examination, Dr. Wysocki opined that Petitioner's current thumb condition was not casually related to the work injury of May 30, 2008, reasoning that he would not expect performing wiping motions over a table would be significant enough injury to alter the natural history of underlying thumb CMC arthritis or cause a new onset of thumb CMC arthritis. Dr. Wysocki stated that he would recommend a thumb MCP arthrodesis, thumb MCP joint fusion, a ligament reconstruction suspensionplasty, or thumb amputation. Dr. Wysocki placed her at maximum medical improvement barring any further surgical intervention to the right hand, and he believed an appropriate work restriction would be no lifting, pushing, pulling greater than five pounds with the right hand for gross motor only, with no fine motor use. Dr. Wysocki also suggested a functional capacity evaluation to more accurately set her permanent restrictions. RX 1.

Dr. Wysocki testified by way of evidence deposition on February 1, 2013 concomitantly with his report. Dr. Wysocki testified that with regard to causation, he did not expect a low energy activity and mechanism such as wiping down a table to be significant enough trauma to a thumb CMC joint to either generate CMC arthritis or serve as a significant trauma to cause an aggravation of a pre-existing condition. He defined "aggravation" to be performing an activity or sustaining trauma such that it alters the natural history of whatever the underlying process is. "If someone undergoes an activity or undergoes a trauma that is so intense that it alters the natural history of it and causes almost irreversible damage to that underlying condition, that would be considered a kind of permanent and an effective aggravation of that preexisting condition, something more than just something that brings out manifestations." RX 1, Pg. 45.

Dr. Wysocki attributed the onset of symptomatology following the May 30, 2008 accident to a manifestation of symptoms. He testified that the accident manifested a potentially mild underlying CMC thumb arthritis, and that the pain Petitioner experienced following the accident drove her to have the surgical procedures she underwent prior to presenting to him. He indicated that the symptoms she was currently experiencing could be triggered by a reaction to the graft jacket implant, symptomatic impingement as the metacarpal approaches the scaphoid, or pain upon substantial hyperextension at the MCP joint. Dr. Wysocki testified that the restrictions he recommended for Petitioner were not caused or aggravated by the events of May 30, 2008. Dr. Wysocki noted that Petitioner was primarily problematic in the radial side of the right hand and in the right thumb, and testified that Petitioner's right hand had significant restrictions with thumb movement. Dr. Wysocki stated that even if Petitioner were to undergo additional surgery, she still had a guarded prognosis. RX 1.

At Arbitration, Petitioner testified that she has been given three options for treatment. She can leave her hand and thumb as they are, have the thumb amputated and move her index finger to the location of her thumb, or have the thumb joint fused. If her physician was confident that her thumb would work and be less painful, she indicated that she may undergo surgery. However, her physician has indicated that the thumb amputation may not alleviate her pain, and the fusion may not provide her additional functionality. As such, she has elected to forego any further treatment.

During her treatment, Petitioner testified that Dr. Hoffman took her off work on May 30, 2008. Petitioner stated that Dr. Traina "went back and forth" regarding her off work status, taking her off work when her hand became painful, and returning her to restricted work of one-handed work only at other times. Although Petitioner initially testified Respondent could not accommodate her restrictions, she later testified that she does not remember if she returned to Respondent after her accident to request employment within her restrictions.

Petitioner was terminated from her employment with Respondent on September 30, 2008. She received short term and long term disability from Respondent from June 2008 until July 10, 2009. She did not work again until June 10, 2011, when she began working for Linder's Cleaning Service in a one-handed capacity in what Petitioner described as a supervisory position. Linder's Cleaning moved out of state, and in December 2012, Petitioner began her own cleaning company. She employs two other individuals. Petitioner testified that she sets appointments, takes checks, accompanies her employees to cleaning jobs to ensure their performance, talks to the customers, and ensures the happiness of the customers.

Regarding her limitations in her right hand, Petitioner testified on direct examination that her thumb is of no useful consequence. She presently experiences a dull ache sensation all of the time, and if she bumps or strains it, it causes pain. Petitioner also experiences cramping in her entire right hand. She indicated that she has to use her right hand "sometimes", and she has learned to manipulate her right hand to get dressed or cook. Petitioner can pick up objects using her fingertips, and may steady a pan with the right hand, but she cannot pick it up and move it with her right hand. She continues to garden with her wife using her left hand. Petitioner takes Norco for pain relief, which is prescribed by Debbie Hayes.

On cross examination, Petitioner testified that in her supervisory capacity for Linder's Cleaning, she would only lift things using her right fingertips. Petitioner acknowledged that she can drive as long as she does not have to make any sharp moves. Although she indicated that she cannot carry things, such as a plate or cup of coffee, because her hand cramps up, she testified that she can "sometimes" carry paper or a folder, and "on a good day" carry a binder. According to Petitioner, she cannot carry a tray, a spatula, turn a key, or vacuum with her right hand. She has no problems with her left hand, and her right arm is well. On redirect examination, Petitioner indicated that when she visits her cleaning sites, she pitches in and helps her staff carry in items.

Respondent admitted Restroom(s) Daily Cleaning Checklist and Service Work Verification Sheet forms as RX 4. The Restroom Daily Cleaning Checklists include Petitioner's signature as the cleaning service representative, and indicate twelve items that are checked off by both the cleaning service and the General Manager. The Service Work Verification Sheets represent the date, time, and vendor performing the cleaning service and the service performed, as well as the signature of the servicers and the general manager. RX 4.

Chad Wahl testified for Respondent. He is employed by Menards as a General Manager. Mr. Wahl testified as to RX 4, documents that require a manager's signature to verify that the restrooms at Menards were cleaned as indicated. Mr. Wahl testified that he is familiar with Linder's Cleaning Service, as they performed cleaning services for Menards. He indicated that several individuals have cleaned the bathrooms, and he personally observed Petitioner cleaning

the bathrooms "quite frequently." Although he could not give dates of service, he saw her mop, wipe down the restrooms, and sweep on several occasions. He could not attest to whether he was using one hand or two.

Petitioner was called as a witness by Respondent. Petitioner testified that her signature appears in RX 4, and that the "JA" is her signature as well. When asked if Petitioner cleaned at Menards or simply signed the records in RX 4 in a supervisory capacity, Petitioner stated that she "occasionally would clean a mirror or wipe off the counter. I always had someone with me that would mop, that would do the sweeping. There was [sic] always two of us. I signed in a supervisory role." Petitioner indicated that Menards' managers rarely saw what she did, and she would often have to track one down to sign the verification.

Four surveillance videos with dates of September 13 through September 20, 2011, October 5 through October 7, 2011, April 23 through April 25, 2012, and July 16 through July 17, 2012 were admitted into evidence by Respondent. The videos reflect Petitioner using her right hand to open a car door with a key, open a bottle of motor oil, and lift, carry and push objects. They also reflect Petitioner entering individual homes and Menards to perform cleaning services. On some occasions, she is accompanied by another individual and on others, she cleans by herself. On the videos, Petitioner can be seen mopping utilizing both hands, and lifting and gripping objects with her right hand, such as a vacuum, bottles, garbage bags, buckets, brushes, cleaning supplies, pieces of paper, and rolls of paper. RX 7-10.

Steven White, Ryan Bordis, and Terry Norwicki testified as to the surveillance videos on behalf of Respondent. All gentlemen work for Robison Group as private investigators, and all were assigned to survey Petitioner on various dates. Mr. White, Mr. Bordis and Mr. Norwicki testified that their respective cameras were in good working condition during the surveillance of Petitioner, that the videos depict what each individual saw through their camera lens, and that the video tapes were not edited. Mr. Norwicki testified that he had a trainee with him during his surveillance activities, and both he and the trainee show the same video from different angles, which he reviewed. He indicated that although the video he took and that of the trainee are meshed together to constitute the videos that are admitted into evidence. He is unfamiliar with the process of meshing the two videos together, as he does not perform that activity himself.

Ashley McNamee, a news anchor for a local NBC affiliate, testified for Petitioner in rebuttal to the surveillance video. She stated that the surveillance videos were edited as evidenced by jump cuts, referring to the displaced timing sequences in the videos. On cross examination, Ms. McNamee stated that a jump cut could be due to the camera person stopping and starting the camera.

Petitioner was recalled as a witness on her own behalf after having viewed the surveillance videos admitted as RX 7-10. She testified that the videos were filmed after June 10, 2011, the date in which she began working for Linder's Cleaning, and after she was released to one-handed duty. Petitioner acknowledged that she can lift the vacuum, but stated she can do so only by utilizing her knee and the fingertips of her right hand while lifting the heavy part with her left hand. She also acknowledged her ability to use a "small mop" and to utilize a key to open a door with two fingers of her right hand.

CONCLUSIONS OF LAW

In regard to the disputed issue (C), Respondent disputed that Petitioner suffered an accident arising out of her employment.

To obtain compensation under the Illinois Workers' Compensation Act, a claimant must show by a preponderance of the evidence that he has suffered a disabling injury arising out of and in the course of his employment. 820 ILCS 305/2; *Metropolitan Water Reclamation District of Greater Chicago v. Illinois Workers' Compensation Comm'n*, 407 Ill. App. 3d 1010, 1013 (1st Dist. 2011). The "arising out of" component refers to an origin or cause of the injury that must be in some risk connected with or incident to the employment, so as to create a causal connection between the employment and the accidental injury. *Id.* Courts have recognized three general types of risks to which an employee may be exposed: (1) risks distinctly associated with the employment; (2) risks personal to the employee; and (3) neutral risks, which have no particular employment or personal characteristics. *Id.*; *Illinois Institute of Technology v. Industrial Comm'n*, 314 Ill. App. 3d 149, 162 (2000). Injuries resulting from a neutral risk are not generally compensable and do not arise out of the employment, unless the employee was exposed to the risk to a greater degree than the general public. *Metropolitan Water Reclamation District of Greater Chicago,* 407 Ill. App. 3d at 1014. "It is the function of the Commission to judge the credibility of witnesses, determine the weight to be given to their testimony, and to draw reasonable inferences from that testimony." *Nunn v. Industrial Comm'n*, 157 Ill. App. 3d 470, 478 (4th Dist. 1987).

In the present case, the Arbitrator finds that the risks to which Petitioner was exposed on May 30, 2008 were distinctly associated with her employment for Respondent. Petitioner testified that on May 30, 2008, the restaurant was especially busy and she, as a manager, was attempting to keep the dining room clean by bussing tables and then wiping them down. She was hurriedly wiping off a table with her right hand when she felt a pop around her thumb joint. Although Petitioner's job duties were not elicited during testimony, the Arbitrator reasonably infers that wiping down tables was within the purview of Petitioner's job duties that she may reasonably be expected to perform as manager in order to keep the dining room clean to facilitate an expeditious flow of diners. The Arbitrator finds that Respondent's daily operations, namely serving its dining customers, of its restaurant on the date of accident created an increased risk of injury, as it caused Petitioner to hurriedly wipe down the table at issue. Therefore, the Arbitrator finds that Petitioner has sustained an injury that arose out of and in the course of her employment with Respondent.

In regard to disputed issue (E), Respondent disputed that timely notice of the accident was given to Respondent, and Petitioner alleged that notice was given to Brooke Tucker with the job title of General Manager on May 30, 2008. Arb. X 1. Petitioner testified at Arbitration that on her date of accident, Petitioner told Matt Boyer or Paul Shaffer. Petitioner testified she also told Brooke Tucker, the General Manager, the following Monday, and Dan Roark, a district manager. Based upon Petitioner's unrebutted testimony, the Arbitrator finds that Petitioner has proven that notice of the accident was given within the time limits stated in the Act.

In regard to disputed issue (F), it is well settled in Illinois that employers take their employees as they find them. *Sisbro v. Industrial Commission*, 207 Ill.2d 193, 205 (2003). An employee will not be denied recovery simply because of the presence of a pre-existing condition so long as it can be shown that the employment was also a causative factor. *Id.* Recovery will depend on the employee's ability to show that a work-related accidental injury aggravated or accelerated the preexisting disease such that the employee's current condition of ill-being is causally connected to the work-related injury. *Id.* at 204-205. Further, the Workers' Compensation Act is a remedial statute and should be liberally construed to effectuate its main purpose–providing financial protection for injured workers. *Interstate Scaffolding, Inc. v. Illinois Workers' Compensation Comm'n*, 236 Ill.2d 132, 149 (2010); *Beelman Trucking v. Illinois Workers' Compensation Comm'n*, 233 Ill.2d 364 (2009)(the Workers' Compensation Act is a remedial statute intended to provide financial protection for injured workers and it is to be liberally construed to accomplish that objective).

The Arbitrator notes that no causation opinion appear in the records of Dr. Traina or Dr. Williams, both of whom surgically treated Petitioner's thumb. The solitary mention of work-relatedness from either physician appears in the Short Term Disability Claim Form of June 2008, in which Dr. Traina checked the box "No" in response to the question, "Is condition work related?" RX 3. The Arbitrator declines to find this response dispositive of the issue of causation, given the lack of explanation or basis for same.

In support of their respective causation positions, Petitioner tendered the opinions of Dr. Rhode, and Respondent proffered those of Dr. Wysocki. The Arbitrator finds the opinions of Dr. Wysocki to be more credible than that of Dr. Rhode, and accordingly gives the opinions of Dr. Wysocki more weight. Dr. Wysocki reviewed substantially more treatment records and studies than did Dr. Rhode. Dr. Rhode testified that in formulating his opinions, he reviewed the MRI of July 24, 2008, a verbal history from Petitioner, radiographs obtained in his office, and a Section 12 examination report from Dr. Wysocki. PX 19. He did not have the records of Dr. Hoffman, Dr. Traina, Dr. Williams, Deborah Hayes, or any additional studies. Dr. Wysoki, however, had reviewed all of the medical records as did Dr. Rhode, but also had reviewed the records of Dr. Hoffman, Deborah Hayes, Dr. Williams, Dr. Rhode, operative notes from November 13, 2009, February 25, 2009, March 4, 2010 and June 24, 2010, records from emergency department visits at Methodist Hospital on November 20, 2009 and February 23, 2010, and multiple imaging studies, including radiographs, MRI and bone scan dated June 11, 2008 through April 6, 2011. RX 1.

Additionally, Dr. Rhode did not render any actual, substantive treatment to Petitioner. Although Dr. Rhode saw Petitioner on nine separate occasions, he acknowledged that he did not render any treatment to Petitioner, other than referring her to physicians more specialized than him, because he stated that he did not want to "do something that I felt was outside the scope of my practice, which I felt this was." RX 19. As such, the medical monitoring and proffering of opinions that Dr. Rhode performed and proffered for Petitioner is not far afield from the services performed of Dr. Wysocki. As such, the persuasiveness of Dr. Rhode's opinions as a treating physician is limited by the lack of treatment actually rendered to Petitioner.

Similarly, the Arbitrator is not persuaded by the opinions of Dr. Rhode in light of his repeated testimony that "his is out of the scope of practice for what I do." (PX 19, Pg. 11) and that he did not "feel comfortable treating this patient surgically" because of same. PX 19, Pg. 13. Simply put, if Dr. Rhode felt that Petitioner's condition and requisite treatment were outside the scope of his practice and expertise, and more suited to that of a hand specialist, then the opinions of a hand specialist, such as Dr. Wysocki, should properly be given more weight.

Dr. Wysocki testified that the manifestation of symptoms following her work accident drove her to undergo surgery, but then later testified that the work injury was not a causative factor in her need for surgical intervention. RX 1, Pg. 46, 49. Dr. Wysocki further opined that Petitioner's current diagnosis was right thumb pain, stiffness and dysfunction status post surgical treatment of CMC arthritis, but also stated that her "current thumb condition" was not causally related to the work injury of May 30, 2008. RX 1. In applying the Act liberally, *see Interstate Scaffolding, Inc.*, 236 Ill.2d at 149, the Arbitrator adopts the more liberal interpretation of Dr. Wysocki's testimony and finds that as a result of the May 30, 2008 work accident, Petitioner suffered an aggravation of her pre-existing CMC joint arthritis, which caused her condition to become symptomatic and necessitated her subsequent surgical treatment.

Although the Arbitrator adopts the opinions of Dr. Wysocki, the Arbitrator notes that it is not necessary that Petitioner's work accident alter the natural state of her thumb condition to be considered a causative factor in the development of her condition, but rather, the accident need only aggravate or accelerate Petitioner's pre-existing condition such that Petitioner's current condition of ill-being can be said to be causally connected to the work injury. *See Sisbro,* 207 Ill.2d at 204-205.

In this case, Petitioner sought immediate treatment following her work accident, repeatedly gave a consistent history to her treating physician of a sudden onset of symptomatology in her right thumb and hand following the work accident, and continued to suffer constant symptomatology in same following the work accident. Additionally, Petitioner testified that she had not suffered any problems in her right hand before the work accident, nor had she been treated by a physician for any right hand symptoms. Although Respondent points to Dr. Rhode's treatment record of June 11, 2008 as evidence of prior right hand complaints, that record reveals Petitioner had a singular complaint of pain prior to May 30, 2008 that was less severe than the pain resultant from her work accident. PX 16. The Arbitrator finds that same is insufficient to negate the considerable amount of evidence that supports a finding of causation. Therefore, the Arbitrator finds that Petitioner's current condition of ill-being is causally related to the work accident of May 30, 2008.

With regard to disputed issue (J), Respondent disputed liability for medical bills based upon accident, and specifically disputed the reasonableness and necessity of the medical bills for Dr. Rhode and Comprehensive Emergency Solutions based upon an excessive choice of physicians and duplicity, respectively.

Pursuant to Section 8(a), Petitioner is entitled to two choices of "all medical, surgical and hospital services provided by the physician, consultant, expert, institution or other provider of services recommended by said initial service provider or any subsequent provider of medical

services in the chain of referrals from said initial service provider." The Arbitrator finds that Debbie Hays referred Petitioner for treatment with Dr. Williams (PX 4), as reflected in the records of Dr. Williams and per Petitioner's testimony regarding same. The Arbitrator finds that Dr. Hoffman referred Petitioner for treatment with Dr. Traina (PX 1), as reflected in the records of Dr. Hoffman and per Petitioner's testimony regarding same. With regard to Dr. Rhode, his records indicate that Dr. Hoffman referred Petitioner to him. PX 16. Dr. Hoffman's records, however, do not reflect any referral from Dr. Hoffman to Dr. Rhode. Petitioner testified that 'Penny [from her attorney's office] did tell me' to go see Dr. Rhode.

The Arbitrator finds that Petitioner's first choice of physician was Dr. Hoffman, and Dr. Traina to be in the chain of referrals with Dr. Hoffman. Debbie Hays was Petitioner's second choice of physician, with Dr. Williams in the chain of referrals with her. The Arbitrator notes that no bills appear in PX 17 from Debbie Hayes, and none of her records were offered as an exhibit into evidence. In the event that Petitioner is not tendering Ms. Hayes as a provider in this case, Dr. Williams then becomes Petitioner's second choice of physicians. Regardless, Petitioner's choice of Dr. Rhode constitutes Petitioner's third choice of physicians. Because Petitioner has exceeded her choice of physicians pursuant to Section 8(a) with the treatment with Dr. Rhode, Respondent is not liable for any medical bills associated with the services of Dr. Rhode.

Respondent also denied liability for medical bills from Comprehensive Solutions with dates of service of November 20, 2009 and February 23, 2010, contending that the bills were duplicative in that they were submitted and paid by the Illinois Department of Healthcare and Family Services, as reflected in PX 18. A review of the Department's payment information and the bills submitted in PX 17 reflect that the medical bills from Comprehensive Solutions are for emergency services rendered to Petitioner for complaints to her right hand and thumb. The Arbitrator finds the services reflected in the medical bills of Comprehensive Solutions to be reasonable and necessary in the care and treatment of Petitioner's condition.

Based upon the aforementioned findings and in light of the Arbitrator's conclusions with regard to disputed issues (C) and (F), Respondent shall pay all reasonable and necessary medical services, with the exception of bills from Dr. Rhode, as provided in Sections 8(a) and 8.2 of the Act, subject to the fee schedule. Respondent is not liable for medical bills incurred by Petitioner for the services of Dr. Rhode.

In regards to disputed issue (K), the issues of whether a claimant is temporarily totally disabled and the length of time for which he is entitled to temporary disability benefits are questions of fact to be resolved by the Commission. *Archer Daniels Midland Co. v. Industrial Comm'n*, 138 Ill. 2d 107, 118-119 (1990). In Illinois, it is well-settled that an employee is temporarily totally incapacitated from the time an injury incapacitates him from work until such time as he is far recovered or restored as the permanent character of his injury will permit. *Id.* at 118. In order to be eligible for temporary total disability benefits, a Petitioner must prove not only that she did not work but also that she was unable to work. *City of Granite City v. Industrial Comm'n*, 279 Ill. App. 3d 1087, 1090 (1996). "[W]hen an employee who is entitled to receive workers' compensation benefits as a result of a work-related injury is later terminated for conduct unrelated to the injury, the employer's obligation to pay TTD workers' compensation

benefits continues until the employee's medical condition has stabilized and he has reached maximum medical improvement." *Interstate Scaffolding, Inc.*, 236 Ill.2d at 135-136 (emphasis added).

Petitioner sought temporary total disability benefits from May 30, 2008 through June 9, 2011. Arb. X 1. Petitioner's employment with Respondent was terminated on September 30, 2008 while she was off work per Dr. Traina. PX 2.

Petitioner testified that Dr. Hoffman took her off work on May 30, 2008. However, the objective medical records of Dr. Hoffman do not indicate that he took her off work or restricted her work when she presented to him. Dr. Hoffman prescribed medication and referred Petitioner to Dr. Traina for further treatment. PX 1. In the absence of more substantive treatment to indicate that Petitioner was unable to work and without any notations from Dr. Hoffman regarding her work status, there is insufficient evidence to indicate that Petitioner was temporarily totally disabled at that time.

The records of Dr. Traina indicate that he took Petitioner off work beginning on June 11, 2008 and released her to one handed work on July 28, 2008. On August 27, 2008, Dr. Traina again took Petitioner off work until October 13, 2008, when she was released to one-handed work. PX 2.

Petitioner presented to Dr. Williams for treatment on October 22, 2009, and Dr. Williams performed surgery on Petitioner's right thumb on November 13, 2009. PX 4. Although Dr. Williams makes no mention of her work status during his treatment of her, he released her to work without restrictions on December 1, 2009, which reasonably supposes a period of temporary disability. Dr. Williams released her from his care on January 18, 2010. PX 4. The Arbitrator reasonably infers Dr. Williams intended some work restriction on Petitioner's right upper extremity until December 1, 2009 when he released her to full duty, and that her condition stabilized as of January 18, 2010 when Dr. Williams released her from his care.

Petitioner returned to Dr. Traina with continued complaints on February 15, 2010. Although Dr. Traina's records do not reflect that he restricted or removed Petitioner from work at that time, the record evidences that Petitioner's condition declined or destabilized following Dr. William's release of her from his care, given that Petitioner testified her pain increased at that time and that she subsequently underwent three additional surgical procedures to treat her right thumb condition. Specifically, Petitioner underwent a removal of carpometacarpal implant of the right thumb with irrigation and debridement and insertion of antibiotic cement spacer and removal of retaining pins on February 25, 2010. PX 2. On March 4, 2010, Dr. Traina performed a carpometacarpal reconstruction of the right wrist at the first metacarpal with a graft jacket implant, at which time she was placed in a thumb spica cast. PX 13. Petitioner underwent a third surgical procedure on June 24, 2010 to excise tissue protruding from her wound. PX 2. Considering the significant treatment she received in conjunction with Petitioner's testimony that Dr. Traina intermittently restricted her to one-handed work, the Arbitrator finds that Petitioner's condition had not stabilized nor was she at maximum medical improvement during this period of time, which the Supreme Court instructs is the determinative inquiry in ascertaining temporary total disability given Petitioner's termination on September 30, 2008. *Interstate Scaffolding, Inc.*,

236 Ill. 2d at 149. Therefore, Petitioner is entitled to temporary total disability benefits during this time period.

After concluding treatment with Dr. Traina, Dr. Rhode took Petitioner off work from April 6, 2011 through April 18, 2012, at which time he placed permanent restrictions on her of no use of the right upper extremity. PX 16. Although the Arbitrator finds the opinions of Dr. Rhode to be unpersuasive, there is nothing in the record to indicate that Petitioner's condition had stabilized and reached maximum medical improvement during the time period of April 6, 2011 until June 9, 2011 to contradict Dr. Rhode's orders for Petitioner to remain off work. Dr. Wysocki placed Petitioner at maximum medical improvement on October 19, 2011 at the time of his examination, barring any further surgical intervention, and testified that if she chose to undergo further surgical treatment, it would alter her status. Dr. Wysocki also testified that the pain she experienced following the work accident of May 30, 2008 drove her to have the four surgical procedures she underwent prior to being examined by him. RX 1. Given Dr. Wysocki's opinions and the permanent restrictions he recommended for her, it is reasonable to infer that Dr. Wysocki would not have placed Petitioner at maximum medical improvement during the time period in which Dr. Traina surgically treated Petitioner's right thumb, or between April 6, 2011 and June 9, 2011, the time period in which Petitioner was off of work per Dr. Rhode.

Based upon the foregoing, Respondent shall pay Petitioner temporary total disability benefits of $442.31 per week for a total period of 152 3/7 weeks, representing June 11, 2008 through January 18, 2010, and February 15, 2010 through June 9, 2011. By ceasing temporary total disability benefits on June 9, 2011, the Arbitrator is not concluding that Petitioner had reached maximum medical improvement on that date, but rather, June 9, 2011 is the last date in which Petitioner sought temporary total disability benefits. Arb. X 1. The parties stipulated that Respondent is due a credit of $1,674.00 for short term disability payments made to Petitioner, and $17,409.60 for long term disability payments made, for a total credit of $19,083.60 to be deducted from Petitioner's temporary total disability benefits.

In regard to disputed issue (L), based upon the foregoing and the record in its entirety, as a result of her work accident of May 30, 2008, Petitioner sustained an aggravation of her right thumb carpometacarpal joint arthritis, which necessitated a right thumb CMC joint arthroplasty and three subsequent remedial procedures, including a removal of the carpometacarpal implant of the right thumb with irrigation, debridement, and removal of retaining pins, a carpometacarpal reconstruction of the right wrist at the first metacarpal with a graft jacket implant, and a right thumb irrigation and debridement to excise tissue. Following treatment, Petitioner began working with restrictions for Linder's Cleaning Service on June 10, 2011, and thereafter became self-employed in December 2012 working in a permanently restricted capacity.

At Arbitration, Petitioner testified to severe limitations and near complete loss of use of her right hand and thumb, and she demonstrated an apparent inability to grip or lift objects. However, Petitioner's testimony is undermined by the surveillance videos admitted into evidence depicting Petitioner performing laborious activities with her right upper extremity, including cleaning the restrooms at Menards using her right hand just as often as her left, and carrying heavy objects into clients' homes with her right hand, including a fully stocked cleaning bucket and a vacuum, and other objects that require manual dexterity. The activities she is seen

performing on the surveillance videos casts into doubt her testimony that she is unable to lift basic objects with her right hand, such as a cup of coffee, paper, or a folder, or perform mundane activities. Although she testified that she "always" performed cleaning services with the aid of another individual who would mop and sweep, the surveillance videos revealed Petitioner oftentimes cleaning by herself and performing the activities she insinuated on direct examination she could not do with her right hand. Ultimately, the surveillance videos exhibit that Petitioner is physically capable of performing more activities with her right hand and thumb than what she testified to and exhibited at Arbitration.

Nonetheless, after observing Petitioner's right upper extremity at Arbitration, the Arbitrator finds that Petitioner suffered significant atrophy and deformity in her right thumb and hand as a result of the treatment for her right thumb condition that would reasonably inhibit the functionality of her right hand. Dr. Wysocki noted that Petitioner was primarily problematic in the radial side of the right hand and in the right thumb. He stated that her right hand had significant limitations with thumb movement, and recommended a work restriction of no lifting, pushing, pulling greater than five pounds for gross motor only, with no fine motor use. RX 1. Although additional surgical procedures have been recommended to Petitioner to lessen her reported pain and improve the functionality in her right thumb and hand, Petitioner has elected to forego those procedures.

In light of Petitioner's injury and the treatment it necessitated, her permanent restrictions of the right hand, Petitioner's continued complaints and limitations in her right thumb and hand, and taking into consideration the physical capabilities Petitioner exhibited on the surveillance videos, the Arbitrator finds that Petitioner sustained permanent partial disability to the extent of 55% loss of use of her right hand, pursuant to Section 8(e). Therefore, Respondent shall pay Petitioner $398.08 for 112.75 weeks, representing 55% loss of use of the right hand.

STATE OF ILLINOIS)
) SS.
COUNTY OF)
WILLIAMSON

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

LARRY WHARTON,

Petitioner,

14IWCC1013

vs.

NO: 10 WC 38986

THE AMERICAN COAL COMPANY,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by both the Petitioner and Respondent herein, and notice given to all parties, the Commission, after considering the issues of occupational disease, causal connection, evidentiary rulings and permanent partial disability, and being advised of the facts and law, reverses the Decision of the Arbitrator, which is attached hereto and made a part hereof.

1. Petitioner retired from Respondent on August 8, 2010. Prior to retirement, he had been a Coal Miner for 37 years and was regularly exposed to rock dust (mostly lime dust), silica dust, roof bolting glue, rock fiber for cement, diesel fumes and rock bond. Petitioner was also occasionally an Examiner, which required him to walk through return airway locations, which are areas that pick up all the dust from the air.

2. On his retirement date Petitioner was a Mechanic and had been exposed to all of the above mentioned fumes, dusts and glues on that day. He quit on that day, as he had begun to have breathing problems.

3. As a Mechanic, Petitioner worked on the ram cars, which are cars that Miners use to dump coal into that comes across on a conveyor belt. The cars have diesel engines. The engine has a scrubber system with water to cool the exhaust. The exhaust then comes out of a cone shaped paper filter. If the water gets too low the tank is supposed to shut down.

However, a few times it malfunctioned and the paper filter caught on fire, which emitted a thick smoke.

4. During a 1993 layoff from mining Petitioner worked for Walmart.

5. Petitioner smoked cigarettes until 1977. He smoked a pack per day.

6. While working for Respondent Petitioner developed a cough, would have shortness of breath and difficulty climbing multiple flights of stairs. In the 6 months prior to trial, Petitioner noticed that occasionally when he exerted himself, he would get dizzy and have to stop what he was doing to catch his breath.

7. Petitioner underwent black lung testing 6 times over the years. He also worked at other coal mines prior to working for Respondent, and thus could have been exposed to some of the same fumes and dust.

8. On May 4, 2007 a negative chest x-ray reading was found by Drs. Rosenberg and Meyer. This was supported by the independent readings of the NIOSH B-readers.

9. Further, a Dr. Houser's initial July 2011 exam did not reveal chronic bronchitis, as Petitioner detailed an insufficient history of cough and sputum production. Additionally, in the history given to a Dr. Instanbouly, no significant sputum production was mentioned by Petitioner.

10. Moreover, when Dr. Instanbouly evaluated Petitioner on January 20, 2014, the medical records of Dr. Davis, which he reviewed, did not support a diagnosis of chronic bronchitis. Dr. Davis' review of systems respiratory was negative.

11. Petitioner was diagnosed by Dr. Davis with acute bronchitis on May 14, 2013, and an upper respiratory infection and pharyngitis on September 11, 2013. There was no evidence of chronic bronchitis.

12. Regarding asthma, Dr. Houser testified that records indicate Petitioner had been diagnosed with asthma before he was ever employed as a coal miner.

After reviewing the transcript and evidence, the Commission reverses the Arbitrator's ruling and finds that Petitioner has failed to sufficiently allege a work-related occupational disease.

While it is clear that Petitioner had respiratory issues, medical records seem to indicate that none were related to his work duties. Dr. Houser testified that records indicate Petitioner had been diagnosed with asthma before he was ever employed as a Coal Miner. Further, Petitioner was not diagnosed with bronchitis until May 14, 2013, which is nearly 3 years after his retirement. The Commission notes that the bronchitis was acute rather than chronic. Lastly, the Commission finds credible the opinions of Drs. Rosenberg and Meyer, who noted a negative chest x-ray in May of 2007. Thus, after 34 years as a Miner, Petitioner did not have coal workers

14IWCC1013

pneumoconiosis. The Commission finds it highly unlikely that Petitioner developed coal workers pneumoconiosis in his final 3 years of work when he did not develop it in the 34 years prior.

Based on the medical evidence and testimony, the Commission reverses and vacates the Decision of the Arbitrator, finding that Petitioner failed to sufficiently claim an occupational disease.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed April 4, 2014 is hereby reversed and vacated as stated herein.

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

DATED: NOV 24 2014
O: 9/25/14
DLG/wde
45

David L. Gore

Mario Basurto

Stephen Mathis

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

WHARTON, LARRY
Employee/Petitioner

Case# **10WC038986**

14IWCC1013

THE AMERICAN COAL COMPANY
Employer/Respondent

On 4/4/2014, 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:

0755 CULLEY & WISSORE
HAROLD B CULLEY JR
300 SMALL ST SUITE 3
HARRISBURG, IL 62946

0143 CRAIG & CRAIG
KENNETH F WERTS
PO BOX 1545
MT VERNON, IL 62864

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

14IWCC1013

LARRY WHARTON
Employee/Petitioner

v.

THE AMERICAN COAL COMPANY
Employer/Respondent

Case # 10WC 38986

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 **Herrin**, on **February 7, 2014**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☒ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☐ What was the date of the accident?
E. ☐ Was timely notice of the accident given to Respondent?
F. ☒ Is Petitioner's current condition of ill-being causally related to the injury?
G. ☐ What were Petitioner's earnings?
H. ☐ What was Petitioner's age at the time of the accident?
I. ☐ What was Petitioner's marital status at the time of the accident?
J. ☐ Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. ☐ What temporary benefits are in dispute?
☐ TPD ☐ Maintenance ☐ TTD
L. ☒ What is the nature and extent of the injury?
M. ☐ Should penalties or fees be imposed upon Respondent?
N. ☐ Is Respondent due any credit?
O. ☒ Other **Sections 1(d)-(f) and 19(d) of the Occupational Diseases Act**

FINDINGS 14IWCC1013

On **August 10, 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's average weekly wage was **$1,413.49**.

On the date of accident, Petitioner was **64** years of age, ***married*** with **0** dependent children.

Petitioner claims no medical.

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

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

ORDER

The Respondent shall pay Petitioner $669.64/week for a period 50 weeks, as provided in Section 8d2 of the Act, because the injuries sustained caused 10% loss of use on a man as a whole basis.

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

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

Edward Lee
Signature of Arbitrator

3/21/14
Date

APR 4- 2014

COUNTY OF WILLIAMSON) SS.

14IWCC1013

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

LARRY WHARTON
Employee/Petitioner

Case # 10 WC 38986

v.

AMERICAN COAL CO, et. al.
Employer/Respondent

MEMORANDUM OF DECISION OF ARBITRATOR

FINDINGS OF FACT

Petitioner, Larry Wharton, was born on July 26, 1946 and was sixty seven years old on the day of arbitration. Petitioner began his thirty-seven years underground coal mining career in 1971. He was exposed to coal, rock, and silica dust, and fumes from roof bolting glue, cement fiber and diesel exhaust. Roof bolting involves drilling a hole and inserting a bolt and tube of glue to shore up the ceiling. Wood fiber cement was used in building brattices made of concrete blocks sealed with the adhesive. Rock dust is an explosion preventive dust used everywhere in the coal mine. The walls, roof, and floors are coated with it. It is sprayed on before or after shifts, and is thrown by hand on the wall after the roof is bolted. Later the area is dusted by machine.

Petitioner's last mining exposures occurred on August 8, 2010 at Respondent American Coal Company's Galatia Mine. He quit mining because his wife became eligible for social security benefits. Otherwise, he would have quit earlier. Petitioner was starting to have a breathing problem and was taking inhalers. He got tired of the dust which made it harder to breathe. In his last job as a mechanic Petitioner worked on a diesel-powered ram car, a machine which is loaded with coal from a conveyer belt behind the miner machine.

After leaving mining Petitioner found work for Southern Illinoisan News working about twenty four hours a week making $8.41 an hour. He loads paper bundles weighing about 20 pounds into a van and makes deliveries to areas that are short of papers. Petitioner has looked for other jobs, but he feels unqualified or no insurance is offered. He will lose his union health insurance if he makes over a thousand dollars a month. He feels lucky to have the job he has. At times he has difficulty exerting himself at work, but he stops what he is doing until he gets his breath back.

As a miner, Petitioner worked as a bottom laborer, a roof bolter, and a mechanic. He began noticing a change in his breathing in the late 1990's. He would have to stop what he was doing when he overexerted himself. Petitioner also developed a productive cough. Currently, he feels able to walk a block or two before becoming short of breath, but does not walk like he used to. Petitioner can climb a flight or two of stairs before having to stop and rest. In the last six to eight months he has noticed a change where sometimes he becomes dizzy exerting himself and must stop for thirty seconds because he is breathing so hard. He described an incident where after climbing three flights of stairs he had chest pain and difficulty breathing. He had an EKG, but

nothing was found. Petitioner began smoking when he entered the Marines, but quit in 1977. He averaged a pack per day, but smoked more while in Viet Nam. He would not return to the mines if offered a job because of his concern that the dust would make his breathing worse. Petitioner stated that he had screening x-rays done while mining.

At Petitioner's request, B-reader/Radiologist, Dr. Henry Smith reviewed Petitioner's August 17, 2010 chest film and found it positive for coal worker's pneumoconiosis (CWP). Dr. Smith saw abnormalities in all lung zones in a profusion of 1/0. Dr. Smith also found Petitioner's May 4, 2007 x-ray to be positive for CWP, category 1/0. (PX 2). Petitioner also submitted the x-ray reports of B-reader/Radiologist, Dr. Michael Alexander. Dr. Alexander interpreted the same films as Dr. Smith and agreed that they were positive, however he categorized them as having a 1/1 profusion. (PX 3). Both doctors found the films to be quality I.

Pulmonologist and Black Lung Clinic Head, Dr. William Houser, examined Petitioner at his attorney's request on July 19, 2011. Petitioner complained of dyspnea while using exercise equipment at the gym. He had a minimal cough with occasional sputum. Petitioner stated that he has had twenty to thirty episodes of bronchitis dating back to the 1960's. He smoked occasionally beginning at age eleven, then regularly from age fourteen to thirty, averaging a pack a day. However in Viet Nam he consumed two and one half packs per day. Dr. Houser noted that Petitioner coal mined for nearly thirty-eight years. Physical examination showed a few crackles at the left lung base. Pulmonary function testing was normal, but Petitioner's chest x-ray was positive for CWP category 1/0. (PX 1, Depo. Exh. 1, pp. 1-2). Dr. Houser took the B-reader exam in the 1980's and failed. (PX 1, p. 41). However, after that time he took particular care to closely work with his B-readers and discuss the films they had both read. (PX 1, pp. 47-48).

Pulmonologist, Dr. Istanbouly, has treated Petitioner on referral from his primary care physician, Dr. Davis. Petitioner related that his former pulmonologist, Dr. Tazbaz had left the area. Dr. Istanbouly is the only pulmonologist in Herrin, other than a doctor who comes once a week. He stated Petitioner had CWP based on his symptoms, exposure and chest x-ray. Petitioner had recently passed a cardiac test and so ischemia was excluded as a cause. (PX 13, pp. 6-8). By definition, Petitioner has chronic bronchitis which was caused or aggravated by his mining exposures. Additional exposure may cause it to progress. Chronic bronchitis may or may not resolve following mining exposure cessation. Dr. Istanbouly agreed that Petitioner has been treated for asthma over the past few years, but he had denied childhood asthma. Coal dust, and welding, diesel, and roof bolting glues fumes can all contribute to asthma. With his chest x-ray abnormality and symptoms, any further mining exposures would risk a reduced lung capacity. He would advise against any return to coal mining. (PX 13, pp. 9-14; See also PX 8).

Dr. Istanbouly's records document his January 20, 2014 black lung evaluation. Petitioner denied ever being diagnosed with asthma. He had a daily mild cough for the last few years, mostly in the mornings, with no significant sputum production. He complained of progressive exertional dyspnea over the past year and becomes short of breath climbing two flights of stairs. Previously he could climb four before experiencing breathing problems. He had a mild runny nose and post nasal drip. The chest x-ray of May 4, 2007 showed small round opacities bilaterally consistent with CWP. This was classified by a B-reader as 1/1. A repeat chest x-ray report of an August 17, 2010 film was again categorized as 1/1. Pulmonary function testing of July 19, 2011 was normal. Petitioner was taking Fluticasone nasal spray for rhinitis and Symbicort as needed, but he was not regularly using it. He had an Albuterol inhaler he used on an as needed basis. (PX 7,

p. 1-2). Petitioner's lungs were normal on physical exam. Dr. Istanbouly concluded that Petitioner had CWP based on his chest x-ray, symptoms, and history of exposure. (PX 7, p. 3).

At Respondent's request B-reader/Radiologist, Dr. Meyer, reviewed Petitioner's quality III chest film of August 17, 2010, finding it negative for CWP. (RX 1, depo. Exh. B). Dr. Meyer also interpreted Petitioner's quality I chest film of May 4, 2007 to be negative for CWP. (RX 2). Dr. Meyer testified that the 2010 film was quality III due to poor contrast and mottle. (RX 1, p. 40). Poor contrast can make it harder to evaluate the lung parenchyma, and mottle refers to the films' granular appearance. (RX 1, pp. 41-42). Quality III is the lowest quality before a film is considered unreadable. (RX 1, p. 76). Dr. Meyer defined a CWP macule as a collection of inflammatory cells which may have mild fibrosis or adjacent emphysema. At the site of the tissue reaction lung function is changed, whether measurable or not. (RX 1, pp. 55-56). CWP can be a chronic progressive disease in some miners even after exposure cessation, and can progress to life threatening conditions. (RX 1, pp. 58-59). He agreed that the only treatment for a person with CWP is removal from dust exposure. CWP first appears radiographically, and as it becomes more significant it causes pulmonary function or clinical abnormalities. (RX 1, pp. 60-61). CWP is very slow and insidious in its onset, and one might not know they have it until a positive x-ray. (RX 1, p. 66). Dr. Meyer had no reason to disagree with NIOSH or the Department of Labor about the causes of COPD or emphysema. (RX 1, pp. 63-64). He stated that secondary signs of emphysema can be seen on a chest x-ray. (RX 1, p. 59-60).

Dr. Meyer charges $115.00 per B-reading and does 160 to 200 B-readings each month. He does between zero and four depositions each month, charging $500.00 an hour. Dr. Meyer reads between 20 and 40 CT scans for occupational disease each month, charging $275.00 dollars for each scan. He is generally retained by the coal companies. He stated that coal macules can become calcified and can be the same size as a granuloma. (RX 1, pp. 66-69). It is possible for CWP to show up for the first time in the last month before the miner quits mining. (RX 1, p. 71). Dr. Meyer failed the B-reader exam the first time he took it. (RX 1, p. 75).

At Respondent's request, Pulmonologist/B-reader, Dr. Rosenberg, reviewed the records of the Carbondale and Herrin Clinics, Dr. Meyer and Smith's B-reading of the August 17, 2010 x-ray, Dr. Houser's July 19, 2011 evaluation, and the August 7, 2010 x-ray. (RX 3, depo exh. 2, p. 1). Dr. Rosenberg did not believe Petitioner had CWP, and felt that any bronchitis he had was a result of GERD because it improved with GERD treatment. He also felt that any mining-related chronic bronchitis would dissipate with the cessation of mining exposures. (RX 3, depo exh. 2, pp. 3-4).

On cross-examination Dr. Rosenberg acknowledged medical record entries regarding pulmonary symptoms and medications that were consistent with asthma. (RX 3, pp. 26-32). He agreed that roof bolting glues, adhesives used to repair chutes, and diesel fumes are all exposures in the mines that can cause or aggravate asthma. He conceded that the American Thoracic Society states that the most common cause of workplace asthma is the aggravation and worsening of pre-existing asthma. (RX 3, pp. 32-34). Asthma might make a person more susceptible to pulmonary infection. Petitioner has had problems with pneumonia. He agreed that Petitioner could have asthma or reactive airways disease. (RX 3, pp. 34-36). If Petitioner had difficulty with his asthma on a certain day he may have been incapable of heavy manual labor. Asthma is a condition that waxes and wanes. (RX 3, pp. 38-39).

Dr. Houser subsequently reviewed the records from the Carbondale Clinic, the Herrin Clinic, Dr. Davis, and Dr. Tazbaz's and Dr. Rosenberg's deposition. (PX 5). While initially he did not diagnose chronic bronchitis, he stated that the records did not rule in or rule out chronic bronchitis. (PX 12, p. 4). Additional mining exposures could worsen chronic bronchitis. (PX 12, pp. 6-7). The records demonstrated a history of asthma. He explained that coal mine exposures could have aggravated or caused the asthma. Additional mining exposures can aggravate Petitioner's asthma and cause it to progress. (PX 12, pp. 7-8). Dr. Houser disagreed with Dr. Rosenberg regarding a connection between GERD and chronic bronchitis, stating that there is not a lot of evidence connecting the two. Chronic bronchitis as well as asthma can be multifactorial and the mining environment could be a contributor. (PX 12, pp. 9, 11-12). Dr. Houser stated that mine-dust-related chronic bronchitis will likely improve with cessation of exposure, but in some patients it persists. He agreed that coal dust does not cause asthma, but it can aggravate it. Other mining exposures such as diesel exhaust and roof bolting glues can cause asthma. (PX 12, pp. 12-14). He also explained why he disagreed with Dr. Rosenberg's opinion that chronic bronchitis does not cause airflow obstruction. Although Dr. Rosenberg blamed Prinivil for any chronic bronchitis, Prinivil causes a dry, not a productive cough. It would have no bearing on whether coal dust caused chronic bronchitis. (PX 12, pp. 15-17). Dr. Houser also explained why Dr. Rosenberg incorrectly stated that emphysema caused by coal dust develops only if there is CWP. He stated that it is common knowledge that coal dust can cause emphysema independent of CWP. Dr. Houser provided references to support his opinion. (PX 12, pp. 17-19). He felt that the best action for an asthmatic miner is to avoid exposures that aggravate it. (PX 12, p. 20).

On referral from Dr. Davis Pulmonologist, Dr. Tazbaz, examined Petitioner on January 4, 2013 for CWP and cough. He noted that Petitioner coughed every day, ten to twelve times a day. The cough is productive and chronic bronchitis was a possibility. Petitioner wheezed about once a month, but had not taken medications which initially helped in the 1990's. Petitioner's GERD was under control, and for the last year and a half he can walk on a treadmill for up to 25 minutes. He has no shortness of breath. Dr. Tazbaz had no chest x-ray to confirm CWP, but opined to Petitioner's attorney that he read Petitioner's x-ray as positive for CWP category 1/0. (PX 4). Pulmonary function testing on January 18, 2013 was normal. (RX 9)

The parties introduced Petitioner's medical records from various entities, some of which were duplicative. Carbondale Clinic records indicate acute bronchitis was diagnosed on September 30, 2004. Bronchial problems since age 18 were reported. Advair was restarted, and Petitioner was given a Z-Pak and Robitussin p.m. (PX 9, p. 46). On May 3, 2001 a history of pneumonia, shortness of breath, and bronchitis were noted. (PX 9, p. 27). Acute bronchitis also was diagnosed on July 13, 1998, and November 23, 1990. (PX 9, pp. 47-48). A May 3, 2001 anesthesia questionnaire noted asthma as a baby. (p. 55).

Logan Primary Care Records show entries documenting cough, bronchitis, black lung, and/or inhaler use. (PX 6, pp. 11, 19-21, 26-28, 30, 40-43, p. 45-47). Petitioner's chest x-ray of June 18, 2013 noted no pulmonary vascular congestion and clear lungs. (PX 6, p. 32-33).

Herrin Clinic records indicate no pulmonary symptoms on many occasions. However, the entries also document cough, bronchitis, black lung, and/or inhaler use (PX 10, pp. 2, 5, 8-10, 27, 29, 31- 32, 37, 39, 42-45 65-66, 80-82). On June 9, 2009 Petitioner's GERD was controlled. (PX 10, p. 17). On March 16, 2009 Petitioner reported walking about 1.5 miles per week if the

weather is nice. (PX 10, p. 20). Petitioner's chest film showed no interstitial abnormality but calcified nodules in the right hilar region were observed. (PX 10. p. 69).

Respondent introduced records from NIOSH. On June 28, 2007 Petitioner was told that his May 4, 2007 spirometry was normal. Also submitted were x-ray reports from 1975-2007. The reports for early films are not relevant to whether Petitioner had CWP when he left the mines. Moreover on the first two reports, neither the date, nor Petitioner's name, nor the readers' name, nor the type of reading, A or B is designated. Many reports contain only the readers' initials. (RX 4).

Respondent also introduced VA Clinic records. A January 12, 2012 chest x-ray for black lung showed mild obstructive pulmonary disease and a hiatal hernia. (RX 7, p. 2-3). Shortness of breath on exertion was reported on September 24, 2013, and on minimal exertion on September 19, 2012. (RX 7, pp. 16, 22). In a January 23, 2012 questionnaire for disability benefits, a nurse practitioner noted that Petitioner had never been diagnosed with a respiratory condition. This observation may have been strictly based on the VA records, as it was later stated that his file was reviewed, and he had no ongoing diagnosis of respiratory disease or conditions other than environmental allergies. (RX 7, pp. 28, 42). The respiratory condition was related to bronchitis which did not require the use of inhaled medications or oral bronchodilators. The accuracy of this statement is debatable. (RX 7, pp. 30-31). Petitioner's condition required antibiotics. Petitioner reported a 38 year history of recurrent respiratory infections with 1-2 instances a year. He attributed this to his mining exposures and had been diagnosed with Black Lung. He has had only one instance of upper respiratory infection since retiring from the mines. (RX 7, p. 31). Petitioner also reported mild exertional dyspnea with activities such as climbing over two flights of stairs. He reported no ongoing cough, though he clears his throat a couple times a day. (RX 7, p. 39). Pulmonary function testing of January 2, 2012 suggested a very mild small airways obstruction. Enlistment papers showed childhood asthma. The respiratory condition was most likely due to his long history of occupational exposures as a coal miner and history of smoking. (RX 7, p. 43). Petitioner was diagnosed with bronchitis and was following up for a chronic problem. Shortness of breath on exertion was noted. (RX 7, pp. 45-46). Shortness of breath on exertion was again noted on August 16, 2010. (RX 7, pp. 50-51).

Petitioner introduced records showing his gross pay working for the Southern Illinoisan in 2013 was $8,279.44. He made less the previous three years. (PX 11).

CONCLUSIONS OF LAW

Issue (C): Did Petitioner suffer disease which arose out of and in the course of his employment by Respondent?

The Arbitrator resolves the issue of CWP in Petitioner's favor. Dr. Meyer became a B-reader in 1999 at the recommendation of his co-worker, Dr. Wiot, a prolific reader of x-rays for coal companies. (RX 1, p. 19-20). See, *Lefler v. Freeman United Coal Mining Co*, (9-25-08), 08 IWCC. 1097. Dr. Meyer also is generally retained by the coal companies. (RX 1, pp. 68). As noted in the facts he makes a considerable amount of money doing B-readings and CT exams in occupational disease cases. Dr. Houser does many coal miner examinations and depositions, but he has been the Medical Director of a Black Lung Clinic since 1979 and has done between three to four thousand black lung clinic exams. His opinions were candid and credible. (PX 1, pp. 4-5,

33-34). Dr. Houser is not a B-reader or radiologist, but has become competent by consulting with his B-readers over the years regarding their chest x-ray readings. (PX 1, pp. 47-48).

Dr. Smith has been a B-reader since 1987 and is a consultant to multiple occupational medical clinics. (PX 2, CV, pp. 2, 5). Dr. Alexander has been a B-reader since 1992 and has made presentations on the ILO classification system and the appearance of pneumoconiosis. (PX 3, Alexander CV, pp. 2, 5). Dr. Tazbaz and Dr. Istanbouly also concluded Petitioner had CWP. While the NIOSH exhibit indicates otherwise, most films predate Petitioner's last exposure by many years. Many of the reports, including the most recent report from the 2007 film appear to have been altered, inasmuch as the readers' social security numbers are blacked out by someone. (RX 4). The readers' affiliations are unknown. The arbitrator also considers negative treatment x-rays, but notes Dr. Meyer's testimony that a standard radiologist at a small hospital's failure to note CWP on a film taken for other purposes is less valuable. (RX 1, pp. 50).

Dr. Rosenberg's opinion was based solely on a records' review which did not include all the relevant records introduced at trial. He agreed that coal dust inhalation can cause emphysema, chronic bronchitis, and COPD, and can aggravate reactive airways disease. (RX 3, pp. 60-61). However, in many questions concerning the effects of coal mine dust, routinely opined that one must look at the specific individual and epidemiologic studies or what exists in the mining population. (RX 3, pp. 56-57, 63-66). However, he referenced no authorities supporting his qualified views. Dr. Rosenberg's view that minimal exposure is acceptable for CWP victims does not reflect medical objectivity. (RX 3, pp. 52-53). Even he agreed that the less exposure the better, and that for emphysema, bronchitis or COPD, the best medical advice is to stay away from exposures that can cause or aggravate it. (RX 3, p. 68). Contrary to the DOL and NIOSH, he does not believe that coal dust can cause emphysema absent CWP. (RX 3, p. 69-70). Dr. Houser stated it was common knowledge that this can occur, and cited references for his opinions. (PX 12, pp. 17-19). Dr. Rosenberg also felt that any mining related chronic bronchitis would dissipate with the cessation of mining exposures. (RX 3, depo exh. 2, pp. 3-4). However, Drs. Istanbouly and Houser testified that this is not always the case. (PX 12, p. 12; PX 13, p. 10). Dr. Rosenberg contended that chronic bronchitis does not cause obstruction. (RX 3, p. 64-65). Dr. Houser explained why that view is incorrect. (PX 1, p. 15-16). Dr. Rosenberg was not convincing on these topics.

The Arbitrator also concludes that Petitioner has an occupational bronchitic/asthmatic condition. Petitioner must prove his occupational exposure was a causative or aggravating factor in his disease. He need not prove it was "sole or even the principal causative factor." *Gross v. IWCC*, 2011 IL App (4th), 100615WC, ¶22. While the medical histories pertaining to a history of asthma and productive coughing conflict, Petitioner was taking medications designed to prevent cough or to treat asthma. (RX 3, pp. 30, 40-42). Dr. Rosenberg stated that a physician may diagnose bronchitis when the real problem is asthma. (RX 3, p. 30). The medical records of Logan Primary Care show on December 23, December 17, 2013, and November 19, 2013, black lung and COPD were included in Petitioner's major problems list. (PX 6, pp. 40-43, 45-47). VA Clinic records show a chest x-ray of January 12, 2002 was interpreted as showing mild obstructive pulmonary disease and a hiatal hernia. (RX 7, pp. 2-3). Pulmonary function testing of January 2, 2012 suggested a very mild small airways obstruction. (RX 7, p. 43). However, subsequent testing by Drs. Tazbaz and Istanbuoly were normal. It is clear that Petitioner had episodes of bronchitis, and more recently issues with dyspnea. Petitioner has been on inhalers

and his testimony was credible. There is no other credible explanation for his symptoms other than 37 years of mining exposures.

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

The lung tissue scarred by CWP cannot function and by definition there is impairment of function at the damage site. (PX 1, pp.13-14; RX 1, p. 56). The Commission has recognized that even in the absence of measurable impairment, a CWP diagnosis equates to disability under the Act. See, *e.g., Samuel v. FW Electric*, 08 IWCC 1296 (2008); *Cross v. Liberty Coal Co.*, 08 IWCC 1260 (2008); *Chrostoski v. Freeman United Coal Mining Co.*, 07 IWCC 0226 (2007). A concurrence of three justices in a recent Appellate Court decision also made such a conclusion. *Freeman United Coal Mining Co. v. Illinois Workers' Compensation Commission*, 2013 IL App (5th) 120564WC, ¶33-35 (concurrence).

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

Based on the above findings, which include CWP, shortness of breath, bronchitis and dyspnea, Petitioner is permanently and partially disabled under Section 8(d) (2) to the extent of 10% loss on a MAW basis. The Petitioner is not entitled to 8d1 benefits because "He quit mining because his wife became eligible for social security", supra, i.e, he left his mining job voluntarily.

Issue (O): Was there an injurious practice under Section 19(d)? Was disablement timely?

Respondent's injurious practice defense has no merit in this case. Petitioner's smoking history is remote, and the contention lacks legal foundation. *See, Global Products v. Workers' Compensation Commission*, 392 Ill. App. 3d 408, 911 N.E. 2d 1042, 1046 (1st. Dist. 2009),.

Petitioner's disability was timely under Section 1(f), as his symptoms and positive x-ray abnormalities were all present within two years from his last exposure date of August 8, 2010.

STATE OF ILLINOIS)
) SS.
COUNTY OF CHAMPAIGN)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Patricia O'Neal,
Petitioner,

vs. NO: 13 WC 25525

14IWCC1014

Adecco,
Respondent.

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed March 13, 2014, is hereby affirmed and adopted.

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

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

14IWCC1014

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 $6,800.00. 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: NOV 24 2014

Daniel R. Donohoo

Charles J. DeVriendt

Ruth W. White

o-11/05/14
drd/wj
68

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

O'NEAL, PATRICIA
Employee/Petitioner

Case# **13WC025525**

ADECCO
Employer/Respondent

14IWCC1014

On 3/12/2014, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

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

0157 ASHER & SMITH
CRAIG SMITH
PO BOX 340
PARIS, IL 61944

2904 HENNESSY & ROACH PC
STEPHEN KLYCZEK
2501 CHATHAM RD SUITE 220
SPRINGFIELD, IL 62704

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)

PATRICIA O'NEAL
Employee/Petitioner

v.

ADECCO
Employer/Respondent

Case # 13 WC 25525

Consolidated cases: N/A

14IWCC1014

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Nancy Lindsay**, Arbitrator of the Commission, in the city of **Urbana**, on **November 25, 2013** and in **Springfield** on **January 13, 2014.** After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☒ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☐ What was the date of the accident?
E. ☐ Was timely notice of the accident given to Respondent?
F. ☒ Is Petitioner's current condition of ill-being causally related to the injury?
G. ☐ What were Petitioner's earnings?
H. ☐ What was Petitioner's age at the time of the accident?
I. ☐ What was Petitioner's marital status at the time of the accident?
J. ☐ Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. ☒ 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, **03/05/2013**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$5,084.81**; the average weekly wage was **$338.98**.

On the date of accident, Petitioner was **40** years of age, ***single*** with **2** dependent children.

Respondent shall be given a credit of **$3,513.44** for TTD, **$633.71** for TPD, for a total credit of **$4,147.15**.

ORDER

Respondent shall pay Petitioner temporary total disability benefits of **$286.00**/week for **37 6/7th** weeks, commencing on **03/06/13** through **11/25/13** as provided in Section 8(b) of the Act. Respondent shall be given a credit of **$3,513.44** as stipulated to by the parties.

Petitioner is entitled to prospective medical care, in the form of left shoulder arthroscopic surgery, as recommended and outlined by Dr. John Rowe.

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.

Kenny Lindsey
Signature of Arbitrator

3.7.14
Date

ICArbDec19(b)

MAR 12 2014

FINDINGS OF FACTS and CONCLUSIONS OF LAW

This case involves a claim for prospective medical care. Petitioner alleges repetitive trauma to her left shoulder and arm which manifested itself on March 5, 2013. The issues in dispute are accident, causal connection, temporary total disability (TTD) benefits, temporary partial disability (TPD) benefits, and prospective medical care. Petitioner was the sole witness at the arbitration hearing which began on November 25, 2013; however, proofs remained open. Proofs were closed on January 13, 2014.

In conjunction with the submission of their proposed decisions, the attorneys for both parties submitted a Stipulation regarding TTD and TPD paid and TTD owed/claimed. A copy of that Stipulation is marked as Arbitrator's Exhibit 5 and has been made a part of the record.

The Arbitrator finds:

On March 5, 2013 Petitioner was working for Respondent, a temporary employment agency, as an assembler at the TRW Plant in Marshall, Illinois.

Petitioner testified that as an assembler, she worked on an assembly line comprised of four stations. For the first two stations Petitioner would face north and the components would come off a conveyor belt on her left side, which she would take off the conveyor belt and put on the machine using her left arm. On the last two stations, Petitioner would face south, which would require her to also take component parts off with her left hand and arm. The conveyor belt would always be bringing parts to Petitioner on her left side.

Petitioner's job consisted of putting together component parts for a box for automobile air bags. Petitioner described her job having a time element in that the hourly goal was completion of 190 parts. Petitioner testified that in the very first station ("the lead off station") she would attempt to do more than the quota for the day, stating that if the very first station does not get 190 parts or more, there is no way the rest of the stations will reach their quota because if the parts do not get the proper conformal coat, then the part will not pass to the next stations. Therefore, Petitioner has to do more than 190 parts at the first station in order to make sure they reached their quota for the day.

Petitioner described the conveyor belt as being approximately three feet wide, thereby requiring her to reach across the conveyor belt with her left arm to get the component parts and put them in a machine that is in front of her. Petitioner explained that she would extend her left arm, pick up the part, and proceed with putting it into the machine. Petitioner testified that her job requires her to pick up the parts and add them to a component (that was coming down the conveyor belt). Since the conveyor belt is located on Petitioner's left, she is required to reach across with

her left arm to pull the part and/or pick it up and to place it in front of a machine, which is in front of her.

Petitioner further testified that in the first station she would put the parts on the machine, and then she would go back to the conveyor belt and repeat the process with her left arm until she had handled the appropriate number of parts to reach her quota.

Petitioner described station two as being similar to a rotisserie chicken/ferris wheel in that it centers around a machine that goes round and round in a circular motion and contains bars (like seats on a ferris wheel). Petitioner testified there are thirty bars/slots. Petitioner explained that she takes the parts off the conveyor belt with her left hand and arm, and puts them in the slots. Petitioner further described the process as similar to a ferris wheel, and she described the ferris wheel has having thirty seats and each bar holds ten components that she would take off the conveyor belt. Her description was that the ferris wheel would have ten seats on each row, and if she did not get the ten loaded on the first run, then she would just have to go to the next one because once it goes so far down, one cannot put on any more parts because the machine has an automatic shutoff if you stick your hand in too far. Petitioner testified she worked at eye level and above with her hands and arms.

Petitioner further testified that she uses her left hand to make sure that her right hand does not push the part too far. Otherwise it will fall. If the part falls, or if one picks up the part without gloves, it is an automatic loss of the part because they are fragile. According to Petitioner, Respondent would then automatically scrap the part for safety reasons. Petitioner is required to load the bar/ferris wheel seat as it travels around on the ferris wheel, and then when it comes back to her, she has to take the parts off.

In station three, Petitioner would move to the opposite side of the conveyor belt, continuing to use her left hand and arm. Petitioner testified she would take components that come out of the conformal coat and flip them over. The part is read, and once the clear signal is given, she puts the parts together and puts them back on the conveyor belt with her left hand. Petitioner stated that she holds a cover with her right hand, and when the part comes off the conveyor belt, she uses her left hand to stick the part inside the casing, and then puts it back on the conveyor belt so that the casing will go to the next station.

According to Petitioner, station four is at the very end of the conveyor belt. Petitioner explained that she takes components off of the belt with her left hand, and places them in a machine that reads the numbers. There are then three stacks of lids that go on the compartments. At that time, she uses both of her hands to operate a screwdriver machine, which screws the lid on the box. Petitioner then will take them off of the machine, and put them on the rack with her left hand and arm. She described the rack as having a top shelf of about five feet and a bottom shelf of about knee level. The shelf will hold over one hundred of the compartments. At all four stations, the process continues to be timed, with the first, third, and fourth stations showing how many went out that hour.

Petitioner testified that she usually worked a ten hour day with is a morning break, a lunch period, and an afternoon break.

Petitioner testified that in late January, 2013, she began noticing problems with her left arm. According to Petitioner she continued performing her job as an assembler and in February and March, 2013, she started noticing that it was harder to hold her left arm up. Petitioner testified she could not put deodorant on, and she eventually required help with clothing because she could not lift her arm over her head. On March 5, 2013, Petitioner went to the Human Resources Office and requested that Respondent move her to a different location so that she would not be using her left arm all the time. According to Petitioner, Human Resources refused to move her. Instead, Petitioner was advised to go to Terre Haute Regional Hospital to Occupational Health and to fill out an accident report.

Petitioner testified that she filled out an Incident Report on March 5, 2013, underwent a urine analysis at a medical facility in Marshall, Illinois, and then proceeded to Terre Haute Regional Hospital, where she was seen by Dr. Singh in the Occupational Medicine Clinic. According to the Report and the records, Petitioner gave a history of having sustained an accident on/approximately January 28, 2013. Petitioner explained that she began working at TRW in October and began having shoulder problems in November. Petitioner initially attributed her symptoms to getting used to her new job. She could not recall a specific accident or date; rather her arm had just been hurting – in particular raising her arm over her head. When doing so Petitioner would notice radiating pain from her shoulder into her left neck and chest. Occasionally, Petitioner noticed her shoulder felt stiff and tight. It was worse at night and she was having trouble dressing herself or putting deodorant on. Petitioner rated the pain as constant and a 9-10/10. Petitioner denied any numbness, tingling, or weakness in her left arm. According to Dr. Singh, Petitioner had tried Biofreeze, heat and ice with no relief. She had been wearing a makeshift sling at home and trying Tylenol with codeine (which a doctor had given her while treating for another injury). Petitioner was unable to take Ibuprofen or aspirin due to side-effects. Petitioner was noted to have previously undergone a left-sided carpal tunnel release, cubital tunnel release and ulnar nerve release. Petitioner denied any previous left shoulder injuries. (AX 4 - PX1, Amended)

On physical examination Petitioner had tenderness to her AC joint and the posterior distal region of her shoulder. She exhibited pain into the muscles on the left side of her neck and experienced pain with forward flexion at 45 degrees, abduction at 45 degrees, adduction at 30 degrees. Petitioner was unable to perform internal or external rotation due to pain. X-rays of Petitioner's left shoulder were negative. Petitioner was diagnosed with left shoulder pain. She was given Tylenol # 3 to take, as needed, and advised to continue using her available prescription medication. She was instructed to alternate using ice and heat. Due to the length of time Petitioner had been having problems and the fact she couldn't raise her arm overhead she was advised to undergo an MRI. Petitioner was also given a restriction of no lifting, carrying, pushing, or pulling over 6 – 10 pounds or reaching above her shoulders. (AX 4 - PX 1, Amended; RX 1)1

1 That same day Dr. Singh issued a written report to Respondent and TRW Automotive summarizing the visit (AX 4 - PX 1, Amended)

Petitioner underwent an MRI on March 7, 2013 which showed slight osteoarthritis in the AC joint and a small cyst in the proximal humerus. (AX 4 - PX 1, Amended)

Petitioner was re-examined by Dr. Singh at Terre Haute Regional Hospital (Occ Med Dep't) on March 8, 2013. She continued to complain of pain in the region of the AC joint and biceps head. She denied any radiating pain down her left arm but still complained of neck stiffness. She had been following the doctor's earlier instructions but with no relief of pain. Although there wasn't much to be seen on the MRI, the doctor still felt she should see an orthopedic specialist due to her limited range of motion and inability to raise her arm over her head. Treatment recommendations and work restrictions remained unchanged. (AX 4 - PX 1, Amended) Dr. Singh again followed up the exam with a letter to Respondent and TRW.

Petitioner was next seen by Dr. Jeffery Bollenbacher at Sports & Orthopedicss, P.C. on March 15, 2013. According to his office note (labeled "New Patient Evaluation Workmens' Compensastion [sic]") Petitioner gave the same history as when she presented to Dr. Singh. She acknowledged that nothing at her workplace was heavy but she was on an assembly line and engaged in a lot of repetitive motion. Petitioner did not think the ergonomics at work were very good. Petitioner had not been working since March 5, 2013 but her condition wasn't improving. Petitioner described it as an occasional stabbing pain and, other times, an ache. According to Petitioner her bra strap really made her shoulder hurt. Upon examination Petitioner's ability to lift her left arm was limited to 90 degrees, extension to 40 degrees, and external rotation to 35 degrees. Jobe's and Neer's signs were positive. The doctor's impression was adhesive capsulitis, impingement syndrome, an AC joint sprain/strain, and mild osteoarthritis of the AC joint. He injected Petitioner's shoulder and advised her to begin a home exercise program. Formal occupational therapy was also recommended subject to approval from workers' compensation. Petitioner was also advised to use ice for pain as needed and to continue with her home medications and add Celebrex if her family doctor concurred. Petitioner was further advised that she could return to work with a lifting limitation of 10 lbs. and no reaching above the shoulders. (AX 4 - PX 3, Amended; PX 1, Amended; RX 3)2

Petitioner returned to see Dr. Bollenbacher on April 12, 2013 as instructed. She reported the injection helped but also reported increased discomfort due to having to drive a stick-shift truck while her regular car was being worked on. She had been attending physical therapy at the doctor's office until the previous week when she was sick. Petitioner was noted to be right hand dominant. Her diagnoses remained unchanged and her treatment recommendations were only modified to add a Medrol Dosepak. Her restrictions remained unchanged and she was to return in three weeks. (AX 4 - PX 3, Amended; PX 1, Amended)

On May 3, 2013 Petitioner returned to see Dr. Bollenbacher. Petitioner reported that on April 23, 2013 (approximately a day after a physical therapy visit) she "couldn't" move her neck and experienced left shoulder pain. She ended up calling the doctor about it. Petitioner reported "throbbing pain" in her left shoulder that would come and go after her exercise program, physical therapy, and increased activity. Her diagnoses remained unchanged. Her work restrictions were

2 Copies of Dr. Bollenbacher's office notes were furnished to Respondent and its carrier.

lessened to the extent the weight was increased from 10 lbs. to 25 lbs. Petitioner was advised to return in four weeks. In a Medical Treatment Report/Employee Injury/Illness Treatment Report Dr. Bollenbacher listed Petitioner's diagnosis as "impingement resolving/repetitive injury." The doctor ordered physical therapy. (PX 2)(AX 4 - PX 1, Amended; PX 3, Amended)

At Respondent's request, Petitioner underwent an examination pursuant to Section 12 on May 23, 2013, with Dr. Lawrence Li. Thereafter, Dr. Li issued a written report based upon his examination and review of certain medical records (Dr. Bollenbacher's). He agreed with Petitioner's diagnosis of adhesive capsulitis. He further opined that the treatment provided by Dr. Bollenbacher was reasonable and necessary for adhesive capsulitis. However, Dr. Li did not feel that Petitioner's adhesive capsulitis was related to the March 5, 2013 reported injury, stating that such a condition is most commonly found in females between the ages of forty and fifty. He also agreed with injections, physical therapy, anti-inflammatory medication, and use of a Medrol Dosepak to treat Petitioner. Dr. Li stated that the only restriction that Petitioner would have would be no over chest work. Finally, he felt she would be at maximum medical improvement within two months to one year. (R Group X 5)

On May 30, 2013, an initial evaluation was performed at Paris Community Hospital per Dr. Bollenbacher's recommendation for physical therapy. Paris Community Hospital Physical Therapy set up eleven physical therapy appointments to begin on June 4, 2013, and end on June 27, 2013. Petitioner was unable to receive physical therapy because Respondent's carrier denied treatment, and refused to authorize treatment. (PX 3)

Petitioner presented to Dr. John Rowe at the Family Medical Center on July 9, 2013 for a second opinion regarding her shoulder. Petitioner described her job with TRW and related that while performing those duties she began experiencing some intermittent activity-related pain which by March 5, 2013 became severe enough that she had limited range of motion and trouble undressing. Petitioner also reported neck pain but without any radiating pain to her extremity and no numbness or tingling. Despite being off work since March 13, 2013 Petitioner reported ongoing and persistent shoulder pain both posteriorly and superiorly. On examination Petitioner displayed some atrophy of her deltoid and there was some prominence and tenderness to palpation of her AC joint. Her biceps tendon and anterior joint line was also tender. Petitioner displayed positive impingement and Hawkins and O'Brien's testing was done with pain on apprehension and load and shift and relocation. The doctor reviewed Petitioner's previous MRI which he felt was of poor quality. Dr. Rowe felt Petitioner had evidence of AC joint arthritis, impingement and a questionable anterior labral Bankart lesion. The MRI was read by the Center's radiologist and noted to be consistent with impingement but there was no evidence of joint effusion, a biceps tendon problem, or a rotator cuff tear. Dr. Rowe further opined that Petitioner's condition was casually related to Petitioner's work-related activities "on the basis of acumulative repetitive trauma." Dr. Rowe based his opinion upon his understanding that the biomechanics of the shoulder and Petitioner's explanation of her work-related activities. He stated that Petitioner had not yet reached maximum medical improvement, and that he would consider her temporarily partially disabled. His restrictions consisted of lifting, pushing, pulling no more than five pounds with the upper extremity; avoiding climbing ladders; no work at or above shoulder level with left upper

extremity; and avoid forceful grasping, pushing, pulling, and torquing of left upper extremity; and avoid repetitive motions with her left shoulder. He further instructed Petitioner not to perform any work requiring reaching with left shoulder extremity at or above shoulder level with the arm fully extended. He recommended that an MRI arthrogram be performed. (PX4; PX 5)

Petitioner testified that her appointment with Dr. Rowe lasted approximately one hour.

Petitioner signed her Application for Adjustment of Claim on July 25, 2013. (AX 2)

By letter dated August 7, 2013 Petitioner was advised to report to the Edgar County Human Resources Center on August 8, 2013 at 6:00 a.m. where she would be provided light duty work Monday through Friday for forty hours/week. Petitioner was to be paid $9.25/hour. (PX 8)

An MRI arthrogram was performed on August 7, 2013. According to the Radiologist's report, Petitioner had a type II acromion, an intact rotator cuff, labrum, and biceps, and findings consistent with a history of a frozen joint. (RX 4)

Dr. Rowe next saw Petitioner on August 20, 2013. He reviewed the MRI arthrogram personally. Petitioner was continuing to complain of signficant activity limiting pain in her left shoulder, including being awakened from sleep, limited ability to ride with her husband on his motorcycle, and pain with dressing and lifting and reaching objects in front of her. It was his opinion that Petitioner had a tear of the middle glenohumeral ligament and avulsion of the anterior labrum with some tendinopathy of the supraspinatus tendon. Dr. Rowe noted in his office note that Petitioner was now greater than eight months of left shoulder pain with significant limitation of activities. Petitioner had tried multiple injections, had had a course of physical therapy, and continued to have significant pain. Based upon his interpretation of the MRI arthrogram, he felt Petitioner did have a labral tear. He recommended that she undergo surgery consisting of an arthroscopy of the left shoulder with repair of the labrum if indicated, subacromial decompression, distal clavicle excision, and biceps tenotomy versus repair depending upon findings. He continued to place work restrictions of no lifting greater than twenty pounds; no work at or above shoulder level; and is to do no repetitive pushing, pulling, or lifting of her upper extremity. At that point, he was requesting authorization to proceed with surgical intervention. (PX4; PX 5)

On September 16, 2013 Petitioner filed her Petition for Section 8(a) medical treatment (PX 6) and Section 19(b) Petition. (PX 7)

Following the MRI arthrogram, Dr. Li was requested to issue an addendum report. In his letter of October 8, 2013, Dr. Li noted that he had reviewed the Radiologist's Report from the arthrogram as well as Dr. Rowe's medical records. Dr. Li disagreed with Dr. Rowe's recommendation of arthroscopy of the left shoulder. Dr. Li agreed that the MR arthrogram confirmed a frozen shoulder. It was his opinion that there was no evidence of any pathology in Petitioner's shoulder that required surgery.

At the arbitration hearing Petitioner testified that Dr. Rowe has told her she needs surgery

and she would like to have surgery authorized. She continues to notice limited motion of her shoulder. Petitioner testified that she needs assistance with getting clothing items over her shoulder. Petitioner described constant pain in her shoulder and occasional popping. The pain medication makes her sleepy. Petitioner testified that she has a newborn granddaughter who weighs seven pounds and Petitioner is unable to hold her. Petitioner feels she lacks strength in her shoulder. Petitioner also testified to occasional right shoulder pain which she believes is due to overcompensating.

Petitioner testified she has been off work since March 6, 2013. On cross-examination she acknowledged that she didn't work from December 20, 2012 through January 3, 2013 due to a calf problem. When asked about her history to Dr. Li in which she stated she began noticing problems in her shoulder in January of 2013, Petitioner explained it was probably the very end of January. She also testified that she spent some time on the "Work to Loan" program ("WOLP") while on restricted duty. Petitioner would supervise mentally challenged adults while they engaged in day to day activities. Petitioner usually stood while supervising so that she didn't have to use her left arm. During that time Petitioner acknowledged that she received weekly checks but the amount she received would be dependent upon the number of hours she worked at the program.

Petitioner testified that the Case Management Nurse was present at the IME but when Petitioner requested that the nurse attend and take part in the IME, the nurse refused. Petitioner testified that Dr. Li spent approximately three to five minutes with her. According to Petitioner, Dr. Li asked her questions about her employment but he did not weigh her, measure her, take her blood pressure, or use a stethoscope to take her heart beat. The only physical part of the examination was to have her hold her arms out in front of her, and she was asked if she could push down on his hand.

On further cross-examination Petitioner acknowledged that she worked for TRW in October of 2012 and that prior to that she did home health care. Petitioner's hobbies include walking, crocheting, and her kids (they play baseball, football, and basketball); however, she hasn't crocheted in some time and when she did, she did so wiith her right hand and not her left hand. Petitioner is right hand dominant.

The Arbitrator concludes:

1. Accident (Issue C). Petitioner sustained an accident on March 5, 2013 arising out of and in the course of her employment with Respondent. Petitioner's testimony was credible and her job description unrebutted. As such, she showed that her job required her to perform cumulative repetitive duties. Petitioner had no prior shoulder problems and there was no evidence presented to show any pre-existing trauma or disability in Petitioner's left shoulder. March 5, 2013 is a viable manifestation date. While Petitioner's symptoms and complaints may have begun earlier, it is on that date that Petitioner discussed with her doctor her belief that her complaints were associated with her work duties for Respondent.

2. Causal Connection (Issue F). Petitioner's current condition of ill-being in her left

shoulder is causally connected to her March 5, 2013 accident. This is based upon a chain of events and the opinion of Dr. Rowe whose opinion is deemed more credible and persuasive than that of Dr. Li. Petitioner's description of her job duties as an assembler was unrebutted and demonstrated that her job required her to perform cumulative repetitive duties. There was no history of pre-existing trauma, disability, or previous problems relating to her left shoulder. Petitioner's testimony, the medical records, and the opinion provided by Dr. Rowe support a determination of ongoing causation. The Arbitrator also concludes that Dr. Rowe's opinion is more credible than that of Dr. Li, and it is supported by the record. While Dr. Li did not believe Petitioner's shoulder condition was related to the March 5, 2013 reported injury he did not provide any explanation for his opinion and nothing in his reports suggests he had a clear, complete, and thorough understanding of Petitioner's job. The significance of this deficiency is further magnified by the fact Dr. Li also believed Petitioner should be restricted from above chest level work activities and Petitioner testified that portion of her job did, in fact, require at or above eye level work with her hands and arms which would constitute above the chest work. Additionally, Dr. Li appears to have misinterpreted Dr. Rowe's surgical recommendation as Dr. Li believed there were certain specific procedures Dr. Rowe was planning on performing beyond that of the arthroscopy. To the contrary, Dr. Rowe's intent is to perform an arthroscopy and at that time, and based upon his findings, proceed with additional procedures if appropriate based upon the findings. Indeed, he may do nothing more than the arthroscopy if the findings warrant nothing further being performed. Finally, the Arbitrator notes that Dr. Li did not review all of Petitioner's treating medical records.

3. Prospective Medical Care (Issue K). Based upon the Arbitrator's causation determination and the persuasive and credible testimony of Dr. Rowe, the Arbitrator concludes that Petitioner is entitled to prospective medical care in the form of an arthroscopy of the left shoulder with repair of the labrum if indicated, subacromial decompression, distal clavicle excision, and biceps tenotomy versus repair depending upon his findings.

4. Temporary Benefits (Issue L). Petitioner testified she has been off work since March 6, 2013 except for when she participated in the "WOLP." The parties stipulated that Petitioner has received $3,513.44 in temporary total disability benefits (TTD) and $633.71 in temporary partial disability benefits (TPD). (AX 1, 5) However, the stipulations of the parties (AX 1 and AX 5) contain some inconsistencies regarding the period of TTD. AX 1 alleges two periods of time with a short break in TTD (May of 2013) during which time Petitioner received TPD. AX 5 is silent as to any period of TPD being claimed and reflects a stipulation that Petitioner is entitled to TTD from March 6, 2013 through November 25, 2013. Respondent's dispute with regard to TTD and TPD has been based upon liability and not the periods of time. Accordingly, the Arbitrator is going to give greater weight to the stipulation of the parties found in AX 5 as it was based upon the attorneys having further time to review the issue as they had requested and, in accord with her liability determination above, awards Petitioner temporary total disability benefits (TTD) from March 6, 2013 through November 25, 2013, a period of 37 6/7 weeks based upon AX 5. Respondent is entitled to a credit for the TTD it has paid. Based upon this same stipulation there appears to be no claim for TPD at this time.

****

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

John Ortiz,
Petitioner,

vs. No. 12 WC 17509

Hard Rock Concrete Cutters,
Respondent.

14IWCC1015

DECISION AND OPINION ON REVIEW

A Petition for Review having been timely filed by Petitioner and notice given to all parties, the Commission, after considering the issues of accident, causal connection, temporary total disability, medical expenses, prospective medical treatment, and Respondent's credit for prior payments, and being advised of the facts and law, modifies the amount of credit awarded to Respondent for prior payments and otherwise affirms and adopts Arbitrator Flores' Section 19(b) Decision. A copy of the Arbitrator's Decision is attached hereto and made a part hereof. The Commission further remands this case to the Arbitrator for further proceedings for a determination of a further amount of temporary total compensation or of compensation for permanent disability, if any, pursuant to *Thomas v. Industrial Comm'n*, 78 Ill. 2d 277, 399 N.E.2d 1322, 35 Ill. Dec. 794 (1980).

Petitioner, a 40 year old concrete cutter employed by Respondent for over seven years, was injured on April 23, 2012 while using a core drill to make holes in concrete. He bent to vacuum slurry from the floor and raised up under a pipe that protruded 14" from the wall and struck him between his neck and left shoulder. Petitioner alleged injury to his cervical and lumbar spine. Respondent accepted the cervical injury, but denied that Petitioner's lumbar complaints were related to his April 23, 2012 work accident. Petitioner filed a Section 19(b) Petition, seeking authorization for cervical injections and treatment for his lumbar complaints. Respondent's Section 12 examiner, Dr. Zelby, opined that Petitioner was at maximum medical improvement with regard to his cervical injury by December 5, 2012 and found that his lumbar condition was not work-related. Respondent terminated all benefits based upon Dr. Zelby's opinions.

14IWCC1015

Prior to the Section 19(b) hearing on June 21, 2013, the parties filed a Request for Hearing, stipulating that Respondent was entitled to a credit of $35,166.04 for temporary total disability payments and an advancement toward permanency which it had paid prior to hearing. In her September 3, 2013 Decision, Arbitrator Flores found Respondent was entitled to a total credit of $36,166.04. Respondent timely filed a Section 19(f) Petition to Correct Clerical Errors, requesting several changes for perceived clerical mistakes in the Decision. Arbitrator Flores denied the Petition in its entirety, and Petitioner filed this appeal to the Commission.

After reviewing the entire record, including Respondent's Section 19(f) Petition, the Commission finds that the Arbitrator's calculation of credit for pre-hearing payments was erroneous and contrary to the parties' pre-hearing stipulation. Therefore, the Commission corrects the Arbitrator's award of credit for pre-hearing payments by reducing the amount credited to Respondent to $35,166.04 and otherwise adopts and affirms the Arbitrator's Decision.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Arbitrator's Decision, filed on September 3, 2013, is modified with respect to Respondent's credit for pre-hearing payments. Respondent shall receive credit for $35,166.04 for pre-hearing temporary total disability payments of $29,599.80 and $5,566.24 paid as an advance against permanency.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the reasonable and necessary medical bills of ATI, as documented in PX8, at the fee schedule rate, pursuant to Sections 8(a) and 8.2 of the Act. Petitioner's claim for the outstanding medical bills of Dr. Gireesan is denied.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay to Petitioner the sum of $810.95 per week for a period of 32.29 weeks, commencing April 24, 2012 through December 5, 2012, that being the period of temporary total incapacity for work under Section 8(b) of the Act.

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

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

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

14IWCC1015

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $30,000.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in the Circuit Court.

DATED: NOV 24 2014

Daniel R. Donohoo

o-09/09/14
drd/dak
68

Charles J. DeVriendt

Ruth W. White

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

ORTIZ, JOHN
Employee/Petitioner

Case# **12WC017509**

14IWCC1015

HARD ROCK CONCRETE CUTTERS
Employer/Respondent

On 9/3/2013, 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 0.06% 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:

0009 ANESI OZMON RODIN NOVAK KOHEN
JOHN M POPELKA
161 N CLARK ST 21ST FL
CHICAGO, IL 60601

1832 ALHOLM MONAHAN KLAUKE ET AL
STACEY E HILL
221 N LASALLE ST SUITE 450
CHICAGO, IL 60601

STATE OF ILLINOIS)
)SS.
COUNTY OF COOK)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b) & 8(a)

John Ortiz
Employee/Petitioner

v.

Hard Rock Concrete Cutters
Employer/Respondent

Case # 12 WC 17509

Consolidated cases: N/A

14IWCC1015

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Barbara N. Flores**, Arbitrator of the Commission, in the city of **Chicago**, on **June 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 **TTD overpayment and credit, prospective medical care**

FINDINGS

On the date of accident, **April 23, 2012**, Respondent *was* operating under and subject to the provisions of the Act.

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

On this date, Petitioner ***did not*** sustain an accident resulting in a low back injury that arose out of and in the course of employment as explained *infra*.

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

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

In the year preceding the injury, Petitioner earned **$63,254.40**; the average weekly wage was **$1,216.43**.

On the date of accident, Petitioner was **40** years of age, ***single*** with **1** dependent child.

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

Respondent shall be given a credit of **$29,599.80** for TTD, **$0** for TPD, **$0** for maintenance, and **$5,566.24** for other benefits (i.e., permanent partial disability advance payment), for a total credit of **$36,166.04** as agreed by the parties. *See* AX1 & Arbitration Hearing Transcript at 161-162.

Respondent is entitled to a credit of **$0** under Section 8(j) of the Act. *See* AX1.

ORDER

As explained in the Arbitration Decision Addendum, Petitioner failed to establish that he sustained a compensable low back injury as a result of the accident on April 23, 2012 and he further failed to establish a causal connection between any claimed current condition of ill being and his injury at work on April 23, 2012.

Temporary Total Disability

Respondent shall pay Petitioner temporary total disability benefits of $810.95/week for 32 & 2/7th weeks, commencing April 24, 2012 through December 5, 2012, as provided in Section 8(b) of the Act. Respondent shall pay Petitioner the temporary total disability benefits that have accrued from April 24, 2012 through June 21, 2013, and shall pay the remainder of the award, if any, in weekly payments. Respondent shall be given a credit of $29,599.80 for temporary total disability benefits that have been paid.

Medical Benefits

As explained in the Arbitration Decision Addendum, Respondent shall pay reasonable and necessary medical bills of ATI as provided in Sections 8(a) and 8.2 of the Act. Petitioner's claim for the outstanding medical bills of Dr. Gireesan is denied.

Prospective Medical Care

As explained in the Arbitration Decision Addendum, Petitioner failed to establish causal connection between his claimed current condition of ill being and accident at work. Thus, Petitioner's claim for prospective medical care is denied.

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

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

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

Signature of Arbitrator

August 30, 2013
Date

ICArbDec19(b)

SEP 3 - 2013

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b) & 8(a)

John Ortiz
Employee/Petitioner

v.

Hard Rock Concrete Cutters
Employer/Respondent

Case # 12 WC 17509

Consolidated cases: N/A

14IWCC1015

FINDINGS OF FACT

The issues in dispute include accident regarding Petitioner's claimed low back condition, causal connection regarding all of Petitioner's claimed current conditions, Respondent's liability for payment of certain medical bills, a period of temporary total disability, Respondent's entitlement to credit under Section 8(j) of the Act, and Petitioner's entitlement to the recommended cervical epidural injections. Arbitrator's Exhibit[1] ("AX") 1. The parties have stipulated to all other issues. AX1.

Background

Petitioner testified that he was employed by Respondent as a concrete cutter on April 23, 2012 and for approximately 7 ½ years. Tr. 10-11. He was also a Laborers' Union member of Local 76. Tr. 11, 15. As a concrete cutter, his duties included using a core drill to drill holes through concrete to allow for placement of pipes, etc., and using a roto hammer. Tr. 11, 14. Petitioner testified that core drilling required a lot of lifting and he would carry approximately 40-50 pounds of equipment at a time and 300 pounds total. Tr. 13. Core drilling also required him to stand and stand on a ladder. Tr. 13. A core drill weighs approximately 150 pounds without the blade or bit and he would have to mount it either on the floor or on the wall depending on what he was drilling. Tr. 14. Petitioner testified that he would drill anywhere from 15 to 45 minutes depending on the material that he was drilling. *Id.* Occasionally, Petitioner testified that he also helped others using a wall saw to cut window and door openings and using a slab saw, which is a flooring machine used to cut trench for plumbing and electrical. Tr. 12.

April 23, 2012

On April 23, 2012, Petitioner testified that he was core drilling toward the end of the day and he called the office to let them know that he would not be able to finish. Tr. 16. He testified that he was told to complete the job because there was another job for him the following day. *Id.* Petitioner testified that he bent down to vacuum the concrete and water slurry and "stood up kind of fast." *Id.* He testified that there was a "pipe sticking out of the wall about twelve inches [and about 4-5 feet up off the ground]. It had a shut-off valve on the top of it, and I struck my back and neck. And I fell forward knocking my [safety] glasses off and my hard hat." Tr. 16-17.

[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. Joint exhibits are denominated "JX." Exhibits attached to depositions will be further denominated with "(Dep. Exh. _)." The Arbitration Hearing Transcript is denominated as "Tr." with corresponding page numbers.

Petitioner testified that he was hit so hard that he felt like something fell off the ceiling and hit him and that he did not know what hit him when he fell forward. Tr. 17. He was on the ground for approximately 5-10 minutes trying to pull himself together and he slowly crawled to his equipment cart where he sat for another 5-10 minutes. Tr. 17-18. Petitioner testified that he felt light-headed and started feeling pain in his left shoulder. Tr. 18. He started to drill again, but felt his shoulder stiffen up and could barely lift his arm above shoulder level. *Id.* Petitioner testified that he reported the injury, but was asked if he could finish the job and did so. Tr. 18-19. He testified that he then went and completed paperwork at the steel mill and drove to the clinic on-site. Tr. 19-20. The steel mill provided transportation to the local hospital, St. Catherine's in East Chicago Indiana. Tr. 21-22.

Petitioner testified that he had never injured his left shoulder or neck before April 23, 2012, and that he has never before filed a workers' compensation claim. Tr. 20-21. He was injured while working for Respondent injuring a finger on his left hand sometime in October of 2011 and injured while working for a prior employer when he fell off of a ladder once. Tr. 20-21, 61.

On cross-examination, Petitioner testified that he did not recall being involved in a motor vehicle accident on May 6, 1998 or filing a claim with State Farm. Tr. 61-62. Petitioner further denied having a history of low back pain. Tr. 62.

Medical Treatment

The medical records reflect that Petitioner went to the St. Catherine Hospital emergency room on April 23, 2012. PX1. Petitioner reported that "he was working and bent over and when he stood up he hot [sic] his upper back just below neck to the steel pipe. Pt said he is having pain to affected area and feels neck is stiffening." *Id.*, at 4. A nurse noted that Petitioner "hit L shoulder mid upper back on pipe after getting up from bending down. No obvious injury noted. Onset 1430." *Id.* He also reported that "he was vacuuming in the 84 inch hot strip area of the mill when he bent over and as he stood up he hit his upper back on a steel pipe just below his neck." *Id.*, at 5. Petitioner underwent x-rays of the cervical spine, thoracic spine, and left shoulder, which were normal. *Id.*, at 14; Tr. 24. He was diagnosed with a back contusion, cervicalgia, and sprains and strains of joints and adjacent muscles and discharged with instructions to see his personal physician. PX1; Tr. 23-24. Petitioner did not report any low back complaints. PX1. Petitioner testified that he also took a drug test. Tr. 23; PX1 at 10.

Petitioner testified that on April 27, 2012 Dr. Plunkett was not in, so he saw Dr. Johansson. Tr. 24. The medical records reflect that Petitioner saw Dr. Plunkett and reported that he "backed up into a pipe at work about four days ago complaints of pain over the posterior medial aspect of his left chest between the spine and the shoulder and I can't really see anything there. He complains of some vague numbness in both hands. He's been able to do everything else. It did not sound like a dangerous mechanism. He doesn't have any complaints in his legs. He liked to see a workman's comp.. He has a name of somebody and so I've given a referral to that." PX2 at 5-6, 8. On examination, Petitioner had no tenderness over the spine, no bruising, ability to lift his arms, normal gait, and normal strength. *Id.* Petitioner did not report any low back complaints. *Id.* Dr. Plunkett placed Petitioner off work from April 24, 2012 through April 28, 2012 and until further evaluation by a specialist. *Id.* On cross-examination, Petitioner testified that he has not worked at all since his last day of work with Respondent. Tr. 62.

On April 30, 2012, Petitioner saw Dr. Gireesan reporting pain in the left upper back after an injury at work on April 23, 2012. JX3 (Dep. Exh. 2 at 5-6); Tr. 24. Petitioner denied headaches and, other than decreased range

of cervical motion, Petitioner's examination was normal. *Id.* Dr. Gireesan diagnosed Petitioner with traumatic myofascial syndrome of the left upper back and neck area, ordered physical therapy, and placed Petitioner off work since he could not drive a car and felt pain with standing. *Id.* Petitioner did not report any low back pain or symptoms. *Id.*; JX3 at 8-11.

A May 2, 2012 physical therapy note reflects that Petitioner had a chief complaint of bilateral cervicothoracic pain and bilateral upper extremity numbness and tingling which began on April 23, 2012 after being struck by a pole when standing up at work. PX4 at 102. Petitioner underwent Physical therapy at ATI from May 2, 2012 through October 4, 2012. PX4; Tr. 25. Petitioner testified that he noticed more pain during physical therapy, but it was explained to him that they had to do what they were doing to help Petitioner feel better. Tr. 25-26.

On May 24, 2012, Petitioner returned to Dr. Gireesan reporting headaches on the left side every other day that worsened with driving. JX3 (Dep. Exh. 2 at 7-8); Tr. 26. Other than decreased range of cervical motion, Petitioner's examination was normal. *Id.* Dr. Gireesan added a diagnosis of displacement of the intevertebral disc, site unspecified, without myelopathy with pain in the neck and both upper extremities, ordered a cervical spine MRI and continued physical therapy. *Id.* Petitioner did not report any low back pain or symptoms. *Id.*; JX3 at 11-12.

On May 29, 2012, Petitioner underwent the recommended cervical MRI and saw Dr. Gireesan reporting severe pain and increased headaches with driving. JX3 (Dep. Exh. 2 at 9-10, 15-16 & Dep. Exh. 3); Tr. 26. Dr. Gireesan maintained Petitioner's diagnoses and indicated that "[w]e will wait for the radiologist's report for definitive interpretation." *Id.* Dr. Gireesan kept Petitioner off work, prescribed more physical therapy, and refilled Petitioner's Norco, Naprelan, Ambien and Lioderm prescriptions. *Id.* Petitioner did not report any low back pain or symptoms. *Id.*; JX3 at 12-19.

The interpreting radiologist's cervical MRI report notes the following: (1) degenerative changes of the cervical spine most pronounced at C5-C6 where there is a shallow right paracentral/foraminal disc protrusion associated with mild right neural foraminal stenosis and no significant spinal canal stenosis at any level; and (2) nonspecific symmetric prominence of the lingual and palatine tonsils that may be reactive. JX3 (Dep. Exh. 2 at 15-16).

A June 3, 2012 physical therapy note reflects that Petitioner "had an incident of LBP, however, this has mostly dissipated." PX4 at 122.

On June 12, 2012, Dr. Gireesan reviewed cervical MRI, reported difficulty sleeping due to pain. JX3 (Dep. Exh. 2 at 11-13); Tr. 26. Petitioner continued to complain of pain, headaches and radiating pain into the left arm, but he reported improvement with physical therapy. *Id.* Dr. Gireesan kept Petitioner off work and ordered continued physical therapy. *Id.* Petitioner did not report any low back pain or symptoms. *Id.*; JX3 at 19-21.

On June 19, 2012, Petitioner reported difficulty sleeping, numbness in his fingers that increased in therapy, pain in the left neck with radiation to the left upper extremity, and headaches. JX3 (Dep. Exh. 2 at 14-16). Dr. Gireesan kept Petitioner off work and ordered continued physical therapy. *Id.* Petitioner did not report any low back pain or symptoms. *Id.*

A physical therapy note dated June 21, 2012 reflects that Petitioner reported "[increased] LBP since weekend Pt reports not doing anything unusual, stood for a while over the weekend[.]" PX4 at 137(*emphasis* added).

Under "Tolerance to TX" the physical therapist noted that Petitioner reported worsened pain after physical therapy. *Id.*

On June 26, 2012, Petitioner reported pain in the interscapular area and root of the neck, but gaining significant range of motion in the neck, "*pain in the lower back area last week. John informs me the therapist was working on his back when something triggered the pain in the back area.* John reports 40% improvement in his condition." JX3 (Dep. Exh. 2 at 17-18) (*emphasis* added). Dr. Gireesan updated Petitioner's diagnoses to include a back sprain, kept Petitioner off work and ordered continued physical therapy. *Id.* Petitioner did not report any low back pain or symptoms. *Id.*; JX3 at 21-22. Dr. Gireesan ordered physical therapy on June 28, 2012 for the cervical spine and "mechanical LBP/Strain[.]" PX4 at 95-96.

On July 10, 2012, Petitioner reported a burning pain in the neck on the left side, no radiation to the hands or arm, increased pain with lifting weights at physical therapy, and low back pain. JX3 (Dep. Exh. 2 at 19-22); JX3 at 22-24; Tr. 28-30. Dr. Gireesan performed trigger point injections which Petitioner testified that provided him with relief for a couple of days. *Id.* Dr. Gireesan discontinued physical therapy for one to two weeks, kept Petitioner off work, and maintained his prior diagnoses. *Id.*

A week later on July 16, 2012, Petitioner reported continued neck and low back pain but less burning in the left shoulder since the last trigger point injection and a 50% improvement in terms of neck pain relief with physical therapy and the injections. JX3 (Dep. Exh. 2 at 21-22); JX3 at 24-25; Tr. 27. Dr. Gireesan administered additional trigger point injections, ordered continued physical therapy to be followed by a work conditioning program, and kept Petitioner off work. *Id.*

On July 25, 2012, Petitioner returned to Dr. Plunkett noting that he had followed up with an orthopedic surgeon Dr. Gireesan and that he had undergone physical therapy with some continued discomfort in his chest, back, and neck. PX2 at 7. Petitioner reported some anxiety and vague headaches. *Id.* Dr. Plunkett also noted that Petitioner's blood pressure was borderline elevated and that "[t]here is a great component of stress and anxiety here. *Not sure what all his time off from work he is doing for him* [sic]." *Id* (*emphasis* added).

On August 20, 2012, Petitioner reported 40% improvement in his condition, neck pain that waxed and waned with days and activities although physical therapy seemed to help him, and worsened pain when he was not doing physical therapy. JX3 (Dep. Exh. 2 at 23-26); JX3 at 25-26; Tr. 30. Dr. Gireesan updated Petitioner stenosis to displacement of intervertebral disc, site unspecified, without myelopathy and recommended cervical epidural steroid injections to be performed at a pain clinic. *Id.* He ordered continued physical therapy and kept Petitioner off work. *Id.* Petitioner did not report any low back pain or symptoms. *Id.*

First Section 12 Examination – Dr. Zelby

Petitioner underwent an independent medical evaluation with Dr. Zelby at Respondent's request on September 24, 2012. RX5 (Dep. Exh. 2); Tr. 31. Dr. Zelby submitted to a deposition on May 15, 2013. RX5. Petitioner testified the appointment lasted no more than 10 minutes. Tr. 31.

Petitioner provided a history in which he reported that he was bent over vacuuming concrete slurry and hit his upper back on a pipe when standing up. RX5 & RX5 (Dep. Exh. 2). For the first time, Petitioner reported also hitting his head on the pipe. *Id.* He reported that he felt dizzy after he started to work again, so he sought medical treatment. *Id.* Petitioner reported that he had a severe headache, dizziness, neck pain and pain in the left shoulder blade with difficulty abducting his shoulder on the following day. *Id.* He also had numbness in his

left arm from the elbow down to his fingertips and continued to have this symptom in the mornings at the time of the IME. *Id.* Petitioner also reported a past medical history of hypertension and a fractured femur after a motor vehicle accident in 1985. *Id.*

On the date of the exam, Petitioner continued to complain of neck pain and pain between his shoulder blades. *Id.* He also reported headaches 2-3 times per week, difficulty sleeping, exacerbated symptoms by turning or moving too quickly, and pain at a level of 9/10 on the date of examination. *Id.* However, Dr. Zelby noted that Petitioner rested and moved comfortably, with no pain behaviors to suggest this was an accurate representation of his pain. *Id.* Petitioner also reported that he was on a new medication for hypertension and Dr. Zelby noted he had high blood pressure and told Petitioner to talk to his primary care physician about this right away. *Id.*

On examination, Petitioner was 216 pounds and 6'2" tall. *Id.* His neurological examination was normal for speech, cognition, CN 2-12, cerebellar, Romberg, and additional neurologic testing. *Id.* His cervical examination revealed tenderness with palpation to the lower cervical and upper thoracic regions in the midline, even with non-physiologic light tough. *Id.*

Dr. Zelby explained that he palpates the spine to see if there is a reproducible spasm. *Id.* Superficial light touch is touching so light that it would not be strong enough to result in any painful stimuli, and Petitioner reported this touching to be severely painful. *Id.* His cervical range of motion was limited. Spurling's maneuver was positive centrally with non-physiologic pressure. *Id.* Dr. Zelby explained that Spurling's test is axial loading the spine to look for fractures and that Petitioner reported severe neck pain while Dr. Zelby was lightly touching his head. *Id.* Hoffman's, squatting, straight leg raising, toe walking, heel walking, and Patrick's maneuver were negative bilaterally. *Id.* Dr. Zelby explained that Hoffman's test looks for pressure on the spinal chord. Straight leg raising looks for nerve irritation or potential problems in the lumbar spine. *Id.* Motor examination was normal: this exam included gait, posture, spasm and strength, and chord. *Id.* Squatting, toe walking and heel walking all test strength and coordination. *Id.* Posture is observed for scoliosis. *Id.* Spasm may be present and suggest a muscular process. *Id.* Sensory examination revealed diminished sensation in the entire left upper extremity but was otherwise normal. *Id.* Sensory exam tests the nervous system. *Id.* Reflex exam was normal except Petitioner had inconsistent behavioral responses which were positive for pain on superficial light tough, pain on simulation and non-anatomic sensory changes. *Id.* Measurements of the extremities revealed no atrophy and pulses were normal which meant there were no vascular issues. *Id.* Tinel's, Phalen's, and Adsons tests, which test nerves in the arms and first rib and brachial plexus, were negative bilaterally. *Id.*

Dr. Zelby reviewed Petitioner's MRI films and noted that they showed mild degenerative changes throughout the cervical spine with disc space heights well preserved. *Id.* At C2-3, there was a minuscule bulging disc. *Id.* At C3-4, there was a miniscule bulging disc and slight left uncovertebral joint hypertrophy without stenosis. *Id.* At C4-5, there was a broad-based bulging disc that minimally abutted the ventral thecal sac. *Id.* There was no stenosis. *Id.* At C5-6, there was a broad-based right paracentral disc/osteophyte complex, with mild effacement of the central CSF to the right, and mild right lateral recess foraminal stenosis. *Id.* At C6-7, there was a mild broad-based bulging disc, with minimal effacement of the central CSF. *Id.* There was no stenosis. *Id.* At C7-T1, there was a broad-based bulging disc and modest left uncovertebral joint hypertrophy, with trace left formaminal stenosis. *Id.*

Dr. Zelby noted that these degenerative changes were all mild, and easily age appropriate for Petitioner. *Id.* In laymen's terms, the MRI showed "mild aging of the spine with some bone spurs, consistent with someone in his early 40s. There are no acute or post-traumatic abnormalities." *Id.*

Ultimately, Dr. Zelby diagnosed Petitioner with cervical spondylosis and a cervical strain. *Id.* Dr. Zelby noted that Petitioner had never reported hitting his head and falling forward in any of the other medical records. *Id.* He agreed with Dr. Gireesan's diagnosis of traumatic myositis, which is essentially a soft tissue muscular contusion, but opined that Petitioner's injury resulted in no other infirmity to the spine or nervous system. *Id.* He also noted that Petitioner's MRI showed mild cervical spondylosis with degenerative changes, but no acute abnormalities and a predominant finding at C5-6 on the right, which had nothing to do with Petitioner's constellation of symptoms on the left. *Id.* He opined that the radiographic abnormality was not caused, aggravated or even made symptomatic as a consequence of the work injury. *Id.*

Dr. Zelby also noted that Petitioner had non-radicular left upper extremity complaints, with occasional and less severe non-radicular right upper extremity complaints and that cervical epidural steroid injections would be of no benefit since his symptoms did not correlate to his MRI findings. *Id.* Dr. Zelby explained that cervical steroid injections, "in the right circumstances are intended to relieve inflammation and pain associated with the nerves." *Id.*

With the exception of obvious non-anatomic sensory changes, Petitioner was neurologically normal. *Id.* When questioned about the non-anatomic sensory changes, Dr. Zelby explained, "Mr. Ortiz described loss of sensation in the entire left upper extremity. There's really no condition, irrespective of cause, that could affect the brain or spinal cord that could result in that kind of neurologic abnormality. There is no anatomic basis for the reported loss of sensory function." *Id.* Dr. Zelby opined that Petitioner's injury was a thoracic muscular contusion as well as perhaps a mild cervical strain and noted that Petitioner's persistent subjective complaints were out of proportion to his objective findings, particularly with the amount of treatment he had already received. *Id.*

Dr. Zelby recommended 3-4 weeks of work conditioning/hardening and indicated that Petitioner would then be at maximum medical improvement. *Id.* He released Petitioner back to work in the light-to-medium physical demand level indicating that Petitioner could return to work full duty after completing work hardening. *Id.* Dr. Zelby opined that only six weeks of physical therapy was reasonable and that Petitioner's medical treatment had been prolonged and protracted given the objective information about Petitioner's condition. *Id.*

Continued Medical Treatment

On September 25, 2012, Petitioner reported increased pain in his neck with radiation into both upper extremities that increased while watching television. JX3 (Dep. Exh. 2 at 27-28); JX3 at 26. Petitioner also reported 40% improvement in his condition and Dr. Gireesan continued to epidural injections. *Id.* Dr. Gireesan kept Petitioner off work and indicated that he would wait to see Dr. Zelby's recommendations. *Id.* Petitioner did not report any low back pain or symptoms. *Id.*

Petitioner testified that he completed physical therapy on October 4, 2012. Tr. 31; PX4.

On October 30, 2012, Petitioner reported continued left sided neck pain that worsened with activity, completing physical therapy, continued headaches, having his blood pressure under control, and pain in both elbows especially when he put pressure on them. JX3 (Dep. Exh. 2 at 29-30); JX3 at 26-27. Dr. Gireesan kept Petitioner off work and ordered work hardening and a functional capacity evaluation in light of Dr. Zelby's recommendation. *Id.* Petitioner did not report any low back pain or symptoms. *Id.*

Petitioner underwent work hardening at ATI from November 18, 2012 through December 5, 2012. Tr. 32; PX4. Petitioner testified that his pain increased and, as the days went on, work hardening was harder so that he could barely do anything they were asking him to do toward the end. Tr. 33-34.

Functional Capacity Evaluation

On December 6, 2012, Petitioner underwent a functional capacity evaluation ("FCE") at ATI. PX4 at 8-16; Tr. 34-35. The physical therapist indicated that the results were valid, although the report contained Petitioner's pain reports and pain behaviors in addition to objective data collected to determine the validity of testing. *Id.*

On cross-examination, Petitioner testified about certain tests performed during the FCE. He reported low back and neck pain during heel-toe walk testing and testified that it was a sharp pain. Tr. 54. During gait testing, Petitioner reported that he could not walk too far before he needed to sit down and sat during most breaks; he testified that he did so because his low back started acting up. Tr. 54-55. During stairs testing, Petitioner reported or demonstrated his head forward, holding onto the handrails, and slow labored steps alternating his foot with each step while ascending and descending, and reporting "my lower back is killing me." Tr. 55-56. Petitioner completed 22 of 50 steps terminating it with a report/behavior of "pain in my neck and my back from trying to hold myself up." Tr. 55-56. Petitioner testified that this was true and every time he went up he felt a pulling strain on his neck and that is when he had [pain in the] lower back. Tr. 56.

During standing tolerance testing, Petitioner reported or demonstrated his head forward, feet close and parallel to one another, and asked "[y]eah, can we move it? It hurts my neck to look down" at 5 minutes, he shifted his feet in place at 6 minutes, he moved his weight from side to side at 10 minutes, he reported "[i]t is really starting to bother my neck" at 15 minutes, he demonstrated a facial grimace and reported "[i]t is really starting to bother me from holding my hands up" at 16 minutes, he sat down at 21 minutes and reported "[t]here was a lot of pain in between my shoulder blades" at the termination of testing. Tr. 57-58. Petitioner testified that this was accurate. Tr. 58.

Petitioner testified[2] that his ability to heel-toe walk as identified in the FCE does not generally represent his abilities on every day since his accident because "[l]ike I said before, every day is different. From one day to the next day is different. I could be in more pain on one day and less the next day, but something will aggravated." Tr. 58-59. He testified that it was a bad day on the date of his FCE. Tr. 59. He added that he did not believe that he could do more on a good day "... Because I have tried to do things, and once I do them, the pain is just increasing. And it shuts me down for the rest of the day, maybe three, four days." Tr. 59-60.

On redirect examination, Petitioner reiterated that the way he felt on the day of the FCE is different from every other day. Tr. 64.

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[2] The Arbitrator notes that Petitioner's counsel made an objection just prior to the eventually re-phrased question posed by Respondent's counsel in the following exchange: "[Petitioner's counsel]: I object to the question as being unduly vague and too far-reaching. She's asking for every single day from the date of the accident to that date? That's not an appropriate form of the question. [Respondent's counsel]: I could go day by day. [Petitioner's counsel]: if you think that's going to help you, I think that's how you would have to do it. He can't answer for every day with one answer, and he probably doesn't recall, your Honor. The Arbitrator: Counsel, speaking objections are unnecessary. Sustained." Tr. 58.

Continued Medical Treatment

On December 10, 2012, Petitioner returned to Dr. Gireesan reporting "*[p]ain in the interscapular area, low back since it work related injury* [sic,]" completing physical therapy and work conditioning, and undergoing a functional capacity evaluation. JX3 (Dep. Exh. 2 at 31-32) (*emphasis* added); JX3 at 28-30; Tr. 35. Dr. Gireesan noted that Petitioner was still severely restricted in his activities, he had not seen any change in his condition, and he believed that a new MRI was appropriate to see if there was any interval change. *Id.* Petitioner did not report any low back pain or symptoms. *Id.*

Petitioner underwent the recommended MRI on December 17, 2012 at Northwestern Memorial Hospital. JX3 (Dep. Exh. 2 at 43-44); Tr. 35. The interpreting radiologist noted mild degenerative changes in the cervical spine without evidence of high grade neural foraminal or spinal canal stenosis and a 6 x 8 mm hyper intense T2 signal lesion at the midline floor of the mouth/anterior tongue base compatible with a thyroglossal duct cyst. *Id.*

Petitioner also saw Dr. Gireesan on December 17, 2012, reporting pain in the neck with radiation to the upper extremities. JX3 (Dep. Exh. 2 at 33-34); Tr. 35-36. Dr. Gireesan reviewed Petitioner's MRI noting a bulging disc at C6-C7 with no significant compression on the spinal cord. *Id.* He kept Petitioner off work, continued to recommend cervical epidural injections, and indicated that he awaited the FCE report to steer toward a vocational training program. *Id.* Petitioner did not report any low back pain or symptoms. *Id.*

Petitioner testified that he last received temporary total disability benefits through January 9, 2013 as indicated in a letter from Respondent. Tr. 36-38; PX5.

On March 15, 2013, Petitioner returned to Dr. Gireesan reporting pressure at the base of the neck, pain with sudden neck movements, radiating pain into the interscapular area on both sides, and inability to carry objects for too long. JX3 (Dep. Exh. 2 at 35-36); JX3 at 30-32; Tr. 38-39. Dr. Gireesan had not yet seen the FCE report on this date. *Id.* He reviewed Petitioner's December 17, 2012 MRI again indicating that it showed a bulging disc at C5-C6 and C6-C7. *Id.* Dr. Gireesan also noted the following:

> [Petitioner] wants to try cervical epidural steroid injections. *I informed [Petitioner] that the findings we have on the MRI are rather subtle. I do not see the extruded disc impinging on the spinal cord or the nerve roots. I also informed [Petitioner] that surgery by way of fusion is a big operation and that I would not recommend this until he has exhausted all the other options.* Id., (*emphasis* added).

Dr. Gireesan did not recommend or mention surgery in any of Petitioner's records other than in this progress note. JX3 (Dep. Exh. 2). Petitioner did not report any low back pain or symptoms. *Id.*

Second Section 12 Examination – Dr. Zelby

Petitioner submitted to a second independent medical evaluation with Dr. Zelby at Respondent's request on April 3, 2013. RX5 & RX5 (Dep. Exh. 3); Tr. 39. Petitioner testified the appointment lasted no more than 5 minutes. Tr. 39. On cross-examination, Petitioner testified that he experienced increased pain because he did not take his medication and due to bumps in the road and bouncing around while driving to the examination. Tr. 48-51.

On the date of his second evaluation, Petitioner reported that he had been in work conditioning for four weeks, but his symptoms increased during the second week so his pace of work conditioning was decreased. *Id.* He reported increased pain and stiffness in his neck, extending into both trapezius regions and the pain tingling and extending circumferentially into both upper extremities down to the tips of the fingers. *Id.* Petitioner also reported that he had all of the same pain in his neck, arms, and hands but also felt weakness in his hands. *Id.* His pain level was 8/10 improved from 9/10 earlier that morning. *Id.* Petitioner reported that he felt his symptoms were exacerbated by moving quickly, lifting, bending and fixed postures and that nothing gave him relief although he was taking pain medication and muscle relaxers. *Id.*

On examination, Dr. Zelby noted tenderness to palpation of the lower cervical and upper trapezius regions in the midline; even with non-physiologic light touch. *Id.* However, pressure in the same areas with testing of upper extremity strength elicited no pain. *Id.* The rest of the physical examination remained essentially the same as during Petitioner's first independent medical evaluation exam. *Id.*

Dr. Zelby reviewed Petitioner's December 17, 2012 MRI and noted that the study was unchanged since the last MRI. *Id.* He also reviewed additional medical records, work conditioning reports and Petitioner's FCE. *Id.*

Dr. Zelby noted that, despite Petitioner's complaints, his neurological examination was essentially normal and his MRI revealed mild degenerative changes without neural impingement. *Id.* Dr. Zelby again noted Petitioner's subjective complaints stating that "[h]is ongoing subjective complaints, their reported severity and their reported persistence cannot be explained by the objective medical evidence, and these complaints are completely inconsistent with the natural history of his objective medical condition." *Id.* Dr. Zelby also indicated that while Petitioner's FCE was described as valid, it made no sense in the context of the objective medical evidence and underlying medication condition stating that "[t]here is no medical evidence to suggest that Mr. Ortiz could not safely return to all of his usual vocational and avocational activities without restrictions." *Id.* At his deposition, Dr. Zelby testified that Petitioner's heart rate remained steady throughout the FCE testing and noted that this finding was suggestive that the test results were not an accurate representation of Petitioner's maximum abilities because maximum exertion should increase the heart rate as should the pain levels that Petitioner reported at the time of the FCE. *Id.*

On cross examination, Dr. Zelby admitted that pain cannot be measured and that he looks to see if the findings on the diagnostic studies correlate with the symptoms described. *Id.* He also testified that objective medical evidence would not be enough for him to prescribe epidural steroid injections because there would need to be corresponding pain complaints to support such an order. *Id.* He also acknowledged that the physical examinations in both of his reports were very similar, but explained that this was because Petitioner had essentially a normal physical examination on both occasions. *Id.* He also testified that he took Petitioner's word regarding his complaints and that is why he recommended work conditioning after the first examination. *Id.* Dr. Zelby also admitted that, hypothetically, if a disc is impinging on the thecal sac, an epidural injection would potentially help resolve symptoms arising from that condition. *Id.* He also explained that trigger point injections are intended to address a knot in the muscle that has point tenderness and is intended to relax the area and that a bulging disc is not caused by trauma but rather by degeneration and that a protrusion could be caused by trauma, but there were no protrusions identifiable in Petitioner's MRIs. *Id.*

Ultimately, Dr. Zelby felt Petitioner had reached maximum medical improvement in December of 2012 at the latest and could return to work after the some work hardening because Petitioner had no condition to explain his symptoms as it related to the spine – nothing in the nervous system, muscles, nerves joints or bones connected to the spine. *Id.* He also opined that Petitioner was not a candidate for cervical epidural injections because he

did not have a medical condition which would be treated with these injections and found that he required no additional medical treatment regardless of the cause. *Id.*

Continued Medical Treatment

On April 10, 2013, Dr. Gireesan, reviewed functional capacity evaluation test results, continued to recommend cervical epidural injections. On April 10, 2013, Petitioner reported pain in the neck with radiation to both shoulders, worsened pain if he did anything excessive and significantly diminished endurance, and being released per the functional capacity evaluation to sedentary to light duty work. JX3 (Dep. Exh. 2 at 38-39); JX3 at 38-39; Tr. 39-40. Dr. Gireesan released Petitioner to work in the sedentary-light capacity, continued to recommend cervical epidural steroid injections, and noted that he reviewed Dr. Zelby's most recent IME report. *Id.*

Correspondence

On April 19, 2013, Petitioner received a certified letter from Respondent dated April 6, 2013 addressed to PO Box 59334, but Petitioner testified that he address is PO Box 25627. PX7; Tr. 41. The letter directed Petitioner to return to work on April 12, 2013, which had already passed by the time he received a letter. Tr. 41-42. The letter also directed Petitioner to call Respondent by April 10, 2013 at 11:00 a.m. Tr. 42. Petitioner notified his attorney and forwarded the letter to him via e-mail. Tr. 42-43.

On cross-examination, Petitioner testified that he received his temporary total disability checks previously at PO Box 59334 in Chicago. Tr. 60-61. He acknowledged that he currently physically resides at 4726 N. Winchester, that he indicated his residence at 528 N. Francisco Ave. when he filed his application for adjustment of claim, and that at some point in time he also resided at 3526 W. Armitage Ave. Tr. 60. On redirect examination, Petitioner testified that he also received temporary total disability checks at PO Box 25627. Tr. 64-65.

Continued Medical Treatment

Petitioner returned to Dr. Gireesan on May 9, 2013 reporting continued neck pain with radiation to the middle back, pain down the medial aspect of both forearms, attempting to play ball with his kids and change the spark plugs in his truck with increased pain, and difficulty sleeping due to pain. PX6; Tr. 43. Dr. Gireesan continued to recommend epidural steroid injections and noted Petitioner "*is unable to his work as a concrete cutter. Him.*" PX6 (*emphasis* added). Petitioner did not report any low back pain or symptoms. *Id.*

Deposition Testimony of Dr. Gireesan

Respondent took the deposition of Dr. Gireesan, who admitted to meeting Petitioner's attorney prior to the deposition although further information was not garnered about the meeting. JX3.

Dr. Gireesan testified that on April 30, 2012, Petitioner did not report hitting his head, he denied headaches, and there was no mention of dizziness. *Id.* He testified that it was his understanding that Petitioner hit the pipe with the upper portion of his back in the area between his neck and the shoulder on the left side. *Id.* Throughout Petitioner's treatment, Dr. Gireesan acknowledged that he did not document any grimacing during cervical range of motion testing, pain with palpation, Spurling's maneuver, Hoffman's maneuver, or Waddell's signs (which he indicated that he did not know what Waddell's signs were). *Id.* Dr. Gireesan also testified that

Petitioner had full strength in his extremities and intact vibratory sensation. *Id.* he also testified that, while Petitioner had always complained of pain in both shoulders, it may have not been documented in his written records and he acknowledged that certain pain diagrams referenced throughout the deposition were not contained in his certified records. *Id.*

Dr. Gireesan also admitted that in reviewing Petitioner's MRI, he relied on the radiologist for a definite interpretation. *Id.* He also reviewed Petitioner's MRI at the deposition and noted that it revealed a minor bulging disk at the C6-7 level which he clarified was actually at C5-6. *Id.*

Dr. Gireesan testified that he reviewed Petitioner's functional capacity evaluation and admitted that, although the FCE indicated that he only demonstrated the ability to lift up to 8 or 14 pounds, Petitioner could carry up to 20 pounds in groceries and the like as, "[t]hey are not big weights anyway." *Id.* Furthermore, Dr. Gireesan testified that the FCE "is a rough guideline, you know, I would say sedentary to light, you know, where he could function." *Id.* He believed Petitioner could function at the light physical demand level even though the functional capacity evaluation placed him at the sedentary physical demand level. *Id.*

On cross examination, Dr. Gireesan testified that normally he does not document grimacing in his medical records and that he recalled Petitioner grimacing and displaying pain behavior during his examinations, but that he did not document this because he "what I mainly focus on, do they have any neurological deficit in terms of weakness or sensory changes in gait. Those are the major areas that we focus on." *Id.* Dr. Gireesan testified that Spurling's and Hoffman's maneuvers only test for large protrusions putting pressure on the spinal chord. *Id.*

Dr. Gireesan testified that on April 30, 2012, he diagnosed Petitioner with traumatic myositis because early on after someone gets hurt and they have no major structural problems, they treat it like a soft tissue injury and then after six weeks, on May 29, 2012, he ordered an MRI which found a right paracentral foraminal disc protrusion associated with mild neuroforaminal stenosis. *Id.* He testified that this finding would typically produce pain in the shoulder and extremities, but that the MRI did not match Petitioner's complaints because those included pain in both extremities and the protrusion was only on the right side. *Id.* Notwithstanding, Dr. Gireesan opined that the degeneration existed before the accident, but the accident caused it to be symptomatic. *Id.*

Dr. Gireesan testified that, in late June, Petitioner began complaining of low back pain and "I told [Petitioner] that was probably not, you know, related to the work because he got hit on the top… And so I said get therapy and move on with it." *Id.* Dr. Gireesan also testified that Petitioner was no longer complaining of radiation into his arms and hands and that he reported a 40% improvement by July 10, 2012; however, Petitioner reported worsened pain with increased weights at physical therapy so he administered a trigger point injection, which he testified that is intended to address soft tissue pain. *Id.* Dr. Gireesan also testified that Petitioner's pain was reportedly worsening when he was not in therapy, prompting him to recommended cervical epidural steroid injections, which are intended to address the disc protrusion and "deep" pain. *Id.*

Dr. Gireesan disagreed with Dr. Zelby's opinion that epidural steroid injections were not necessary because he only saw Petitioner on one occasion, although Dr. Gireesan agreed that Petitioner did not have any neurological deficits. *Id.* He further disagreed with Dr. Zelby and testified that an epidural injection is not an invasive procedure and perhaps it could enhance Petitioner's function; Petitioner had muscular complaints that seemed to have resolved, but he still had complaints so maybe epidural injections could help. *Id.*

Dr. Gireesan also testified that the FCE was a valid study which placed Petitioner at the sedentary-light capacity and that there was no way for him to know if the injections would be helpful unless they tried them. *Id.* Ultimately, Dr. Gireesan again testified that Petitioner's cervical condition was aggravated by the work injury, that he could not work full duty, and that his condition was temporary. *Id.* He testified that Petitioner's low back was not something that he injured in the accident at work. *Id.*

Additional Information

Regarding his current condition, Petitioner testified that he feels a stinging sensation in the middle of his neck, burning, sharp pain, numbness in both arms which occurs mainly while he is sleeping and occurs occasionally during the day, back spasms, and sharp pains shooting from the base of his neck down between his shoulder blades. Tr. 43-45. Petitioner also testified that he experiences unspecified symptoms in his low back mainly while going up and down stairs and after sitting for too long. Tr. 45. Petitioner testified that he takes Norco and Flexeril. Tr. 45-46.

Petitioner testified that to the best of his knowledge Petitioner's group Exhibit 8 contains outstanding medical bills from Dr. Gireesan and ATI. Tr. 46-47. He also testified that he wishes to undergo the recommended cervical epidural injections recommended by Dr. Gireesan. Tr. 47.

Brad Bacon

Respondent called Brad Bacon ("Mr. Bacon") as a witness. Tr. 67-68. He is a project manager for Respondent and has been so employed for approximately 8 years before which he was employed as a pastor. Tr. 68. Mr. Bacon testified that April 23, 2012 was a Monday and he was working as the project manager on a job when he received a call from the office about Petitioner. Tr. 69-70. Mr. Bacon testified about a series of conversations between himself and others.

During the first phone call, Mr. Bacon testified that the office told him that Petitioner was having difficulty completing his job and did not know if he could get it done on that date. Tr. 70. Mr. Bacon then received a call from Petitioner that he was hurt and testified that his concern was no longer whether the job was going to be finished but for Petitioner's well-being. Tr. 70. Mr. Bacon called Mr. Dvoratchek, Respondent's owner, and asked him if he wanted Mr. Bacon to go over and see how Petitioner was and what was happening, to which Mr. Dvoratchek responded affirmatively. Tr. 70.

Mr. Bacon then called Petitioner and was on his way from the job site to the first aid center at the steel mill at which time he asked Petitioner some questions including whether Petitioner had been in contact with Randy (Respondent's contact at the steel mill). Tr. 71. Petitioner responded affirmatively stating that Randy told him where to go and Mr. Bacon indicated that he would call Randy and have Randy come get Petitioner so that Petitioner could follow Randy to the first aid place. Tr. 71. Later on, Petitioner called Mr. Bacon back indicating that they were taking him from the first aid place to the hospital and Mr. Bacon told Petitioner that he would meet Petitioner at the hospital. Tr. 71.

Mr. Bacon arrived at the hospital and sat with Petitioner where he was being examined and had a conversation during which he asked Petitioner how the accident happened and where he was injured. Tr. 72. Mr. Bacon testified that Petitioner gestured to the back side of the right shoulder and neck area. Tr. 72. Mr. Bacon asked Petitioner whether he had on his hardhat and safety glasses and whether Petitioner hit his head, which Petitioner denied saying "[n]o, no, no[.]" Tr. 72-73. He also testified that he spent approximately an hour with Petitioner

at the hospital after which a nurse came in and told Petitioner that she would give him a pain medication prescription for him to take after his drug test. Tr. 77-78. Mr. Bacon asked Petitioner whether he felt okay to drive from the hospital in East Chicago, Indiana to Maywood[, Illinois] to get the drug test and Petitioner responded "[n]ope, I'm fine. I'll be good to drive." Tr. 78.

James Dvoratchek

Respondent called James Dvoratchek ("Mr. Dvoratchek") as a witness. Tr. 81-82. He is Respondent's owner and president. Tr. 82. Mr. Dvoratchek testified that he first became aware of Petitioner's injury on April 23, 2012 and that he tried to get "background from the people who had talked with him, and then I contacted Brad Bacon and requested that he go down to the job site and/or hospital to make sure [Petitioner] was okay because I was concerned as to his well-being." Tr. 83.

Mr. Dvoratchek testified that he spoke with Petitioner that evening and asked him how he was under the circumstances to which Petitioner responded that his shoulder and back was a little bit sore. Tr. 83. He spoke with Petitioner about the mechanism of injury and Petitioner reported that while he stood up there was a valve sticking out of the wall that hit him in his back. Tr. 83-84, 115-116. He testified that he asked Petitioner whether "it hit [Petitioner's] neck" or head, to which Petitioner responded "no." Tr. 84-85. Mr. Dvoratchek also testified that he asked Petitioner where he was hit on the back and that Petitioner told him that it was near his shoulder blade. Tr. 84. On cross-examination, Mr. Dvoratchek acknowledged that Mr. Bacon testified that the conversation between Mr. Dvoratchek and Petitioner involved Petitioner providing a brief "[y]eah, yeah" answers; however, the Arbitrator notes that Petitioner's counsel objected to this line of questioning during Mr. Bacon's testimony and the focus of Mr. Bacon's testimony changed. Tr. 74, 116-117.

Mr. Dvoratchek spoke with Petitioner the following day. Tr. 85-86. He called Petitioner because he received a call from the Advanced Occupational Clinic where Petitioner had the drug testing the night before and indicated that Petitioner did not seek additional medical treatment there. *Id.* Mr. Dvoratchek testified that Petitioner told him that he was going to see his own doctor and he asked Petitioner to inform him about his progress. Tr. 86-87.

Mr. Dvoratchek called Petitioner on the Monday of the following week, payday, to know Petitioner's status, but he did not hear back from Petitioner. Tr. 87.

At some point thereafter, Mr. Dvoratchek spoke with Petitioner at which time Petitioner said he saw his doctor on Friday and that the doctor told Petitioner that he had whiplash or something. Tr. 87-88, 122-124. Petitioner told Mr. Dvoratchek that he did not have a neck brace and that he was restricted from working for four weeks and, as a result, Mr. Dvoratchek told Petitioner that he would need to pick up the truck from him because they were busy at that time of year. *Id.* Petitioner told Mr. Dvoratchek that he could not drive, so he arranged to have two employees go to Petitioner's home and pick up the truck and gas credit card with instructions to leave the phone with Petitioner. Tr. 89. The employees returned with the truck, Petitioner's tools, the gas credit card, and phone. *Id.*

Mr. Dvoratchek tried to contact Petitioner again at his home phone number asking to speak with him about the accident and left him several messages, but never received a return call. Tr. 92-94. On July 18, 2012, Mr. Dvoratchek called Petitioner again because he'd received a request for employment verification around that time and he was trying to find out Petitioner status because he understood Petitioner was going to be off work for four weeks as of April and had no progress reports are updated work releases since that time. Tr. 94.

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On July 17, 2012, Mr. Dvoratchek sent Petitioner a letter to Petitioner at 6528 N. Francisco Ave. asking for an update regarding his work restrictions, indicating that Respondent was willing to accommodate Petitioner in a modified duty position if he had restrictions, and inquiring about in employment verification request that Mr. Dvoratchek received via facsimile. Tr. 95-100; RX1(a) & RX1(b). The letter was sent to Petitioner and delivery was attempted, but returned to Mr. Dvoratchek "attempted, not known." *Id.* Petitioner did not contact Mr. Dvoratchek after July 18, 2012. Tr. 100.

On September 13, 2012 and April 6, 2013, Mr. Dvoratchek called Petitioner at his home and left a message to call him back; Petitioner did not return his calls. Tr. 100-102. Mr. Dvoratchek also sent Petitioner a letter on April 5, 2013 that was dated April 6, 2013 to 3256 W. Armitage Ave. offering Petitioner modified duty work and asking Petitioner to get in contact with him. Tr. 103-106, 138-141; RX2(a) & RX2(b). The letter was sent via U.S. Express mail and delivered on April 6, 2013. *Id.* Mr. Dvoratchek also sent a copy of this letter to Petitioner at the PO Box 59334 address via U.S. Express mail which was delivered on April 6, 2013. Tr. 106-109; RX3(a) & RX3(b). Mr. Dvoratchek testified that he sent Petitioner the April of 2013 letter offering Petitioner work up to and including sedentary desk work as a result of a conversation with someone at his workers compensation insurance carrier who helped him put the letter together. Tr. 132-134, 137-138.

Mr. Dvoratchek called Petitioner again on April 10, 2013 at the number listed by Petitioner in the employee phone list and left a message. Tr. 110-111. Petitioner did not return Mr. Dvoratchek's call. *Id.* as of the date of trial, Mr. Dvoratchek testified that he did not have sedentary desk work available for Petitioner. Tr. 115.

Nebojsa Gilgorevic

Respondent called Nebojsa Gilgorevic ("Mr. Gilgorevic") as a witness. Tr. 147. Mr. Gilgorevic is a private investigator hired on April 3, 2013 to do an investigation of Petitioner. *Id.* Mr. Gilgorevic testified that he began his investigation at approximately 11:00 a.m. at a medical appointment that Petitioner had scheduled and identified Petitioner in the doctor's office when he observed Petitioner enter the waiting room and check in with the receptionist who stated Petitioner's name. Tr. 148, 152-153. Mr. Gilgorevic provided video surveillance footage of Petitioner. RX9.

The Arbitrator reviewed the video which reflects Petitioner walking and moving his neck in no apparent discomfort on various occasions. He also entered an automobile in no apparent discomfort and turned his head limitedly in no apparent discomfort.

14IWCC1015

ISSUES AND CONCLUSIONS

The Arbitrator hereby incorporates by reference the Findings of Fact delineated above and the Arbitrator's and parties' exhibits are made a part of the Commission's file. After reviewing the evidence and due deliberation, the Arbitrator finds on the issues presented at trial as follows:

In support of the Arbitrator's decision relating to Issue (C), whether an accident occurred that arose out of and in the course of Petitioner's employment by Respondent, the Arbitrator finds the following:

The parties do not dispute whether Petitioner sustained an accident to the neck on April 23, 2012, but Respondent disputes whether Petitioner sustained a compensable injury to the low back. The Arbitrator finds that Petitioner did not sustain an accident resulting in an injury to the low back that arose out of and in the course of his employment with Respondent as claimed. In so concluding, the Arbitrator does not find Petitioner to be credible. Petitioner's testimony at trial differed significantly from the mechanism of injury that he reported to medical providers, his reports about low back pain began months after his injury at work, and Petitioner's low back pain complaints to Dr. Gireesan and during physical therapy are inconsistent.

At trial, Petitioner reported that he struck his upper back and neck on April 23, 2012. He testified that he crawled back to sit down and collect himself twice before calling for assistance and being instructed to finish his job despite a purportedly severe injury which he did. The emergency room records note that Petitioner had no outward evidence of any injury to the neck or upper back area, which is corroborated by Dr. Plunkett's records during a visit days thereafter.

Then Petitioner came under the care of Dr. Gireesan through an unknown referral. His records reflect that Petitioner had somewhat limited range of motion in the neck, but essentially otherwise normal examinations throughout the remainder of his treatment with the exception of Petitioner's continuing and inconsistent pain complaints in the neck, shoulders, bilateral arms, forearms, hands, and low back. The first reference in the records to any low back pain is in a June 3, 2012 physical therapy note that Petitioner "had an incident of LBP, however, this has mostly dissipated." PX4 at 122. A physical therapy note dated June 21, 2012 reflects that Petitioner reported "*[increased] LBP since weekend Pt reports not doing anything unusual, stood for a while over the weekend[.]*" PX4 at 137 (*emphasis* added). Under "Tolerance to TX" the physical therapist noted that Petitioner reported worsened pain after physical therapy. *Id.* On June 26, 2012, Dr. Gireesan noted Petitioner's report of "*pain in the lower back area last week. John informs me the therapist was working on his back when something triggered the pain in the back area.*" JX3 (Dep. Exh. 2 at 17-18) (*emphasis* added).

Additionally, Petitioner testified on cross examination about the low back pain complaints that he made during his FCE, including a report that his low back was "killing" him and demonstrating slow, labored steps and ceased performing testing activities due to reported low back pain. However, the Arbitrator does not find Petitioner's testimony regarding his low back pain at any point to be credible whatsoever.

Even Dr. Gireesan admitted that Petitioner's claimed low back condition was not related to his injury at work on April 23, 2012 and he testified that when Petitioner began complaining of low back pain "[he] told [Petitioner] that was probably not, you know, related to the work because he got hit on the top… And so I said get therapy and move on with it." Notwithstanding Dr. Gireesan's admissions, Petitioner did not report any low back injury or symptoms for months after his accident, he reported them occasionally to Dr. Gireesan and physical therapists, and, when he did report low back pain, it was related to activities outside of work. Indeed, Petitioner testified that he has not worked since April 23, 2012 and even Petitioner's report of low back pain to Dr.

Gireesan stemming from activities in physical therapy is contradicted by the physical therapy records which reflect Petitioner's reports of low back pain stemming from nothing unusual while at home over a weekend. Moreover, while the surveillance video of Petitioner is limited to one day and not shocking in terms of his activities while being filmed, it reinforces the demeanor representative of a claimant whose subjective complaints are either wholly unfounded by objective medical evidence or overstated, at best.

Based on all of the foregoing, the Arbitrator finds that Petitioner failed to establish by a preponderance of credible evidence that he sustained a compensable injury to the low back at work on April 23, 2012. Thus, all other issues related to the claimed low back condition are rendered moot, and all benefits and compensation related to the claimed low back condition is denied.

In support of the Arbitrator's decision relating to Issue (F), whether the Petitioner's current condition of ill-being is causally related to the injury, the Arbitrator finds the following:

The parties dispute whether Petitioner's claimed low back condition and neck condition are causally related to the accident at work on April 23, 2012. As explained in the accident analysis above, the Arbitrator finds that Petitioner failed to establish that he sustained a compensable low back injury at work and that Petitioner's testimony is not credible and further finds that Petitioner's claimed continued cervical spine condition is not causally related to his injury at work on April 23, 2012 beyond what is indicated by Dr. Zelby in his last Section 12 report dated April 3, 2013. In so concluding, the Arbitrator again finds that Petitioner's testimony is not credible. Moreover, his treating physician, Dr. Gireesan, relied almost exclusively on Petitioner's subjective complaints which are inconsistent with objective medical evidence in making his treatment recommendations and rendering his causation opinions. The Arbitrator assigns little weight to Dr. Gireesan's opinions in light of the record as a whole.

Indeed, Dr. Gireesan acknowledged during his deposition that Petitioner's MRIs revealed mild symptoms and he even amended his findings regarding the location of Petitioner's disc protrusion while reviewing the MRI during the deposition. He also admitted that Petitioner's right paracentral disc protrusion should produce symptoms on the right, not on the left as reported by Petitioner. This admission corroborates Dr. Zelby's review of Petitioner's subjective reports and objective medical evidence as reflected in his Section 12 reports; he also indicated that Petitioner's predominant finding was at C5-6 on the right, which had nothing to do with his left-sided symptoms. Notwithstanding, Dr. Gireesan testified that he administered trigger point injections for Petitioner's reported muscular complaints, which seemed to have resolved, and further recommended cervical epidural injections because they could help Petitioner's subjective complaints despite acknowledging that Petitioner had no neurological deficits. The Arbitrator does not find Dr. Gireesan's causation opinions or recommendations for treatment to be appropriate in light of these admissions and considering the medical evidence—the majority of which resulted in recommended treatment arising from Petitioner's subjectively reported, inconsistent and contradictory pain complaints.

Given this record, the Arbitrator finds the opinions of Respondent's Section 12 examiner, Dr. Zelby, to be persuasive. Dr. Zelby noted that Petitioner's persistent subjective complaints were out of proportion to his objective findings and objective findings noted by Dr. Gireesan; particularly given the amount of treatment Petitioner had already received and the inconsistencies between Petitioner's subjective reports and objective medical evidence. For example, he explained, "Mr. Ortiz described loss of sensation in the entire left upper extremity. There's really no condition, irrespective of cause, that could affect the brain or spinal cord that could result in that kind of neurologic abnormality. There is no anatomic basis for the reported loss of sensory function." Dr. Zelby also noted several inconsistencies between Petitioner's reported symptomatology at the

time of his functional capacity evaluation and his abilities or physical condition on that date. Ultimately, Dr. Zelby opined that Petitioner's injury was a thoracic muscular contusion as well as perhaps a mild cervical strain, which the Arbitrator finds to be persuasive diagnoses based on reliable objective medical evidence when viewing Petitioner's emergency room records, the records of Dr. Plunkett, and the objective medical evidence contained in Dr. Gireesan's records.

Finally, the Arbitrator finds that Petitioner's credibility is further brought into question by additional inconsistencies and contradictions. First, Petitioner's testimony at trial incredibly expounds on the details of his injury adding additional body parts, conditions, and pain complaints that are not corroborated by the medical records. Petitioner did not report any injury to the head to his supervisor or Respondent's owner, emergency room personnel, Dr. Plunkett, or even Dr. Gireesan. The first time that he mentioned any head injury was when he saw Dr. Zelby six months after his accident at which point his medical records already reflected Petitioner's denial of any loss of consciousness, dizziness, head injury, swelling or edema of any kind. Even Dr. Gireesan's records are devoid of a report of falling to the ground on the date of accident, or noting any bruising or lacerations consistent with the type of severe neck—and head, low back, etc.—injury that incrementally increased, but was nonetheless inconsistently reported, as time went on. Second, Petitioner complained of increased weight and high blood pressure at trial, but there is no credible evidence or any medical opinion that Petitioner's increased weight or blood pressure are secondary conditions related to his accident at work. Third, in addition to observing Petitioner at trial, the Arbitrator notes that the surveillance video taken of Petitioner on the date of his last independent medical evaluation is not shocking in and of itself, but it diminishes Petitioner's testimony at trial that he was experiencing a "bad" day with high pain levels when he is filmed walking and getting into and out of a vehicle and turning his head with absolutely no identifiable pain behavior in line with the severe pain reported by Petitioner. In light of the record as a whole, Petitioner's testimony is simply not credible.

Based on all of the foregoing, the Arbitrator finds no credible evidence to support a causal connection finding between Petitioner's claimed continued symptomatology in the neck and his accident at work beyond Dr. Zelby's last Section 12 report and finds that Petitioner failed to establish a causal connection between any claimed current condition of ill being and his work accident on April 23, 2012.

In support of the Arbitrator's decision relating to Issue (J), whether the medical services that were provided to Petitioner were reasonable and necessary, and whether Respondent has paid all appropriate charges for all reasonable and necessary medical services, the Arbitrator finds the following:

As explained above, Petitioner failed to establish a causal connection between any claimed current condition of ill-being and his accident at work on April 23, 2013 beyond that opined by Dr. Zelby in his last Section 12 report dated April 3, 2013. Petitioner claims that Respondent is liable for certain outstanding medical bills from Dr. Gireesan for treatment in 2013 and from ATI for physical therapy from November 2012 through January of 2013. The Arbitrator finds that the bills from ATI were reasonable and necessary, but not those of Dr. Gireesan. Thus, the outstanding medical bills from ATI are awarded pursuant to the Act and Dr. Gireesan's outstanding medical bills from 2013 are denied.

In support of the Arbitrator's decision relating to Issues (K) and (O), Petitioner's entitlement to prospective medical care, the Arbitrator finds the following:

As explained in detail above, Petitioner has failed to establish a causal connection between any claimed current condition of ill being and his work injury. Thus, his claim for prospective medical care is denied.

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In support of the Arbitrator's decision relating to Issues (L), (N) and (O), Petitioner's entitlement to temporary total disability benefits, temporary total disability benefits overpayment and credit, the Arbitrator finds the following:

The parties stipulated that Petitioner is entitled to temporary total disability benefits through September 24, 2012. AX1. Thus, such benefits are awarded. The Arbitrator further awards temporary total disability benefits through December 5, 2012, when Petitioner completed work conditioning in accordance with the opinions rendered by Dr. Zelby that Petitioner reached maximum medical improvement. Thus, Petitioner's claim for temporary total disability benefits after December 5, 2012 is denied. Respondent shall be given a credit of $29,599.80 for temporary total disability benefits that have been paid.

In support of the Arbitrator's decision relating to Issue (M), whether penalties or fees should be imposed upon Respondent, the Arbitrator finds the following:

Given the facts presented in this case, and after considering the parties' motion and response, the Arbitrator finds that Respondent had a reasonable dispute as to whether Petitioner sustained a compensable injury to any body part other than the neck and whether Petitioner's claimed continued condition of ill being in the neck was causally related to his accident at work as alleged. Respondent repeatedly required Petitioner to submit to Section 12 examinations and the record reflects that Petitioner avoided contact with Respondent while residing at one of several residential addresses and receiving mail at two PO box addresses. Respondent's conduct was not unreasonable, vexatious and/or in bad faith. Thus, Petitioner's claim for penalties and fees under Sections 19(k), 19(l) or 16 of the Act is denied.

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Myroslav Ivano ,
Petitioner,

vs. No: 09 WC 50817

14IWCC1016

Excel Builders of Illinois,
AAA Thermal Windows,
Respondents.

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 employment, accident, causal connection, medical expenses, temporary disability and permanent disability, and being advised of the facts and law, vacates the November 13, 2013 Decision of the Arbitrator, which is attached hereto and made a part hereof.

Arbitrator Joann Fratianni found that the date of accident was June 30, 2009 and Respondents were operating under and subject to the Act but an employee-employer relationship did not exist between Petitioner and Respondents. The Arbitrator identifies the Respondents in this case as Zbigniew Tarnowski, individually and d/b/a AAA Thermal Windows, Inc., Excel Builders, Beatrice Spearman, deceased, and the State Treasurer, as ex-officio Custodian of the Injured Workers' Benefit Fund. The Arbitrator found timely notice was provided to Respondents but Petitioner's current condition of ill being is not casually related to the alleged accident. The Arbitrator found in the year preceding the alleged injury, Petitioner earned $0.00. On the date of the alleged accident, Petitioner was 41 years old, married with two dependent children under 18. The Arbitrator further found that Petitioner failed to prove that an accidental injury arose out of and in the course of his alleged employment with Respondents on June 30, 2009.

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After considering the entire record, and for the reasons set forth below, the Commission vacates the June 25, 2013 decision of the Arbitrator.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

The Commission finds:

1. Petitioner filed an Application for Adjustment of Claim listing Respondent as AAA Thermal Windows, Inc., located at 709 S. Lincoln Avenue, Park Ridge, Illinois, on December 11, 2009. Petitioner alleged a date of accident of July 1, 2009, when Petitioner was knocked down by a co-worker who was spooked by a dog, causing injury to the right leg and body.

2. Petitioner filed an Amended Application for Adjustment of Claim on March 24, 2010, amending the Respondents to AAA Thermal Windows, Inc. and Beatrice Spearman. Petitioner listed Beatrice Spearman's address as 735 E. 68th Street, Chicago, Illinois. The remainder of the application concerning injury and accident remained the same as the original filing on December 11, 2009.

3. Petitioner filed a Second Amended Application for Adjustment of Claim on November 5, 2010, this time amending the Respondents to AAA Thermal Windows, Inc., as well as State Treasurer, Ex-Officio Custodian for the IWBF. The remainder of the application concerning accident and injury remained the same as the prior two filings. The Second Amended Application showed proof of service being provided only to AAA Thermal Windows, Inc.

4. A Third Amended Application for Adjustment of Claim was filed on May 24, 2011. This amendment changed the Respondents to Excel Builders of Illinois and AAA Thermal Windows, Inc. Both Excel Builders and AAA Thermal Windows were provided proof of service at 709 S. Lincoln Ave, Park Ridge, Illinois. The remainder of the application concerning accident and injury remained the same as the prior three filings. Neither Ms. Spearman nor the State Treasurer were listed as Respondents in the third and final Amended Application, signed by Petitioner and his attorney.

5. A hearing was held at arbitration on this matter before Arbitrator JoAnn Fratianni in Chicago, Illinois on November 13, 2012.

6. Mr. Zbigniew Tarnowski appeared pro se at hearing on behalf of AAA Thermal Windows, Inc. and Excel Builders of Illinois. Mr. Tarnowski testified at hearing that he thought his business had active workers' compensation insurance coverage on June 30, 2009. Mr. Tarnowski provided a certificate of insurance to Ms. Black, Ms. Spearman's great-niece, dated June 13, 2009, prior to beginning roofing work at 735 E. 68th Street, Chicago, Illinois. Mr. Tarnowski testified that he did not find out that his company's insurance had been cancelled for nonpayment until after Petitioner's injury.

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7. Petitioner's Exhibit 2 is a certified copy of NCCI insurance database findings obtained from the Illinois Workers' Compensation Commission, dated October 27, 2010. The printout shows no findings for AAA Thermal Windows but lists Excell [*sic*] Builders of Illinois, Inc., located at 709 S. Lincoln, Park Ridge, Illinois as a corporation having insurance in the past, but not on the date of Petitioner's injury.

8. The Commission takes judicial notice of the Illinois Secretary of State Corporation/LLC Database reviewed on September 5, 2014 as showing Excel Builders of Illinois, Inc., file number 64419684, as a corporation formed on August 3, 2005. The corporation is shown to be "not good standing" with agent listed as Zbigniew Tarnowski at 709 S. Lincoln, Park Ridge, Illinois.

9. Ms. Jeanette Black testified at arbitration. Ms. Black was Ms. Beatrice Spearman's great-niece. Ms. Black testified that Ms. Spearman lived at 735 E. 68th Street for 52 years and had passed away in January 2011 at the age of 93. Ms. Black testified that she stayed with her great-aunt a lot. Ms. Spearman's sister-in-law also lived at 735 E. 68th Street, which is a four family apartment building. Ms. Black testified that the other two flats in the building had not been occupied for many years prior to Petitioner's accident.

10. Ms. Black testified that she met with Mr. Tarnowski when he came to the property at 735 E. 68th Street on behalf of Excel Builders to bid on a roofing contract in June of 2009. Ms. Black was provided a work proposal by a man named Antoine. The proposal was signed by Antoine Howard on behalf of Excel Builders and accepted by Ms. Black on June 13, 2009. The document is contained in the record as Respondent's Exhibit 3. Neither Ms. Spearman nor Ms. Black provided any tools or supervised any of the work performed. Ms. Black testified Ms. Spearman never met Petitioner.

11. Ms. Black testified that the only dog on the property at 735 E. 68th Street was a Chihuahua that stayed indoors. She did state that a neighbor had a dog contained in a fenced in yard.

12. Petitioner testified by way of a Polish interpreter that he was born February 2, 1968 and was not currently married and had no dependents. On cross-examination, Petitioner clarified that at the time of the July 1, 2009 accident, he did have a wife and two minor sons still living in the Ukraine.

13. Petitioner testified that he met Mr. Tarnowski at a gas station where construction workers congregate to find jobs. Petitioner was hired by Mr. Tarnowski in June 2009 and performed various duties for him, including tuck-pointing and other roofing duties at various jobsites.

14. Petitioner testified Mr. Tarnowski paid Petitioner $12.00 an hour and he usually worked 8-10 hours per day, on a temporary basis, whenever work was available. Petitioner testified that on average, he worked three days a week for Mr. Tarnowski. Petitioner was paid once by check and the remainder of his pay was in cash and paid out.

15. Petitioner testified that all supplies were provided by Mr. Tarnowski and Mr. Tarnowski told Petitioner where to report to work and what duties to perform. Petitioner testified that he never met Ms. Spearman and did not know the property owner at 735 W. 68th Street.

16. Petitioner testified he did not know the exact date of the accident but that it would be listed in the hospital records. (T42). Petitioner testified that on the day of the accident, he arrived at 735 W. 68th Street in Chicago with Mr. Tarnowski and other co-workers to remove a roof. Earlier that same day, Petitioner had been working at another job site with the co-workers and Mr. Tarnowski.

17. As Petitioner, Mr. Tarnowski and other workers were walking in the yard at 735 W. 68th Street to set up machines on the property, Petitioner testified "I slipped and broke my leg, you know. Somebody pushed me...because he was frightened, scared, that coworker." (T20). Petitioner testified that he did not know what caused the co-worker to become scared. Petitioner did not hear a dog bark. Petitioner testified that he fell on the sidewalk, and Mr. Tarnowski called an ambulance.

18. Petitioner was taken to University of Chicago Hospital by ambulance on June 30, 2009. Via a Polish interpreter, it was documented in the record that Petitioner was a 41 year old previously healthy male who fell at work today. It was noted "they" got frightened by a dog barking in the vicinity and started running at which time Petitioner tripped and fell on his leg. Petitioner was diagnosed with right tibial shaft fracture in the mid to distal tibia, as well as a fracture of the lateral malleolus.

19. Petitioner underwent a closed reduction, intramedullary fixation of the right tibia fracture, and open reduction internal fixation of the lateral malleolus on July 1, 2009. He remained in the hospital for several days afterwards.

20. Petitioner was discharged from the University of Chicago Hospital on July 6, 2009. At the time of discharge his right leg was in a cast and he was provided discharge instructions written in English and Russian. There is no evidence in the record Petitioner can read English or Russian. He was also provided a Polish interpreter over the phone at discharge. The discharge instructions stated it was recommended that Petitioner follow up with Dr. Ho's clinic in two weeks. Petitioner was given pain medication, as well as a prescription for stool softeners, and he was advised to be strict non-weightbearing on his lower extremities.

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21. Petitioner testified that after being discharged from the hospital he was able to ambulate with crutches and his right leg was in a cast. Petitioner testified his leg was casted for about a month, and he was on crutches for six months.

22. Petitioner presented to the University of Chicago Emergency Department on August 28, 2009 for suture removal in the right leg. The medical record notes that Petitioner was supposed to follow-up at a clinic after being discharged from the hospital in early July. Through an interpreter, Petitioner stated that he asked his boss to take him to the hospital for follow-up care, but he never did. Petitioner had 20 deeply imbedded sutures removed and was treated for obvious fungal dermatitis with erythema and swelling.

23. Petitioner was advised on discharge from the emergency room on August 28, 2009, to follow up with Dr. Ho for further care. Those instructions were also given to a family member of Petitioner per the medical record. Dr. Ho's records are not in evidence.

24. A medical bill is in evidence, as Petitioner's Exhibit 6, for treatment at the University of Chicago Hospital in the amount of $4,779.68.

25. Petitioner testified that after the cast came off, he still had pain with any movement. His leg was discolored and he experienced cramping pain while sleeping. He continued to use crutches for about six months post surgery and then he used a cane to help him walk for another six months.

26. Petitioner testified that he did not work for approximately a year after the accident.

27. The next treatment record in evidence is an office visit on January 25, 2012 with Dr. Pietz. At that time, it was noted through an interpreter that Petitioner had suffered gradually worsening right lower extremity pain for the past three years. Petitioner presented in order to determine if he needed further medical care or if he was able to return to work. Petitioner complained of radiating pain from the area of surgery and weakness in his right leg and foot. Dr. Pietz diagnosed Petitioner with right limb pain, mild edema to the right lower extremity and tenosynovitis. It was recommended that Petitioner receive further medical evaluation and possible treatment at University of Chicago Orthopedics. Dr. Pietz recommended desk type work due to the limb pain and weakness that would not require heavy lifting, pushing, stooping, pushing or walking or standing for long periods. Dr. Pietz advised Petitioner to return to the office for further treatment PRN for follow-up of limb pain. A medical bill is in evidence as Petitioner's Exhibit 7 for treatment this date in the amount of $125.00.

28. Petitioner testified he has not been able to seek any further medical care for financial reasons.

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29. Petitioner testified that he did receive $5,000.00 from Mr. Tarnowski in February of 2010. Petitioner testified he cannot read English but signed papers at an attorney's office chosen by Mr. Tarnowski when he accepted the $5,000.00. The signed document regarding the $5,000.00 payment is not in evidence. Mr. Tarnowski did not testify regarding the payment.

30. Petitioner testified that he worked for a period after the accident, but not for Respondent. Petitioner testified that about a year after the accident, he started performing cleaning work 3-4 times a month for $50.00 per day. It is unclear from the record if Petitioner still performs any cleaning work or how long the cleaning work lasted.

31. Petitioner testified that his right leg is black and cramps. The Arbitrator noted after viewing at hearing that there was a color difference between Petitioner's right and left legs, with the right looking redder when compared to the left. Petitioner testified that he experiences cramping both in the day and night, worse with activity. Petitioner has difficulty sleeping due to the pain, and he experiences more pain with rainy weather. Petitioner did not experience any of these symptoms in his right leg prior to the work accident. He currently takes Tylenol or Motrin for pain.

32. The Arbitrator did not read the parties pre-trial stipulations into the record, and the handwriting on the Request for Hearing submitted as Arbitrator's Exhibit 1 is extremely difficult to decipher. The Request for Hearing appears to list a date of accident of "6/4/01; Respondent disputes. Respondent also disputes Petitioner sustained accidental injuries that arose out of and in the course of employment, that timely notice of the accident was given or that Petitioner's current condition of ill being is causally connected to the injury. Petitioner stated that his average weekly wage was $800.00 a week and that he was single with no dependents at the time of injury; Respondent disputes. Petitioner's claim for unpaid medical bills is illegible and Respondent disputes. Respondent claims no credit under Section 8(j) of the Act. Petitioner claims to be entitled to temporary total disability for the period July 1, 2009 through August 19, 2012 and Respondent disputes. Respondent claims Mr. Tarnowski paid to Petitioner $5000.00 toward TTD; Petitioner did not agree or dispute. The parties agree the nature and extent of the injury is in dispute. The Commission notes no one offered an explanation as to which Respondent was offering the stipulations contained on the Request for Hearing. For purposes of this review, the Commission presumes that all participants presuming to be Respondents who appeared at hearing join in disputing Petitioner's stipulations.

An Arbitration Decision on this case was filed with the Illinois Workers' Compensation Commission on June 25, 2013. The Arbitrator's decision denotes the Employer/Respondent as "Zbigniew Tarnowski Indv & D/B/A AAA Thermal Windows Inc Excel Builders Beatrice Spearman Deceased & the State Treasurer as Ex-Officio Custodian of the Injured Workers Benefit Fund." The Arbitrator found that on June 30, 2009, Respondents were operating under and subject to the provisions of the Act. On this date, an employee-employer relationship did not exist between Petitioner and Respondents, Petitioner did not sustain an accident that arose out of and the course of employment and Petitioner's current condition of ill-being is not causally

related to the alleged accident. The Arbitrator did find that timely notice was given to Respondent and Petitioner was 41 years old, married, with two dependent children at the time of the alleged accident. The Arbitrator found that Petitioner's average weekly wage was $0.00 and he earned $0.00 in the year preceding the alleged injury. No credit was given for benefits or for any payment toward TTD. The Arbitrator entered an order finding that Petitioner failed to prove that an accidental injury arose out of and in the course of his alleged employment with Respondents on June 30, 2009.

A timely Petition for Review was filed by Petitioner on July 3, 2014. Petitioner took exception with the issues of employment, accident, medical expenses, causal connection, temporary disability, and permanent disability.

Were Respondents Operating Under and Subject to the Illinois Workers' Compensation Act?

The Arbitration Decision denotes the Employer/Respondent as "Zbigniew Tarnowski Indv & D/B/A AAA Thermal Windows Inc Excel Builders Beatrice Spearman Deceased & the State Treasurer as Ex-Officio Custodian of the Injured Workers Benefit Fund." However, the only named Respondents in this matter, pursuant to the Third Amended Application for Adjustment of Claim, are Excel Builders of Illinois and AAA Thermal Windows, Inc. Neither Ms. Spearman nor the State Treasurer were named as Respondents in the final Amended Application for Adjustment of Claim. The proof of service for the third amended complaint only listed Excel Builders and AAA Thermal Windows, both located at 709 S. Lincoln Avenue, Park Ridge, Illinois.

The Arbitrator, in addition to naming Beatrice Spearman and the State Treasurer, also named as a Respondent Zbigniew Tarnowski, individually and d/b/a AAA Thermal Windows, Inc. The NCCI database, as certified by the Illinois Workers' Compensation Commission on October 27, 2010, showed no record of any business with a similar name to AAA Thermal Windows, Inc. NCCI did however have record of all businesses showing insurance at 709 S. Lincoln, Park Ridge, Illinois. Several prior policies for the insured name of Excell Builders of Illinois, Inc. were found. Mr. Tarnowski testified at hearing on November 13, 2012. He appeared pro se and did not, at any time on record, specify the relationship between himself, AAA Thermal Windows and Excel Builders. Mr. Tarnowski was asked by Petitioner's counsel "Q: Mr. Tarnowski, to your knowledge, do you personally, Excel Builders or Triple A Thermal Windows carry Workers' Compensation Insurance as of June 30, 2009? A: I thought I did have, yes...Later on, I found out that I did not have insurance at the time during the accident..." No further questions were asked by Petitioner's counsel of Mr. Tarnowski.

Counsel appearing for Ms. Spearman entered Resondent's Exhibit 2, a proposal dated June 7, 2009 by Excel Builders directed to Jeanette Black, for roof repairs at 735 E. 68th Street. Antoine Howard, on behalf of Excel Builders, signed the proposal and Ms. Black accepted the contract on June 13, 2009. A Certificate of Workers' Compensation and Liability Insurance dated June 13, 2009 for a roofing job at 735 E. 68th, provided to Janet [*sic*] Black by Excel Builders of Illinois, 709 S. Lincoln, Park Ridge, Illinois, was also entered into evidence as

Respondent's Exhibit 3. Ms. Black testified at hearing that Excel Builders provided a proposal for repair of the roof at 735 E. 68th Street. She testified a man named Antoine gave her the bid on behalf of Excel Builders and then Ms. Black also met with Mr. Tarnowski on behalf of Excel Builders.

The Commission notes the Illinois Secretary of State shows Excel Builders of Illinois is an active Illinois corporation, incorporated on August 3, 2005. Zbigniew Tarnowski is listed as the agent of the Corporation with an address at 709 S. Lincoln, Park Ridge, Illinois. The president of Excel Builders is Janina Tarnowski. The Commission finds no evidence in the record to conclude Mr. Tarnowski performed any actions as related to the Petitioner or work to be performed at 735 E. 68th Street that would be outside the duties of an agent of the corporation. Excel Builders is not a fictitious name or misnomer of Mr. Tarnowski. The law is well established that the Commission lacks authority to pierce the corporate veil. See JMH Props. v. Indus. Comm'n (May),332 Ill. App. 3d 831,773 N.E.2d 736, 266 Ill. Dec. 1(4th Dist. 2002); Max Shepard, Inc. v. Indus. Comm'n (Creinin),348 Ill. App. 3d 893, 810 N.E.2d 54, 284 Ill. Dec. 401(1st Dist. 2004). Further, Mr. Tarnowski is not a named Respondent on the Third Amended Application for Adjustment of Claim and therefore, all issues concerning Mr. Tarnowski individually are moot and an award cannot be entered against him.

Excel Builders of Illinois, Inc. entered into a contract to perform construction work at 735 E. 68th Street and, in fulfilling that contract, hired Petitioner to perform roofing and construction work at that address. After review of the record as a whole, the Commission finds Respondent Excel Builders of Illinois, Inc. was a Respondent operating under and subject to the Illinois Workers' Compensation Act.

The Commission finds no evidence in the record of AAA Thermal Windows or anyone doing business as AAA Thermal Windows providing a bid, signing any paperwork, performing services or otherwise doing any business or holding themselves out to do business under such a name. Petitioner did not testify he performed work for AAA Thermal Windows and the work to be performed at 735 E. 68th Street was contracted with Excel Builders. The Commission finds the evidence in the record does not support a finding that Respondent AAA Thermal Windows was operating under and subject to the Illinois Workers' Compensation Act.

The Commission finds Ms. Beatrice Spearman, deceased, was not a named Respondent in the Third Amended Application of Adjustment of Claim and therefore, all issues concerning Ms. Spearman are moot and an award cannot be entered against her or her estate. However, had Ms. Spearman been a properly named Respondent, based on the evidence in the record, the Commission would find Ms. Spearman was not operating under and subject to the Illinois Workers' Compensation Act on June 30, 2009, as she did not supervise the work performed by Excel Builders or Petitioner, she did not provide any tools or materials, the roof to be repaired was for her personal residence, she never met Petitioner, she did not sign the contract for services with Excel Builders, and she was not involved in any type of business enumerated in Section 3 of the Act.

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The Commission further finds that the State Treasurer, as ex-officio custodian of the Injured Workers' Benefit Fund, was not a named respondent in the Third Amended Application of Adjustment of Claim and therefore, the Commission makes no findings concerning the Injured Workers' Benefit Fund or the State Treasurer, as ex-officio custodian. All issues concerning the State Treasurer, as ex-officio custodian of the IWBF are moot.

Was there an employee-employer relationship?

An "employer" is any person or corporation that has any person in its employment and has either elected to become subject to the Act or is engaged in any activities as declared by the Act to be extrahazardous. 820 ILCS 305/1. Section 3 of the Act provides that the Act shall apply automatically to anyone engaging in any business or enterprise involving the erecting, maintaining, removing, remodeling, altering, or demolishing of any structure or in construction work, among other businesses.

The Commission finds Respondent Excel Builders is an employer delineated under Section 3 of the Act as the evidence in the record shows its business is to remove and replace roofing materials and perform construction work.

Based on the evidence in the record, including Mr. Tarnowski's and Petitioner's testimony regarding employment, provisions of tools, and payment for services, Petitioner clearly falls under Section 1(b)2 of the Act as an employee of Excel Builders.

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

Having determined that the Respondent Excel Builders and Petitioner were operating under and subject to the provisions of the Act, and that there was a relationship of employee-employer at the time of the accident, the Commission now determines whether the accident arose out of and in the course of employment.

An injury is accidental within the meaning of the Act when it is traceable to a definite time, place and cause and occurs in the course of the employment unexpectedly and without affirmative act or design of the employee and arises out of a risk connected with or incidental to the employment, so that there is a causal connection between the employment and the accidental injury.

Petitioner testified that he arrived at 735 W. 68th Street in Chicago, Illinois with Mr. Tarnowski and other co-workers on the date of accident to remove the roof from the building. Petitioner had worked another jobsite earlier that morning with the same people. Petitioner testified that he, Mr. Tarnowski, and the other workers were walking on the property at 735 W. 68th Street to set up their machines when he was pushed by one of his co-workers who was frightened. Petitioner testified he fell on the sidewalk and injured his leg. Mr. Tarnowski called an ambulance, and Petitioner was transported from the scene to the University of Chicago Hospital.

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The University of Chicago Hospital Emergency Room record from June 30, 2009 states that Petitioner arrived via ambulance, and the history of injury was obtained through an interpreter. The history notes that Petitioner was a previously healthy 41 year old man who fell at work that day. The record noted that a dog barking frightened "them", and Petitioner tripped and fell on his leg and suffered injury. Petitioner testified he did not know what caused his co-worker to become frightened.

The Commission finds the Petitioner's testimony credible. Petitioner testified through a Polish interpreter. The interpreter stated on the record that she was having trouble understanding Petitioner because he was so nervous. The hospital record is clear regarding the mechanism of injury. Mr. Tarnowski called an ambulance from the scene. The Commission finds Petitioner proved by a preponderance of the credible evidence that he sustained an accident that arose out of and in the course of his employment with Respondent Excel Builders.

What was the date of accident?

The Arbitrator found the date of accident to be June 30, 2009. The Request for Hearing is illegible regarding the alleged date of accident and was not read into the record. While the Application for Adjustment of Claim and each of the amended applications lists a date of accident one day later, July 1, 2009, the medical evidence is clear that Petitioner presented to the University of Chicago Hospital emergency department, by way of ambulance, on June 30, 2009 after a fall at work that day with injury to his right lower extremity. The medical treatment record presents the most credible evidence regarding the accident date. Petitioner testified that he did not know the exact date of the accident, but that it would be on the hospital records (T42). Petitioner merely agreed with his attorney that the date of accident was July 1, 2009 and when asked by the attorney for Ms. Spearman if the accident occurred on July 2, 2009, Petitioner stated that the date would be listed on the hospital records.

The Commission corrects the date of accident to conform to the evidence and finds the accident date to be June 30, 2009.

Was timely notice of the accident given to Respondents?

Petitioner was taken by way of ambulance from the worksite after the injury on June 30, 2009. Petitioner testified that Mr. Tarnowski called the ambulance and was witness to the accident. Mr. Tarnowski did not testify contrary to Petitioner regarding notice of the accident. For the foregoing reasons, the Commission finds timely notice was given Respondent Excel Builders of Illinois.

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

The Commission finds Petitioner credible after review of the record. Petitioner testified that he never had any prior injury to his right leg and his right leg was in good condition before the accident. No prior treatment records are in evidence. Petitioner was taken by ambulance to the hospital immediately after the accident on June 30, 2009 and remained in the hospital for a

week. He suffered right distal tibia-fibula fractures and underwent a closed reduction, intramedullary fixation of the right tibia fracture and open reduction internal fixation of the lateral malleolus. When Petitioner was discharged on July 6, 2009 he was still in a cast, he still had sutures in his leg, and he was only able to ambulate with crutches. Petitioner was advised to follow-up with Dr. Ho at his clinic in two weeks. Petitioner was provided his written discharge instructions in English and in Polish over the phone by an interpreter. Petitioner testified he cannot read English.

After his release from the hospital, the medical records in evidence show that he returned to the University of Chicago Emergency Room on August 28, 2009, almost two months after discharge, for suture removal. The Petitioner was noted in the record, through an interpreter, as stating he kept asking his boss to take him to the hospital for follow-up, but the boss never did. The August 28, 2009 record notes Petitioner's sutures were deeply imbedded, and he had obvious fungal dermatitis with erythema and swelling. Petitioner was advised to follow up with Dr. Ho.

Dr. Ho's clinic records, if any exist, are not in evidence. Petitioner testified that after the cast was removed in August 2009, he still had pain in his right leg with any movement and he experienced cramping with sleep and required assistive devices to ambulate.

The next treatment record in evidence is January 25, 2012 when Petitioner presented to Dr. Pietz with a three year history of right lower extremity pain that had been worsening. The January 25, 2012 record does not note Petitioner to be working or having suffered any intervening accidents. Petitioner was diagnosed with right limb pain, mild edema to the right lower extremity and tenosynovitis. Dr. Pietz recommended Petitioner seek further evaluation of his complaints at University of Chicago Orthopedics and limit work to desk-type jobs.

Petitioner testified that since the accident, he has not returned to work for Respondent. About a year after the accident however, he did start performing some cleaning work three to four times a month. Petitioner testified that he experiences cramping and pain in the right leg that is worse with activity and he has difficulty sleeping due to pain. He continues to take Tylenol or Motrin for his complaints, and he has a visible color difference between his left and right legs as viewed and noted by the Arbitrator. Petitioner testified he has been unable to obtain further medical care due to financial constraints.

When reviewing the record as a whole, including the Petitioner's unrebutted testimony and the treating medical records, the Commission finds Petitioner has proven by a preponderance of the medical evidence that his current condition of ill-being, with regard to his right lower extremity is causally related to the June 30, 2009 accident.

What were Petitioner's earnings?

Petitioner testified that he was hired by Mr. Tarnowski and began working for Excel Builders in June of 2009. He regularly worked three days a week for Respondent, 8-10 hours per day. He was paid daily and in cash on all but one occasion. Petitioner testified he was paid $12.00 an hour. Petitioner's testimony regarding his wages is unrebutted and there is no documentary evidence in the record regarding wages.

Petitioner stipulated on the Request for Hearing form at arbitration that his average weekly wage was $800.00. Respondent disputed the wage calculation but did not provide an alternative calculation. The Arbitrator, in her findings of fact and conclusions of law, found the Petitioner's average weekly wage to be $360.00. The benefit rate was not disputed on the Petition for Review and no arguments regarding benefit rate were made in the parties Statements of Exception and Briefs on Review.

The Commission finds in the year preceding the alleged injury, Petitioner earned an average weekly wage of $360.00.

What was Petitioner's age at the time of the accident? What was Petitioner's marital status at the time of the accident?

The Commission finds on the date of accident, Petitioner was 41 years of age, married with two dependent children under 18.

Were 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 was transported by ambulance to the Emergency Department at the University of Chicago Hospital immediately after the accident and remained there through discharge on July 6, 2009. During his inpatient stay, Petitioner underwent surgery for right distal tibia-fibula fractures. There is no evidence in the record that the treatment he received was not reasonable and necessary. The next medical record in evidence is emergency department care on August 28, 2009 for suture removal and fungal dermatitis on the right leg. There is no evidence that the treatment rendered this date was not reasonable and necessary, and the Commission finds it related to the June 30, 2009 accident. The final treatment record in evidence is the office visit of Dr. Pietz on January 25, 2012 for right lower extremity pain stemming back three years from a fall at work. There is no evidence in the record that this treatment was not reasonable or necessary, and the Commission finds it related to the June 30, 2009 accident.

The Commission finds Petitioner has received all reasonable and necessary medical services. The medical expenses in evidence total $4,904.68 and are contained in Petitioner's Exhibits 6 and 7. Petitioner incurred a bill in the amount of $4,779.68 for treatment at the University of Chicago and $125.00 for treatment with Dr. Pietz related to the June 30, 2009 accident.

The Commission finds Respondent shall pay to Petitioner $4,904.68 for medical expenses incurred pursuant to Section 8(a) and 8.2 of the Act. There is no evidence in the record of any credit due Respondent under Section 8(j) of the Act.

What temporary benefits are in dispute?

Petitioner stipulated on the Request for Hearing that he was temporarily totally disabled from July 1, 2009 through September 19, 2012. The only dispute by Respondent regarding temporary disability was toward liability.

Dr. Pietz provided an opinion regarding Petitioner's ability to work in his January 25, 2012 office note. Dr. Pietz opined that Petitioner was only able to work light duty due to his right limb pain and weakness and he was not to perform any heavy lifting, pushing, stooping or pushing or walk or stand for long periods.

Petitioner's unrebutted testimony is that he never returned to work for Respondent after the June 30, 2009 accident and did not work for about a year after the accident. After that period of time, Petitioner testified that he was able to find work for a short period cleaning for $50.00 a day about three to four days a month. The period of time Petitioner earned this income was never specified. There is no further testimony or documentation in the record regarding this income.

The Commission finds Respondent shall pay Petitioner temporary total disability benefits of $299.67/week for 168 weeks for the period July 1, 2009 through September 19, 2012, as provided in Section 8(b) of the Act.

What is the nature and extent of the injury?

Petitioner suffered a right tibia and fibula fracture on June 30, 2009 and underwent a closed reduction and intermedullary fixation of the tibia fracture and open reduction and internal fixation of the lateral malleolus fracture on July 2, 2009. Petitioner was inpatient at University of Chicago Hospital from June 30, 2009 through July 6, 2009. He was unable to be full weightbearing after discharge and required follow up care for removal of casting and sutures. Petitioner was unable to find transportation and a translator to accompany him for follow-up care until August 28, 2009, at which time he presented to the University of Chicago ER. At that time, x-ray images showed postsurgical changes with fracture fragments in near anatomic alignment and no evidence of hardware complications. At discharge, Petitioner was instructed to follow-up with Dr. Ho and use Nystatin powder for the fungal dermatitis. There is no evidence in the record that Petitioner presented to Dr. Ho or any other physician for treatment until January 25, 2012.

Petitioner presented to Dr. Pietz on January 25, 2012 and stated he had experienced right lower extremity pain since the accident that had been worsening over time. He complained of radiating pain from the area of surgery on his right leg and weakness in his right leg and foot. He was diagnosed with right limb pain, mild edema and tenosynovitis and given work restrictions. It was recommended Petitioner present to University of Chicago Orthopedics for any further

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recommendations regarding his care. No further medical opinions regarding Petitioners work injury or ability to work are contained in the record. Petitioner testified that he requires further treatment that he is financially unable to obtain.

Petitioner testified at hearing that his right leg continues to cramp and is discolored as compared to the left. He has difficulty sleeping and increased pain with rain and activity. He takes Tylenol or Motrin for the pain but the amount and frequency was not stated in the record.

Petitioner testified that he did not work for approximately one year after the June 30, 2009 accident and that he only found temporary employment cleaning for a short time. Dr. Pietz opined on January 25, 2012 that Petitioner required light duty work restrictions. There is no evidence in the record that Petitioner has attempted to find work within those restrictions. At the time of accident, Petitioner was 41 years of age. There is no evidence in the record regarding Petitioner's earning capacity or his occupation other than working as a day laborer for Respondent.

Given the evidence in the record, the Commission finds the accident of June 30, 2009 caused Petitioner to sustain permanent partial disability to the right leg. Respondent shall pay to Petitioner permanent partial disability benefits of $299.67/week for 86 weeks, because the injuries sustained caused the 40% loss of the right leg, as provided in Section 8(e) of the Act.

Is Respondent due any credit?

Petitioner testified that Respondent Excel Builders paid to him an amount of $5,000.00 in February 2010. Petitioner went to an attorney's office, chosen by Mr. Tarnowski, and accepted the money and signed a document. Petitioner testified the document was written in English and he does not read English and does not know exactly what it said. The document was not admitted into evidence at arbitration. Mr. Tarnowski did not testify regarding the $5,000.00 or the reasoning behind the payment. The Request for Hearing denotes Mr. Tarnowski paid $5000.00 toward TTD benefits but Petitioner neither agreed nor disputed the statement and the Respondent's stipulation was not read into the record. No further evidence is contained in the record regarding this payment or whether it served as an advance against any benefits that might be due Petitioner in this matter. The Commission finds there is insufficient evidence in the record to find the February 2010 payment in the amount of $5,000.00 constituted a payment toward any benefit for which Respondent is due credit.

There is no evidence in the record that any other amounts have been paid by Respondent for which it is due a credit. Respondent is not awarded any credit under the Act.

Did Petitioner engage in unsanitary or injurious practices pursuant to Section 19(d) of the Act?

Section 19(d) of the Act states "If any employee shall persist in insanitary or injurious practices which tend to either imperil or retard his recovery or shall refuse to submit to such medical, surgical, or hospital treatment as is reasonably essential to promote his recovery, the

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Commission may, in its discretion, reduce or suspend the compensation of any such injured employee."

The medical evidence in the record shows Petitioner was discharged from the University of Chicago Hospital on July 6, 2009 and provided discharge instructions including recommendations for follow-up treatment in two weeks with Dr. Ho. The discharge instructions were provided in English and Russian. Petitioner testified he does not read English and there is no evidence in the record whether he is able to read Russian. Prior to discharge, Petitioner was able to speak with a Polish interpreter over the phone.

Petitioner did not present himself for follow-up care until August 28, 2009, at which time he was suffering from severely impacted sutures and obvious fungal dermatitis. The history in the record on August 28, 2009 states Petitioner had asked his boss to take him to the hospital for follow-up care on several occasions but he never did. Petitioner's discharge instructions were provided to a family member that day as Petitioner does not speak English and required a translator. It is unclear from the record whether Petitioner followed-up with Dr. Ho or any other medical providers after August 28, 2009 as instructed by the University of Chicago Hospital. The next and final medical record in evidence is that of Dr. Pietz on January 25, 2012 to determine if Petitioner was able to return to work or needed further medical care for right limb pain and tenosynovitis.

Given Petitioner's language barrier, the medical record of August 28, 2009 stating that Respondent was to take Petitioner for follow-up care but failed to do so, and Petitioner's testimony regarding his financial constraints, the Commission declines to find Petitioner engaged in unsanitary or injurious practices that would reduce or suspend any compensation under the Act.

After considering the entire record and for the foregoing reasons, the Commission finds that on June 30, 2009, Respondent Excel Builders of Illinois, Inc. was operating under and subject to the provisions of the Act and an employee-employer relationship did exist between Petitioner and Respondent. Respondent AAA Thermal Windows was not operating under and subject to the provisions of the Act. No other Respondents are named in this case. Petitioner did sustain an accident on June 30, 2009 that arose out of and in the course of employment and timely notice of the accident was given to Respondent. Petitioner's current condition of ill-being is causally related to the accident. In the year preceding the injury, Petitioner earned an average weekly wage of $360.00 and on the date of accident he was 41 years of age, married with two dependent children. The Commission further finds Petitioner has received all reasonable and necessary medical services and Respondent has not paid all reasonable and necessary charges for all reasonable and necessary medical services. Respondent is not entitled to any credit for benefits.

IT IS THEREFORE ORDERED BY THE COMMISSION that the June 25, 2013 Decision of the Arbitrator is vacated.

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IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $299.67 per week for a period of 168 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 reasonable and necessary medical expenses of $4,904.68, as provided in Sections 8(a) and 8.2 of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay Petitioner permanent partial disability benefits of $299.67 per week for 86 weeks, because the injuries sustained caused the 40% loss of the right leg, as provided in Section 8(e) of the Act.

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 Respondent shall have credit for all amounts paid, if any, to or on behalf of Petitioner on account of said accidental injuries.

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: NOV 24 2014

Daniel R. Donohoo

Charles J. DeVriendt

Ruth W. White

o-09/10/14
drd/adc
68

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

IVANO, MYROSLAV
Employee/Petitioner

Case# **09WC050817**

ZBIGNIEW TARNOWSKI INDV & D/B/A AAA THERMAL WINDOWS INC EXCEL BUILDERS BEATRICE SPEARMAN DECEASED & THE STATE TREASURER AS EX-OFFICIO CUSTODIAN OF THE INJURED WORKERS BENEFIT FUND
Employer/Respondent

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On 6/25/2013, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

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

0293 KATZ FRIEDMAN EAGLE ET AL
DAVID BARISH
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CHICAGO, IL 60602

5031 ASSISTANT ATTORNEY GENERAL
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AAA THERMAL WINDOWS INC
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FBIGNIEW TARNOVSKI D/B/A
EXCEL BUILDERS OF ILLINOIS
709 S LINCOLN AVE
PARK RIDGE, IL 60068

0817 CONDON & COOK LLC
DANIEL WOODS
745 N DEARBORN ST
CHICAGO, IL 60654

STATE OF ILLINOIS)
)SS.
COUNTY OF COOK)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

MYROSLAV IVANO,
Employee/Petitioner

v.

ZBIGNIEW TARNOWSKI, Individually and d/b/a AAA THERMAL WINDOWS, INC., EXCEL BUILDERS, BEATRICE SPEARMAN, Deceased, and THE STATE TREASURER, as Ex-Officio Custodian of THE INJURED WORKERS BENEFIT FUND,
Employer/Respondent

Case # 09 WC 50817

Consolidated cases: NONE.

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An *Application for Adjustment 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 **Chicago**, on **November 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. ☒ Were Respondents operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☒ Was there an employee-employer relationship?
C. ☒ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondents?
D. ☒ What was the date of the accident?
E. ☒ Was timely notice of the accident given to Respondents?
F. ☒ Is Petitioner's current condition of ill-being causally related to the injury?
G. ☒ What were Petitioner's earnings?
H. ☒ What was Petitioner's age at the time of the accident?
I. ☒ What was Petitioner's marital status at the time of the accident?
J. ☒ Were the medical services that were provided to Petitioner reasonable and necessary? Have Respondents 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 Respondents?
N. ☒ Are Respondents due any credit?
O. ☒ Other: Did Petitioner Engage in Unsanitary or Injurious Practices Pursuant to Section 19(d) of the Act?

FINDINGS

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On **June 30, 2009**, Respondents *were* operating under and subject to the provisions of the Act.

On this date, an employee-employer relationship *did not* exist between Petitioner and Respondents.

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 Respondents.

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

In the year preceding the alleged injury, Petitioner earned **$ 0.00**; the average weekly wage was **$ 0.00**.

On the date of the alleged accident, Petitioner was **41** years of age, *married* with **2** dependent children under 18.

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

Respondents *have not* paid all appropriate charges for all reasonable and necessary medical services.

Respondents 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**.

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

ORDER

The Arbitrator finds that Petitioner failed to prove that an accidental injury arose out of and in the course of his alleged employment with Respondents on June 30, 2009.

The Illinois State Treasurer, ex-officio custodian of the Injured Workers' Benefit Fund, was named as a co-respondent in this matter. The Treasurer was represented by the Illinois Attorney General. **No award is hereby entered against the Fund to the extent permitted and allowed under Section 4(d) of this Act. No award is hereby entered against any Respondent, and no benefits are due Petitioner in this case.** Normally, if a Respondent employer fails to pay any awarded benefits, the Injured Workers' Benefit Fund has the right to recover the benefits paid due and owing the Petitioner pursuant to Section 5(b) and 4(d) of this Act. **As no such benefits are awarded, there is no such right of recovery by the fund. As there are no benefits awarded, the Respondent/Employer/Owner/Officer need not reimburse the Injured Workers' Benefit Fund for any compensation obligations of Respondent/Employer/Owner/Officer that are paid to the Petitioner from the Injured Workers' Benefit Fund.** The parties have stipulated that the Fund has paid no compensation to Petitioner in this case.

All claims for compensation in this matter as made by Petitioner 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

June 21, 2013
Date

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JUN 25 2013

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A. Were Respondents operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?

Petitioner and Respondent, Mr. Zbigniew Tarnowski testified that Mr. Tarnowski was in the roofing business.

Ms. Jeanette Black testified on behalf of Respondent, Beatrice Spearman, deceased. Ms. Black testified that Ms. Spearman was her aunt, and owned the property at 735 East 68th Street, Chicago, Illinois, at the time the roofing contract was entered into. Ms. Black testified the property contained four rental units, or an apartment building. Ms. Black testified she signed a proposal with Respondent Excel Builders on June 7, 2009, to repair the roof on the apartment building owned by her aunt, Ms. Spearman. Ms. Black further testified she did not supervise the work nor did she supply any materials or tools. No testimony was elicited that Ms. Spearman was involved in any type of roofing business. Ms. Black further testified that Ms. Spearman never met Petitioner.

Respondent AAA Thermal Windows was also owned by Respondent Tarnowski.

Based upon the above, the Arbitrator finds that Respondents Zbigniew Tarnowski, Excel Builders and AAA Thermal Windows, were operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act on June 30, 2009.

Based further upon the above, the Arbitrator finds that Respondent Beatrice Spearman, deceased, was not operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act on June 30, 2009.

B. Was there an employee-employer relationship?

Petitioner testified that two weeks prior to June 30, 2009, he was hired by Respondent Zbigniew Tarnowski to complete various jobs, including work on a roof of a building located at 735 East 68th Street, Chicago, Illinois. Petitioner testified that all supplies used were provided by Mr. Tarnowski. Petitioner further testified that he worked temporarily for Mr. Tarnowski two weeks prior to the alleged date of injury, June 30, 2009.

Petitioner testified that he never knew, nor could he identify the property owner, Respondent Beatrice Spearman. Ms. Jeanette Black testified that her aunt, Respondent Beatrice Spearman, had lived in the property building for 52 years. Ms. Black testified the property had four separate rental units, two of which had not been occupied in years.

Petitioner never testified that he performed any work for Respondent AAA Thermal Windows. Mr. Tarnowski testified that he thought he had Workers' Compensation insurance on the date of the alleged accident, June 30, 2009, and had presented the homeowner, Ms. Spearman, a certificate of liability insurance dated June 13, 2009. Mr. Tarnowski testified that he later learned the policy of insurance had been cancelled.

Based upon the above, the Arbitrator finds that on June 30, 2009, an employer and employee relationship existed between Petitioner and Respondents Zbigniew Tarnowski and Excel Builders.

Based further upon the above, the Arbitrator further finds that Petitioner failed to prove that an employer and employee relationship existed between Petitioner and Respondent Beatrice Spearman.

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

D. What was the date of accident?

Petitioner testified he was pushed by a coworker who was frightened. This caused him to trip and break his right leg on June 30, 2009. Petitioner testified that he landed on the sidewalk. Petitioner testified that at time of this incident, he had just arrived at the jobsite and had not begun to set up for the job on that date.

Following this incident, Petitioner was transported by ambulance to the emergency room of the University of Chicago Hospital. A history of injury was recorded at the hospital that Petitioner was scared by barking dogs when he started running, during which he tripped and fell. (Px3) The records reflect that a translator was used to ensure communication with Petitioner (Px3)

The issue thus becomes one of credibility of the Petitioner in this case. Petitioner's testimony is contradicted by the history of injury recorded in the emergency room of the University of Chicago Hospital. (Px3) During Petitioner's testimony, his demeanor and body language was suspect. In addition, Petitioner claimed different accident dates during his testimony, using the dates of June 30, 2009, July 1, 2009 and July 2, 2009.

While the emergency room records reflect a date of June 30, 2009, the Application for Adjustment of Claim reflects an accident date of July 1, 2009, adding to the confusion.

Based upon the above, the Arbitrator finds that Petitioner failed to establish by credible evidence that he sustained an accidental injury that arose out of and in the course of his employment by Respondent on June 30, 2009.

Based further upon the above, the Arbitrator finds that Petitioner failed to establish by credible evidence an accident date for an accidental injury that may have arisen out of and in the course of his employment in this matter.

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

See findings of this Arbitrator in "C" and "D" above.

It would appear that since an ambulance was called to the worksite, that Respondents Zbignew Tarnowski and Excel Builders had actual notice of an alleged injury as defined by the Act.

This Arbitrator so finds under these circumstances.

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

See findings of this Arbitrator in "C" and "D" above.

Based upon said findings, the Arbitrator further finds that Petitioner failed to prove that his current condition of ill-being is causally related to an accidental injury that arose out of and in the course of his alleged employment by Respondents on June 30, 2009.

G. What were Petitioner's earnings?

See findings of this Arbitrator in "C" and "D" above.

Petitioner testified that he earned $12.00 per hour and worked 10 hours each day for three days a week. Petitioner testified that he worked a total of 2 weeks for Respondents.

Based upon the above, the Arbitrator finds the average weekly wage to be $360.00 and the earnings for the year prior to June 30, 2009 to be $720.00.

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

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

See findings of this Arbitrator in "C" and "D" above.

Petitioner testified that on June 30, 2009, he was 41 years of age, married and had two dependent children under the age of 18.

This Arbitrator so finds.

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

See findings of this Arbitrator in "C" and "D" above.

Based upon said findings, the Arbitrator further finds that all claims made by Petitioner for medical expenses incurred from an alleged work injury on June 30, 2009 are hereby denied.

K. What temporary benefits are in dispute?

See findings of this Arbitrator in "C" and "D" above.

Based upon said findings, the Arbitrator further finds that all claims made by Petitioner for temporary total disability benefits incurred from an alleged work injury on June 30, 2009 are hereby denied.

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

See findings of this Arbitrator in "C" and "D" above.

Based upon said findings, the Arbitrator further finds that all claims made by Petitioner for permanent partial disability benefits incurred from an alleged work injury on June 30, 2009 are hereby denied.

N. Are Respondents due any credit?

See findings of this Arbitrator in "C" and "D" above.

Based upon said findings, the Arbitrator further finds no credit is due any Respondent in this matter.

O. Did Petitioner Engage in Unsanitary or Injurious Practices Pursuant to Section 19(d) of the Act?

See findings of this Arbitrator in "C" and "D" above.

Based upon the above, the Arbitrator declines to render a finding as to whether Petitioner engaged in unsanitary or injurious practices pursuant to Section 19(d) of the Act, as such a finding would be 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 COOK	)	☐ Reverse	☐ Second Injury Fund (§8(e)18)
			☐ PTD/Fatal denied
		☒ Modify	☐ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Juan Villalobos,

Petitioner,

14IWCC1017

vs.

NO: 12 WC 29773

The Strive Group,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under Section 19(b) having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of accident, causal connection, medical expenses, prospective medical care, temporary total disability benefits, permanent disability benefits, 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 find that Respondent's behavior in this matter does not merit the award of penalties under Section 19(l) of the Illinois Workers' Compensation Act (hereinafter "Act).

Section 19(l) of the Act reads:

"If an employee has made written demand for payment of

14IWCC1017

> benefits under Section 8(a) or Section 8(b), the employer shall have 14 days after receipt of the demand to set forth in writing the reason for the delay. In the case of demand for payment of medical benefits under Section 8(a), the time for the employer to respond shall not commence until the expiration of the allotted 30 days specified under Section 8.2(d). In case the employer or his or her insurance carrier shall without good and just cause fail, neglect, refuse, or unreasonably delay the payment of benefits under Section 8(a) or Section 8(b), the Arbitrator or the Commission shall allow the employee additional compensation in the sum of $30 per day for each day that the benefits under Section 8(a) or Section 8(b) have been so withheld or refused, not to exceed $10,000. A delay in payment of 14 days or more shall create a rebuttable presumption of unreasonable delay." 820 ILCS 305/19(l) (2013).

Relying on *Continental Distributing v. Industrial Commission*, 98 Ill.2d 407 (1983), the Arbitrator found that Respondent's reliance on the alleged contradicting opinions and misrepresentations of the facts by Respondent's Section 12 examiner, Dr. Hsu, unreasonable. In *Continental*, the court explained:

> The test is not whether there is some conflict in medical opinion. Rather, **[416]** it is whether the employer's conduct in relying on the medical opinion to contest liability is reasonable under all the circumstances presented. This is a factual question for the Commission and will not be disturbed unless it is against the manifest weight of the evidence. Continental Distributing Co. v. Industrial Com.,98 Ill. 2d 407, 415-416,456 N.E.2d 847, 851,1983 Ill. LEXIS 484, 12,75 Ill. Dec. 26, 30(Ill.1983)

First, the Commission notes that Petitioner did not provide any proof of written demands for compensation. Second, on May 21, 2013, Dr. Hsu, Respondent's Section 12 examiner, issued his report finding that Petitioner's conditions were not causally related to the work accident. (RX2) Dr. Hsu opined that, after reviewing additional medical records and diagnostic exams, Petitioner's lumbar strain had resolved. Dr. Hsu explained that Petitioner had had "ample time with conservative care since my last Independent Medical Evaluation. For this reason, I believe that he has resolved his lumbar strain....It appears that he has had some intrascapular pain since my last Independent Medical Evaluation and I would opine that this is unrelated to the work-related injury and likely a pre-existing condition that has been treated by Dr. Sokolowski."

The Commission does not find that Dr. Hsu's findings and opinions on May 21, 2013 contradictory to his findings and opinions on September 26, 2012. As noted above, Dr. Hsu based his May 21, 2013 findings and opinions on the additional medical evidence he was provided. Therefore, Respondent did not rely on contradicting opinions or misrepresentations of

facts, instead, Respondent relied on updated findings and opinions based on a review of updated medical records.

The Commission finds that Respondent's reliance on the findings and opinions of Dr. Hsu was reasonable and, as such, Petitioner failed to prove entitlement to penalties under Section 19(l) of the Act. Therefore, the Commission reverses the Arbitrator's finding regarding penalties under Section 19(l) and vacates the award of penalties.

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 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 $373.33 per week for a period of 27 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 shall be given a credit of $6,026.60 for temporary total disability benefits paid by Respondent.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $62,179.84 for medical expenses under Sections 8(a) and 8.2 of the Act. Respondent is entitled to a credit for medical bills previously paid.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall authorize and pay for all reasonable and necessary costs associated with the lumbar disc surgery prescribed by Dr. Sokolowski, pursuant to Sections 8(a) and 8.2 of the Act.

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 $66,300.00. 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: NOV 2 5 2014
MJB/ell
o-10/06/14
52

Michael J. Brennan

Kevin W. Lamborn

Thomas J. Tyrrell

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

VILLALOBOS, JUAN
Employee/Petitioner

Case# **12WC029773**

14IWCC1017

THE STRIVE GROUP
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:

0758 KREITER, BYCK & ASSOC LLP
PAUL BYCK
180 W WASHINGTON ST SUITE 800
CHICAGO, IL 60602

1408 HEYL ROYSTER VOELKER & ALLEN
DANA HUGHES
120 W STATE ST 2ND FL
ROCKFORD, IL 61105

14IWCC1017

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)

Juan Villalobos
Employee/Petitioner

v.

The Strive Group
Employer/Respondent

Case # 12 WC 29773

Consolidated cases: ____

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Brian Cronin**, Arbitrator of the Commission, in the city of **Chicago**, on **August 16, 2013 and September 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, **July 17, 2012**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$29,120.00**; the average weekly wage was **$560.00**.

On the date of accident, Petitioner was **48** 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 **$6,026.60** for TTD, **$0.00** for TPD, **$0.00** for maintenance, and **$0.00** for other benefits, for a total credit of **$6,026.60**.

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 **$373.33**/week for **27** weeks, commencing **7/30/12** through **10/18/12** and **4/22/13** through **8/16/13**, which is the period of temporary total disability for which compensation is payable under Section 8(b) of the Act.

Respondent shall be given a credit of **$6,026.60** for temporary total disability benefits that have been paid, as indicated above.

Respondent shall pay Petitioner **$62,179.84**, which is an amount equal to the total outstanding medical bills for the reasonable and necessary medical services provided to him, pursuant to Section 8(a) and subject to Section 8.2 of the Act. Any reduction in payment for said bills shall be made in accordance with the Illinois Medical Fee Schedule. Respondent is entitled to a credit for medical bills previously paid.

Respondent shall pay for all reasonable and necessary costs associated with the lumbar disc surgery that Dr. Sokolowski has prescribed, pursuant to Section 8(a) and subject to Section 8.2 of the Act.

Respondent shall pay Petitioner penalties of **$2,640.00** in penalties, for the unreasonable delay in the payment of TTD benefits, pursuant to Section 19(l) of the Act. ($30.00 per day for 12-4/7weeks = $2,640.00)

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.

14IWCC1017

Signature of Arbitrator

March 28, 2014
Date

ICArbDec19(b)

APR 3 - 2014

STATE OF ILLINOIS	)	BEFORE THE ILLINOIS WORKERS'
	) SS	COMPENSATION COMMISSION
COUNTY OF COOK	)	
JUAN VILLALOBOS, Petitioner,	)	14IWCC1017
vs.	)	NO. 12 WC 029773
THE STRIVE GROUP, Respondent.	)	

DECISION OF ARBITRATOR

FINDINGS OF FACT

On the date of the hearing, Petitioner's testimony was interpreted by a Certified Spanish translator, Carina Julian. No other witnesses testified at the hearing. Petitioner testified that he began working for Respondent in October 2006. Since that time, Petitioner worked as a forklift driver for Respondent. His job required, in general, loading and unloading of trailers and filling orders. When unloading merchandise from trailers, the products would be contained in boxes of various sizes and weights, and stacked on pallets. They would be delivered in 48 or 53 foot trailers. When filling orders, he would locate the goods in the warehouse, lift and move the pallet holding the stacked boxes by using a forklift and tear the plastic wrapping securing the boxes together in order to count the correct amount of boxes required in the order. He would then physically lift the number of boxes onto a separate pallet in order to complete the order. Petitioner testified that the work in general had to be done in a fast pace. He stated that his job functions were the same since he began working for Respondent.

The Petitioner testified that he worked second shift, normally eight hours per day, five days per week, but sometimes he would work ten or twelve hours per day for two months or so at a time. He estimated that from 2006 and 2012, he would average approximately 5 months of overtime each year.

On July 17, 2012, Petitioner testified that his first assignment was to unload the products on a 48 foot trailer that arrived from a company named Roadway. He opened

the back of the trailer and noticed the entire area of the truck was filled with pallets and boxes stacked roughly seven or eight feet high. Each skid held approximately 24 to 26 boxes weighing between 30 and 40 pounds each. There were 24 pallets lining the floor of the truck and approximately 20 pallets stacked on top of them. Each pallet was smaller than 4 feet by 3 ½ feet. The boxes on each pallet were wrapped together in plastic, but most of the plastic was torn during transport. This caused the stacks of boxes to lean out of position and become disheveled. Some of the boxes were pushed out roughly half a foot. Petitioner testified that moving pallets by forklift that have unstable and disheveled loads could result in the boxes falling and causing damage to the goods inside them. Therefore, the stacks of boxes needed to be manually lifted and pushed back into place and re-wrapped in plastic before the forklift could remove them from the truck. He estimated about 18 skids were disheveled.

The Petitioner testified that he would normally unload trucks alone, but on this day, after he saw the unorganized condition of the boxes in the trailer, he asked his supervisor for help. A co-worker named Isidro was assigned to help him unload the trailer. There was very little room to squeeze between each load. Therefore, Petitioner stated he drove the forklift up the ramp and slightly moved a double stacked pallet in order to create some space. He and Isidro then began lifting and pushing the boxes back into place. Isidro lifted and pushed the boxes stacked on the lower skid while the Petitioner lifted and pushed the boxes loaded on top of the higher skid at the same time. Petitioner testified that if they did not push at the same time, it could create more instability. They would sometimes switch between lifting and pushing the upper and lower portion of the leaning boxes. Petitioner testified that he exerted very heavy force when lifting and pushing at both the higher and lower positions. He described the weight he was lifting and pushing as heavy. When lifting and pushing the boxes stacked on the higher skid, Petitioner stated his hands were approximately face height with his palms extended outward. Since there was not a lot of room to maneuver, he used his feet and hands for leverage. He testified that he is five feet five inches tall. The worker lifting and pushing below had the entire weight of the boxes and pallet above. Petitioner described the work required in the upper and lower positions as equally strenuous.

Once the boxes were straightened on the top and bottom pallet, Petitioner and Isidro would wrap the group of boxes in plastic then drive them off the truck in a forklift. Petitioner drove the forklift. It had a plastic seat with "a little bit of thickness" and would vibrate when being driven. The forklift would bounce hard when driving over the bump created in the uneven space between the ramp and the truck. He drove the forklift backwards, requiring him to turn his head and twist his body around so that he could see behind him.

The Petitioner testified that after approximately 30 minutes of lifting and pushing the boxes into place, he felt a pretty intense prickling feeling in his lower back and in the scapula area around his left shoulder blade. He complained to Isidro about his pain and then went to the office to report the injury. Since his supervisor was not there, he went back to work only to return to the office 20 minutes later. Petitioner testified that he then informed his supervisor, Joel Corrola, in Spanish about his injury and symptoms. He told Mr. Corrola that he would take some Tylenol and predicted he would feel better. He finished unloading the truck, which took about one hour and a half in total.

Petitioner's next assignment that day was to fill an order containing perfumes. He located the boxes stacked on pallets and removed the skid using his forklift. The boxes were stacked 4 feet high. He then cut the plastic securing the boxes and lifted by hand, the number of boxes he needed to complete the order. He then placed them on a pallet located on the ground, bending down with each box. The boxes were the same size and weighed approximately 20 pounds each. Once he stacked between 20 and 25 boxes on the pallet, he would then use a small roll of plastic to wrap the entire group of boxes. He needed to bend down to cover the boxes on the bottom. Petitioner testified that the pain in his low back and left shoulder increased while performing this job.

While performing his job activities on the next day, July 18, 2012, Petitioner testified that his symptoms worsened. Once again, he complained to his supervisor. According to Petitioner, Mr. Corrola stated he would tell the manager, Brian Garner when he returns to work the following day.

On July 19, 2013, Petitioner testified he continued to have low back and left shoulder blade pain and he spoke to Mr. Corrola again. Mr. Corrola told Petitioner he would talk to Mr. Garner. Petitioner was then instructed to go to the Work Right

Occupational Health clinic ("Work Right"). Petitioner was given certain paperwork to provide to the clinic and was first seen on July 19, 2013. According to Petitioner, his supervisor completed an accident report.

Petitioner testified that he had hurt his low back once before. He did not recall exactly when it occurred but stated it was approximately 9 or 10 years ago. The symptoms were only in the low back and did not travel to either of his legs. He was treated with physical therapy and injections and was discharged from care. Petitioner testified that during the 6 year period he worked for Respondent prior to the July 17, 2012, he never sustained an injury to his back, nor did he have any back pain or treatment. He testified that he never had any back pain that radiated to either of his legs in the past. Furthermore, he stated he never had any previous injuries or symptoms to his left shoulder, shoulder blade or scapula area. He also testified that until this incident, he never reported any other injuries to Respondent since his hire date in 2006.

Petitioner first reported to Work Right on July 19, 2012, providing a history of lifting a pallet and hurting his left shoulder and lower back. (Px. #2) The injury date on the top right corner of each and every page of the Work Right records indicate the date of injury July 17, 2012, however, in one of the sentences, it states he injured himself on July 7, 2012. (Px. #2) Petitioner testified that none of the medical providers at Work Right spoke to him in Spanish. The company physician, Dr. O. Ramsey, wrote that Petitioner complained of progressively increasing pain to the left side of his low back and left shoulder. His pain level was described as an 8-9 out of 10 with the back pain being worse, especially when moving or bending. He did not have any radiating pain to the lower extremities, but straight leg raising was 50 degrees on the left and 65 degrees on the right. (Px. #2) There was no numbness or tingling sensations in his legs.

Petitioner testified that he began experiencing radiating symptoms to his left leg approximately one week after the accident.

Upon examination on July 19, 2012 at Work Right, Petitioner's left shoulder revealed "swelling along posterior aspect of shoulder and scapular region." (Px. #2) There was also swelling and spasms observed along the left sacral region of his low back with tenderness in the sacral and SI joint. (Px. #2) X-rays were taken of the lumbar spine and left shoulder. He was given a TLSO lumbar support and prescribed Flexeril,

Daypro and Toradol. He was given restrictions of no lifting over 20 pounds, no repetitive bending and must allow frequent changes in positions. He was instructed to wear the back brace. (Px. #2) The formal diagnosis was lumbar sprains and strain, lumbago, low back pain, sprain and strain of shoulder and pain in the shoulder region. (Px. #2) He was advised to return to the clinic on July 23, 2012.

On July 23, 2012, which was his next appointment at Work Right, Petitioner continued to complain of low back pain, describing his pain level 8/10. His pain level in the left shoulder and upper back was described as a 5/10. (Px. #2) The medications were helping him sleep. He had slightly restricted range of motion in the neck with tightness and tenderness to palpation in the left upper dorsal spine. The left shoulder range of motion improved but the lumbar range of motion was still restricted. (Px. #2) Straight leg raising continued to exhibit 50 degrees on the left and 65 degrees on the right. Dr. Ramsey ordered continued use of the same medications previously prescribed and ordered physical therapy pending insurance approval. Petitioner was instructed to remain on restrictions. (Px. #2)

Petitioner returned to see Dr. Ramsey at Work Right on July 27, 2013. He reported a slight decrease in pain after taking two vacation days from work. However, the pain returned after he came back to work. (Px. #2) He had pain while driving the forklift. Petitioner testified that his pain increased after 20 minutes on the forklift, exacerbated by riding over bumps while twisting backwards. The records indicate that he was performing light duty at this time. (Px. #2)

Petitioner testified that his employer was not honoring his light duty, other than allowing him to avoid pushing boxes on pallets. He testified that he continued to lift and wrap heavy boxes, often bending during work.

Dr. Ramsey noted complaints of back pain while driving the forklift. (Px. #2) Physical therapy was still not approved. Straight leg raising tests remained unchanged. There was less tenderness to the posterior shoulder with better range of motion. His neck range of motion was still restricted. Lumbar spine range of motion was slightly improved with less tenderness to the left sacral region. The doctor repeated his request for physical therapy pending insurance approval. (Px. #2)

Petitioner testified that the doctor told him he would call Respondent regarding the delay in physical therapy authorization, but Petitioner never heard back.

Dr. Ramsey advised Petitioner to continue his medications and restrictions and return to the clinic on August 2, 2012. (Px. #2)

Petitioner testified that he did not return to Work Right, but instead began treating at La Clinica, a medical facility he found near his home. Petitioner testified that he sought treatment elsewhere because he could not stand the pain. The medical providers at La Clinica speak Spanish according to Petitioner. Petitioner was first seen at La Clinica on July 28, 2012. The "Consultation / History" report on the dame day by Dr. E. Jao, reports the date of accident as July 19, 2012. (Px. #15) However, in the initial questionnaire, the discrepancy in the date of accident is explained in the following manner: "7/18/12 reported by employer" "7/17/12 first reported to employer by patient." (Px. #15) In a July 30, 2012, La Clinica report by Dr. Adrian Zaragoza, he explains that Petitioner felt pain pushing and fixing a stack of pallets at work on July 17, 2012, and reported the incident on the same day, but he was not sent to the doctor until July 19, 2012. (Px. #15) This is consistent with Petitioner's testimony.

The July 28, 2012 La Clinica Questionnaire describes the accident occurring while Petitioner was bending, pushing and lifting heavy boxes on a pallet with a co-worker. His primary complaints of pain were to the low back, mid back and shoulder. He admitted low back pain approximately 10 years ago but stated that condition had resolved. (Px. #15) Dr. Jao noted in the initial "Consultation / History" report that Petitioner had sharp low back pain, left greater than right, with radiation to the left thigh above the knee. Sitting and rotation provoked his pain. (Px. #15) His pain level was an 8-9 out of 10. He also had mid back pain in the left shoulder blade. Dr. Jao reported that Petitioner saw the company physician as recently as a day prior, and sought La Clinica as a second opinion. Petitioner complained that Respondent kept him on the same job position despite work restrictions. (Px. #15)

In the "Physical / Spinal Examination" page on July 28, 2012, the doctor reported a positive straight leg raise on the left. (Px. #15) The left shoulder blade and left low back were circled in a pain drawing dated July 28, 2012, as was the right knee. The drawing had instructions in English. (Px. #15) Petitioner testified that he completed

whatever pain drawings were provided to him, though none were shown to him during testimony. In the "Daily Office Notes" dated July 28, 2012, lumbar radiation is listed as one of the diagnosis. He was referred to pain management. (Px. #15)

Petitioner testified that the radiating symptoms in his left leg progressively worsened. He described a prickling feeling in his left thigh and he later developed cramping in his left calf and tingling to the bottom of his left foot and toes.

Petitioner was seen by Dr. Zaragoza on July 30, 2012. (Px. #15) Yeoman's test was positive on the left. Straight leg raising on this visit was negative but painful. Petitioner reported pain when sitting or standing more than 30 minutes, walking for more than ¼ mile and loss of sleep. (Px. #15) He was given electrical muscle stimulation to the lumbar region and ultrasound to the left scapula. He was diagnosed with lumbar facet and sacroiliac joint pain as well as a sprain in the left scapular musculature. The doctor opined that both conditions are work related. He was taken off of work and prescribed physical therapy and pain management due to the severity of the pain. An MRI was ordered.

On August 1, 2012, Dr. Zaragoza's records indicate Petitioner's lumbar pain "still very acute" that varies from 7/10 to 9/10. In addition, the pain travels down his left posterior thigh. (Px. #15)

A lumbar MRI was performed on August 1, 2012. (Px. #7) The report stated a 2 mm broad base bulge at L4/L5 without central canal or neural foraminal stenosis. There was also a 2 mm broad based bulge at L5/S1 associated with a left sided paracentral annular tear. There was no central canal or neural foraminal stenosis.

Petitioner was seen by Leah Brown PA-C at La Clinica on August 2, 2012. She reported low back pain, mostly left-sided with pain radiating into the anterior left thigh down to the knee. (Px. #15) There was left thigh and buttock pain with lumbar extension and with straight leg raising on the left. There was also intermittent pain over the inferior scapular border. Petitioner reported difficulty sleeping and a pain level of 8/10. He was prescribed Naproxen, Tramadol and Omerprazole and there was consideration for lumbar facet injections if Petitioner did not improve with physical therapy. (Px. #15) Petitioner continued to treat at La Clinica through August, 2012, without much relief. (Px. #15) On August 10, 2013, Dr. Zaragoza reported mild

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improvement in his pain level, to a 6/10, but straight leg raising was positive at 48 degrees of left hip flexion with mild radicular pain to the left lower extremity. Straight leg raising was negative on the right. (Px. #15) Dr. Zaragoza reported that Petitioner was very anxious to return to work because he has not received any workers' compensation pay and he is the only provider at home. (Px. #15) Petitioner testified that he did not receive his first TTD payment until the middle of September, 2012. Dr. Zaragoza felt that a return to work will exacerbate his condition and kept him off of work at that time.

On August 15, 2012, Petitioner reported that a day earlier, while trying to take a picture frame down at home, his pain level almost resulted in a trip to the hospital. (Px. #15) The frame was not heavy but reaching up caused significant pain according to the record. (Px. #15)

On August 30, 2012, Stephanie Riley, PA-C, recorded that Petitioner had continued left-sided low back pain with cramping sensation along the left lateral thigh. Lumbar facet injections were once again considered if his condition worsens. There was also more intense pain over the left scapular border that she felt was likely myofascial in nature. Flexeril was prescribed. (Px. #15)

On September 5, 2012, Dr. Zaragoza noted fluctuating back pain varying from 4 to 5/10 and 7/10 with mild pain to the left lateral thigh. Straight leg raising was positive causing radicular pain to the left lower extremity. (Px. #15) Dr. Zaragoza opined that Petitioner was suffering from persistent facet and discogenic pain and was responding very slowly to conservative treatment. He felt that Petitioner would benefit from lumbar injections as well as trigger point injections to the scapula. He was kept off of work and continued on physical therapy. (Px. #15)

On September 13, 2012, Petitioner was seen by again by Stephanie Riley, PA-C for evaluation for lumbar injections. (Px. #15) The record on that date notes lower back pain with radiation down the right lower extremity and paresthesias in the left lower extremity as well as the left foot which began approximately three days ago. (Px. #15) Straight leg raise test produced lower back pain with radiation down the left lower extremity to the knee. There was decreased sensation in the left leg compared to the right. Lumbar epidural steroid injections from L3 through S1 were recommended "in

light of the patient's symptomatic radiculopathy." (Px. #15) In addition, an EMG was ordered to confirm the radicular symptoms.

Petitioner underwent an EMG nerve test on September 21, 2012. (Px. #15) The complaints noted on the exam were pain in left leg and foot with numbness and tingling into the foot. The test was interpreted as showing "evidence of electrical instability indicating an S1 level nerve pathology." (Px. #15)

On September 24, 2012, Petitioner was examined at Respondent's request by Wellington K. Hsu, M.D., an orthopedic surgery consultant. Petitioner testified that the examination lasted about 4 minutes and that Dr. Hsu did not speak to him in Spanish. According to Petitioner's testimony, Dr. Hsu only asked Petitioner where he was hurting, to which Petitioner responded the left shoulder area, low back and leg. Petitioner testified he was told to walk four steps and Dr. Hsu examined his feet.

Dr. Hsu issued a Section 12 report on September 26, 2012. (Rx. #1) He reviewed various records from Work Right Occupational Health and La Clinica. He noted that Petitioner's history of back pain from about 10 years ago had resolved. Dr. Hsu noted the mechanism of the injury in the records, though he misreported the history in the Work Right records, stating he "slipped on a pallet." His remaining summary of the records is consistent with the mechanism of injury as described by Petitioner during the hearing. (Rx. #1) Dr. Hsu wrote that Petitioner was moving heavy objects including a box that weighed 200 pounds with the assistance of another worker. He noted some confusion with the exact date of accident. (Rx. #1)

In Dr. Hsu's review of the various records, he reported that Petitioner hurt his low back, left shoulder, as well as the thoracic and mid back. (Rx. #1) He outlined various chart notes and reports without specifically mentioning any of the left leg symptoms contained in the records. He wrote that at the time of the exam, Petitioner denied associated symptoms such as radiculopathy or bowel and bladder complaints. (Rx. #1) Dr. Hsu also did not mention any complaints of scapula symptoms in his review of the medical records. On examination, he recorded that Petitioner was able to heel and toe walk without difficulty, and had a negative straight leg raise in sitting and supine positions. He reported positive Waddell signs with axial compression and sensitivity. (Rx. #1) He reviewed the MRI film and noted "very mild L4-5 spondylosis" without

evidence of central or foraminal stenosis, instability or osseous abnormality. (Rx. #1) He did not mention the annular tear at L5-S1 noted in the MRI report and by Petitioner's treating doctors. The EMG results were not part of Dr. Hsu's report. Dr. Hsu concluded that Petitioner's diagnosis was lumbar spondylosis and lumbar sprain. He opined that the work incident directly caused a lumbar strain. He did not believe that Petitioner's "complaints of back pain are a mere manifestation of a pre-existing condition." Nor did he believe the work incident caused any aggravation, precipitation or acceleration of a pre-existing condition. (Rx. #1) When asked specifically whether Petitioner's continuing symptoms or impairment are attributable to some other cause, such as a previous injury or pre-existing condition, Dr. Hsu wrote, "At this time, I believe that the symptoms of low back pain that the examinee complains about can be attributed to the lumbar strain, which was a work-related injury on or about July 18, 2012." (Rx. #1)

Dr. Hsu opined that Petitioner had not reached Maximum Medical Improvement because he still had a decreased range of motion. He believed that the chiropractic and physical therapy care is reasonable in the short term, but that chiropractic care should not be necessary three months after the accident. He recommended a work hardening program for two to four weeks that would allow Petitioner to return to work as a fork lift driver. However, as of September 26, 2012, Dr. Hsu opined that Petitioner could return to restricted work of no heavy lifting over 20 pounds, with bending, crouching and stooping on an occasional basis. (Rx. #1)

Petitioner was seen by Stephanie Riley, PA-C on September 25, 2012, one day after the Section 12 examination by Dr. Hsu. (Px. #15) PA Riley reported Petitioner's constant low back complaints along with complaints of left lower extremity pain with movement. She wrote that Petitioner "reports his pain is along the lateral aspect of the left thigh to the knee. He also reports tingling in the left foot along the dorsal and plantar aspect of the foot and all toes." (Px. #15) There was decreased sensation in the left foot in the L5-S1 distribution as compared to the right. She noted the EMG results showing S1 nerve pathology. She recommended L5-S1 tranforaminal epidural steroid injections for the "symptomatic radiculopathy" and neuropathy. She also recommended continued physical therapy and no work. (Px. #15)

Petitioner saw Dr. Zaragoza on October 4, 2012, at which time he was returned to work with restrictions as of October 8, 2012, based on Dr. Hsu's Section 12 report. Dr. Zaragoza doubted that Petitioner would be able to sit on a forklift for 6 to 8 hours. (Px. #15) He opined that work hardening would result in a poor outcome given his persistent lumbar pain and positive objective findings, and instead recommended aggressive physical therapy and injections by Dr. Jain. (Px. #15)

On October 9, 2012, Petitioner received a left L5-S1 epidural steroid injection by Dr. Neeraj Jain. (Px. #12)

Petitioner testified that Dr. Jain's office arranged for transportation for the procedure.

Dr. Jain's diagnosis was lumbar discogenic pain, lumbar facet syndrome and lumbosacral radiculopathy. (Px. #12)

On October 11, 2012, Dr. Zaragoza noted 30% improvement in pain symptoms since the injection. (Px. #15) Dr. Zaragoza reported an increase in low back pain on October 16, 2012, from occasionally lifting heavy objects at work and sitting on a forklift 2 to 3 hours during 10 hour shifts. (Px. #15) Dr. Zaragoza wrote, "He says despite him telling his supervisor that he is to be doing light duty, his work has not respected the restrictions." (Px. #15) Petitioner also testified that he would work outside of his restrictions after his return to restricted work. Dr. Zaragoza provided further restrictions of 15 pound lifting in 8 hour shifts. (Px. #15)

Petitioner saw Leah Brown, PA-C, on October 23, 2012, as a follow up consultation following the lumbar injection. He reported 50% improvement from the injection with significant improvement in the left lower extremity. (Px. #15) Petitioner testified that the first injection did improve his symptoms. He continued to have upper back pain in the left periscapular area, which increased after 30 minutes of work on the forklift. Left rhomboid trigger point injection was recommended to address the scapular pain. (Px. #15) The injection was performed by Dr. Jain on October 29, 2012. (Px. #15)

Petitioner's low back symptoms fluctuated, though they did improve, through December 2013. (Px. #15) Leah Brown, PA-C, recommended another lumbar injection on November 20, 2012, based on the significant relief from the last injection and the ongoing leg symptoms. (Px. #15) By November 22, 2012, Petitioner indicated pain

levels between 4 and 5 out of 10 in the low back and 2 and 6 out of 10 to the scapula area. (Px. #15) The scapula injection was not effective and a thoracic MRI was ordered. (Px. #15)

On December 8, 2012, Petitioner underwent another L5-S1 injection by Dr. Jain. (Px. #12) Three days later, December 11, 2012, Dr. Zaragoza noted 80% improvement in the low back symptoms with physical therapy and injections. Petitioner had complete lumbar range of motion and was able to lift 20 pounds multiple times with only mild pain and was able to work without exacerbating his symptoms. (Px. #15) He still had burning in his upper back, even with simple tasks. Physical therapy was reduced to once per week for four weeks. (Px. #15) On December 18, 2012, Petitioner indicated to Dr. Zaragoza that he was able to tolerate the forklift for longer periods of time. There was minimal tenderness in the low back, but he was still complaining of upper back pain. (Px. #15) On December 27, 2012, Dr. Zaragoza wrote that Petitioner's scapular pain felt much better after taking a vacation from work, but increased to a 6 out of 10 after returning to his job on December 26, 2012. His low back pain was described as minimal, rating it a 3 out of 10 at the worst. (Px. #15) On January 2, 2013, Petitioner reported a slight increase in low back after working "a bit more." (Px. #15)

On January 8, 2013, Petitioner reported an increase in low back symptoms following his work activities a day prior. Dr. Zaragoza notes indicate Petitioner was wrapping a package on a skid that required him to be bent at the waist while walking with the wrapping tool. (Px. #15) Prior to this activity, his pain level varied from no pain to 4 out of 10, but now was a constant 6 out of 10 and the radicular symptoms returned to his left lower extremity. (Px. #15) Dr. Zaragoza noted Petitioner exacerbated his symptoms and was regressing. He considered a referral for an orthopedic consultation if there was no improvement. (Px. #15) He continued to have fluctuating pain in the left scapula and Dr. Jain performed a left suprascapular nerve block on January 12, 2013. (Px. #15)

Petitioner reported fluctuating low back symptoms throughout January, 2013, but the records on January 29, 2013 note persistent pain traveling to the left leg. (Px. #15) On February 7, 2013, Dr. Zaragoza noted that Petitioner had 3 to 4 weeks of improvement following the second lumbar injection, but now had increased low back and radicular pain to left lower extremity. (Px. #15) The symptoms continued in February

and on February 18, 2013, Petitioner reported lifting a stack of multiple boxes weighing between 15 and 25 pounds one week prior resulted in significant increase in pain. (Px. #15) There was sharp pain traveling to the left thigh and leg with numbness in his toe. Dr. Zaragoza indicated his intention to refer Petitioner to an orthopedic spine surgeon for a second opinion, and urged Petitioner not to do repetitive lifting or other activities at work that would exacerbate his low back condition. (Px. #15)

Dr. Zaragoza referred Petitioner to Mark Sokolowski, M.D., an orthopedic surgeon, whom Petitioner first saw on March 11, 2013. (Px. #4) The records indicate Spanish translation was provided. (Px. #4) On physical exam, Dr. Sokolowski noted back pain with radiation to the left buttock and left leg in a neutral sagittal profile. Forward flexion relieved those symptoms. (Px. #4) Straight leg raise in a seated position was positive on the left to 90 but not the right. He had decreased sensation in the left L4 through S1 distribution on the left with positive Spurling's sign. There was full shoulder range of motion bilaterally, but left periscapular tenderness to palpation. He had positive Neer and Hawkins impingement signs on the left relative to the right. (Px. #4) Dr. Sokolowski interpreted the prior lumbar MRI as showing a lumbar disc herniation and associated tear at L5-S1. The thoracic MRI was negative. (Px. #4) Dr. Sokolowski noted Petitioner's history of injury lifting at work and indicated the steroid injections provided some short term benefit but not definitive improvement. The shoulder symptoms were not improved with injections. His work activities reportedly exacerbate his symptoms, including the vibration of the forklift. (Px. #4) Dr. Sokolowski assessed that Petitioner may be suffering from lumbar radiculopathy, left shoulder rotator cuff tendinitis and cervical pain and radiculopathy as a result of the work injury. (Px. #4) He recommended a third lumbar injection, continued therapy and a cervical MRI. He added restrictions of limiting continuous forklift driving to intervals of one hour or less. (Px. #4)

Petitioner underwent a third lumbar injection by Dr. Jain on March 12, 2013. (Px. #12) He testified that the third injection had minimal benefit. The records indicate the injection helped for about 2 days. (Px. #15) He continued therapy and on April 17, 2013, Dr. Zaragoza noted worsening symptoms. Petitioner complained that Respondent was not respecting his restrictions and he was pushing, pulling and carrying heavy loads

at work. (Px. #15) He could only perform forklift activities 10 minutes before low back pain with increasing radiation to the left leg. (Px. #15) He saw Dr. Sokolowski again on April 19, 2013 and reported significant increase in symptoms even when he performed modified-duty work. (Px. #5) Petitioner complained that he almost went to the emergency room on multiple occasions. (Px. #5) Pain level in the low back was described as a 7 out of 10 and leg and buttock pain 5 out of 10. The cervical MRI was reviewed and showed no acute pathology. (Px. #5) Dr. Sokolowski prescribed lumbar decompression surgery at L5-S1 based on the concordance between Petitioner's symptoms, the "clearly identifiable annular tear at L5-S1" on MRI and the positive EMG findings. (Px. #5) Petitioner was taken off of work due to the severity of the symptoms. A new lumbar MRI was prescribed in anticipation of the surgery. (Px. #5)

Respondent's Section 12 examining physician, Dr. Hsu, issued another report dated May 21, 2013. (Rx. #2) It was based on a review of records and no examination was conducted. (Rx. #2) Dr. Hsu reviewed various updated medical records through Dr. Sokolowski's April 19, 2013 report, including the lumbar and scapula injections and the EMG report. (Rx. #2) In his recitation of the materials reviewed, Dr. Hsu summarized Petitioner's low back complaints, but did not make reference to any of the radiating symptoms in the left leg reported by his physicians. (Rx. #2) With regard to the intrascapular symptoms, Dr. Hsu stated they were not related to the work injury and likely a pre-existing condition, "because there were no complaints of this kind after his work-related injury..." (Rx. #2) Regarding the low back, he opined that his current condition was not caused by the work related injury "because enough time has passed with enough conservative care to resolve his symptoms. I believe that any current symptoms that he has would be secondary to a pre-existing condition, which is lumbar spondylosis, which is easily seen on the MRI reports and films." (Rx. #2) He opined that Petitioner still could be a candidate for restrictions, but could not determine them without a re-examination. (Rx. #2) In any event, those restrictions would be secondary to a pre-existing condition of lumbar spondylosis. (Rx. #2)

Petitioner returned to Dr. Sokolowski on May 22, 2013. (Px. #5) He reviewed the April 23, 2013 MRI and stated: "It is clearly demonstrated once again annular tear on the left at L5-S1. Specifically, T2 weighted axial image #14 of 15 demonstrates neural

impingement on the left. Similarly T2 weighted sagittal image #6 of 13 demonstrates an annular tear quite clearly." (Px. #5) The MRI report indicates disc desiccation at L5-S1 along with a left paracentral, neural foraminal protrusion. (Px. #7) In addition, it states "mild lumbar spondylosis." (Px. #7) Dr. Sokolowski wrote that since there is a lack of instability and persistent L5-S1 symptoms, he is recommending a lumbar decompression at L5-S1 and not a fusion. He advised Petitioner to remain off work pending surgical approval. (Px. #5)

Petitioner continued to treat with Dr. Zaragoza. (Px. #15) On June 5, 2013, Petitioner described his low back pain as mild because he was not working, but the numbness and tingling was increasing in the left lower extremity. (Px. #15) On June 12, 2013, he reported more pain and numbness to the left leg which increases at night. (Px. #15) On July 3, 2013, he reported persistent cramping in the left leg and increase pain sitting and walking 15 minutes or doing bike exercises. There was only nominal tenderness in the left scapula. (Px. #15) On July 17, 2013, he had shooting pain from knee to waist when raising his left leg, along with persistent cramping. (Px. #15) On his last visit with Dr. Zaragoza, July 24, 2013, Petitioner measured his low back pain a 3 to 5 out of 10. He indicated the pain travels to the left thigh with mild tingling to the calf. (Px. #15) He felt his condition improving since being off of work, but was frustrated that any lifting, carrying or sitting causes an increase in pain. He was avoiding strenuous activity at home. (Px. #15) He was advised to return once per month and do daily home exercises. (Px. #15) Petitioner testified that he continues to have low back and left leg symptoms and wants to undergo the prescribed surgery. His leg symptoms are worse after he wakes up. He last saw Dr. Sokolowski on July 1, 2013, but the report from this day is not in evidence. Various medical bills remain outstanding.

Respondent offered into evidence a Utilization Review authored by Dr. Janet O'Brien, internal medicine physician, dated December 11, 2012. (Rx. #3) It is a retrospective request for physical therapy of the lumbar spine once to twice per week for four weeks between October 2, 2012 and October 23, 2012. Dr. O'Brien's review of prior medical records includes a history of low back pain with left lower extremity symptoms aggravated by daily activities. (Rx. #3) She notes a positive EMG on the left

and positive straight leg raising in the records. Dr. O'Brien concluded the additional 4 to 8 visits of physical therapy would not be helpful to Petitioner.

Respondent submitted a Utilization Review by Anesthesiologist, Dr. Rey Ximenes, dated September 17, 2012 in relation to the L5-S1 lumbar injection. (Rx. #4) Dr. Ximenes noted the paracentral annular tear at L5-S1 on MRI and mild positive straight leg raise test on the left. The procedure was not certified because "radiculopathy must be corroborated by imaging studies and/or electrodiagnostic testing." (Rx. #4) The EMG test was not performed until one week after the UR report.

Respondent produced a Utilization Review by Anesthesiologist Dr. Michael Skaredoff, dated November 9, 2012, in relation to the L5-S1 lumbar injection ordered in October, 2012. (Rx. #4) This was an appeal of the previously rejected lumbar injection by Dr. Rey Ximenes. According to Dr. Skaredoff, the injection is used for treatment of radicular pain and should be performed in conjunction with active rehabilitation efforts and is intended to avoid surgery. (Rx. #4) He stated that radiculopathy includes, pain, numbness and or paresthesias in a dermatomal distribution. (Rx. #4) The EMG was available for review and Dr. Skaredoff noted the test demonstrated S1 level nerve pathology. Straight leg raising was mildly positive on the left. He noted the MRI showed an L5-S1 2 mm. broad-based disc bulge with a left paracentral annular tear. Dr. Skaredoff wrote that "Electrodiagnostic studies are helpful in supporting the diagnosis of a compressive radiculopathy, but are not required and do not substitute for imaging studies." (Rx. #4) He concluded that the MRI findings and physical exam findings did not support the request for lumbar injection and the test was not certified. (Rx. #4) According to Stephanie Riley, PA-C, a peer-to-peer consultation occurred on October 17, 2012 with Dr. Skaredoff, at which time she described the radiating nature of Petitioner's symptoms. (Px. #15) According to PA Riley, Dr. Skaredoff's reported criteria for lumbar steroid injection, per OGD guidelines, includes "evidence of radiculopathy by independent MRI studies or EMG and therefore stated criteria has been met as the patient does have evidence of radiculopathy on EMG." (Px. #15) PA Riley wrote that Dr. Skaredoff will likely approve at least one lumbar injection. (Px. #15)

Petitioner's series of left rhomboid trigger point injections to treat the left scapula area were approved by Utilization Review. (Px. Group #16)

CONCLUSIONS OF LAW

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

Based on the findings of fact above, the Arbitrator finds that Petitioner sustained an accident that arose out of and in the course of his employment by the Respondent-employer. Petitioner testified that on July 17, 2012, he and a co-worker were lifting and pushing disheveled boxes stacked on pallets that had arrived on a trailer. Petitioner testified that he would normally perform this job alone, but due to the extent of the unorganized condition of the boxes, he asked his supervisor for help. He described the amount of force used to lift and push the boxes as very heavy. While performing this activity, he felt pain to his low back and left scapula area. According to Petitioner, he reported the injury to his co-worker and supervisor, Joel Corrola, on the date of the accident. The next day, his pain persisted and he complained to his supervisor again. The following day, his symptoms worsened and he was referred to the company clinic, Work Right Occupational Health. His testimony was corroborated by the medical records. No other witnesses testified. The Arbitrator finds Petitioner's testimony credible.

D. What was the date of accident?

Petitioner testified that he was injured on July 17, 2012. He testified that he told his co-worker, Isidro, and his supervisor, Mr. Corrola, on the same day. He was sent to Work Right Occupational Health by Respondent on July 19, 2012. The injury date on the top right corner of each page of the Work Right records indicate the date of injury July 17, 2012, although in one sentence in the body of the report it states July 7, 2012. (Px. #2) Petitioner testified that none of the medical providers at Work Right spoke to him in Spanish. There was no testimony contradicting Petitioner's assertion that the incident occurred on July 17, 2012.

Therefore, the Arbitrator concludes that Petitioner proved by a preponderance of the evidence that the date of his injury was July 17, 2012.

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

The Petitioner testified that he notified his supervisor, Joel Corrola, about the accident on the date it occurred. He complained the following day, and on the third day, he was sent to the company clinic. The initial records from Work Right Occupational Health dated July 19, 2012, indicate Petitioner was sent there by his employer for evaluation and treatment. (Px. #2) The Respondent's supervisor did not testify. Therefore, the Arbitrator concludes that the Respondent was given sufficient notice of the Petitioner's July 17, 2012 work accident within the time period prescribed by the Act.

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

Petitioner testified that he injured his low back and the area around his left shoulder blade on July 17, 2012. Within a week or so, he began feeling radiating symptoms down his left lower extremity. The company physician, Dr. O. Ramsey, wrote that Petitioner complained of progressively increasing pain to the left side of his low back and left shoulder. His pain level was described as an 8-9 out of 10 with the back pain being worse, especially when moving or bending. Straight leg raising was 50 degrees on the left. (Px. #2) Petitioner continued his treatment at La Clinica, and was first seen on July 28, 2012. On that date, Dr. Jao noted in the initial "Consultation / History" report that Petitioner had sharp low back pain, left greater than right, with radiation to the left thigh above the knee. (Px. #15) Leah Brown, PA-C, on August 2, 2012 wrote: "He presents here today with complaints of low back pain mostly left sided with pain radiating into the anterior left thigh down to the knee." (Px. #15) The subsequent medical records, as outlined in the Arbitrator's FINDINGS OF FACT above, document numerous references to Petitioner's radicular symptoms in the left lower extremity. An EMG on September 21, 2012, revealed that there was "evidence of electrical instability indicating an S1 level nerve pathology." (Px. #15) The MRI report confirms an annular tear at L5-S1 on the left. Respondent's Section 12 physician, Dr. Wellington Hsu, issued two reports. The first report followed an examination of Petitioner on September 24, 2012. (Rx. #1) Dr. Hsu summarized the medical records he reviewed, but he omitted any reference to radicular symptoms that were found throughout the records. There is no explanation why Dr. Hsu would have omitted theses symptoms from his report.

The Arbitrator finds these symptoms to be relevant in analyzing Petitioner's condition, and would be important for an evaluating physician to consider in rendering a causation opinion.

Petitioner testified that Dr. Hsu's examination lasted about 4 minutes and that he told Dr. Hsu about his low back, left leg and scapula symptoms. Dr. Hsu wrote that Petitioner denied radicular complaints. (Rx. #1) This is inconsistent with the prior records as well as the report by Stephanie Riley, PA-C, one day after Dr. Hsu's examination. According to PA Riley, Petitioner "reports his pain is along the lateral aspect of the left thigh to the knee. He also reports tingling in the left foot along the dorsal and plantar aspect of the foot and all toes." (Px. #15) There was decreased sensation in the left foot in the L5-S1 distribution as compared to the right. (Px. #15) While Dr. Hsu did not review the EMG performed a few days before his examination, the findings of S1 nerve pathology is consistent with the examinations reported by Petitioner's medical providers and inconsistent with the information contained in Dr. Hsu's report.

Dr. Hsu interpreted the initial lumbar MRI films as showing evidence of "very mild L4-5 spondylosis." He diagnosed Petitioner with lumbar spondylosis and lumbar sprain, although he opined that Petitioner's complaints of back pain were not a manifestation of a pre-existing condition, but rather were "attributed to the lumbar strain." (Rx. #1)

Dr. Hsu issued a second report on May 21, 2013 after reviewing additional treating records. (Rx. #2) Although Dr. Hsu initially claimed that Petitioner's "mild spondylosis" was not the cause of his back pain, his second opinion seems to contradict his first report. Dr. Hsu opined that Petitioner's lumbar sprain must have resolved because he has had "ample time with conservative care since my last Independent Medical Evaluation." (Rx. #2) He concluded that Petitioner's current symptoms "would be secondary to a pre-existing condition, which is lumbar spondylosis, which is easily seen on the MRI reports and films." (Rx. #2) No other treating physician attributes Petitioner's current low back symptoms to spondylosis, and Dr. Hsu himself denied that this "very mild L4-5 spondylosis" was causing his symptoms after he examined Petitioner in September, 2012, although he listed L4-5 spondylosis as one of his diagnoses. Furthermore, Petitioner's treating orthopedic surgeon, Dr. Mark Sokolowski, has recommended surgery to the L5-S1 disc, which is consistent with the positive EMG findings and MRIs. There is no recommendation for future treatment to the L4-5 level. Dr. Hsu does not explain how an L4-5 spondylosis would result in the EMG findings showing an S1 level nerve pathology.

In addition, in Dr. Hsu's second report, he denies that any of the treatments for the intrascapular pain were secondary to the accident because there were "no complaints of this kind" after his work-related injury. (Rx. #2) The Arbitrator finds this opinion to be inconsistent with the numerous medical records. On the first date of treatment at Work Right Occupational Health, the company physician reported that the Petitioner's left shoulder revealed "swelling along posterior aspect of shoulder and scapular region." (Px. #2) X-rays were taken of the left shoulder. The Arbitrator notes that Dr. Hsu's first report omits any reference to scapula pain, even though it is mentioned in the numerous records he claimed to have reviewed. (Rx. #1) For instance, in his first report, Dr. Hsu wrote that Stephanie Riley, PA-C, felt Petitioner's low back pain is likely myofascial in nature after her examination on August 30, 2012. (Rx. #1) However, the actual record by Stephanie Riley, PA-C, does not link Petitioner's low back complaints to myofascial pain, but rather states, "We will add Flexeril, as his scapular pain is likely myofascial in nature ..." (Px. #15)

The Arbitrator concludes that Dr. Hsu's opinions lack credibility. It is unknown why Dr. Hsu omitted all of the numerous references to both the radicular symptoms in the left lower extremity and the pain in the left scapula area contained in the records. The Arbitrator finds these symptoms to be relevant in formulating a causation opinion. Furthermore, the opinions in Dr. Hsu's reports are conflicting. In his first report, Dr. Hsu felt that Petitioner had no symptoms associated with a pre-existing condition, yet in his second report, Dr. Hsu attributed Petitioner's symptoms to an L4-5 spondylosis which he previously described as "very mild". Petitioner's low back and left leg symptoms were apparent before and after Dr. Hsu's first report. There is no explanation by Dr. Hsu as to when Petitioner's lumbar strain symptoms ended and spondylosis symptoms started, nor is there evidence of any intervening event. Petitioner testified that until the accident, he had not had any lumbar symptoms in the six years that he worked for Respondent. Dr. Hsu does not deny that Petitioner may need ongoing restrictions but cannot provide an opinion without an examination.

The Arbitrator finds the opinions of Petitioner's treating orthopedic surgeon, Dr. Mark Sokolowski, to be more credible than those of Respondent's examining orthopedic surgeon, Dr. Hsu. Dr. Sokolowski opined that Petitioner is in need of lumbar decompression based on his review of the MRI films, positive EMG test and clinical examinations. (Px. #4, Px. #5) In addition, the lumbar injections provided short term relief but did not resolve Petitioner's symptoms. All of Petitioner's medical providers, including Dr. Sokolowski, have opined that Petitioner's current condition is work related. (Px. #4, Px. #5, Px. #15). Therefore, the Arbitrator concludes that Petitioner's current

condition of ill-being, requiring L5-S1 decompression, is causally related to the work injury of July 17, 2012. The Arbitrator further concludes that Petitioner's left scapula pain and treatment is also causally related to the work injury of July 17, 2012. This is consistent with all of the treating medical records as well as the Respondent's own Utilization Review summary and determination. (Px. Group #16)

J. Were the medical services provided to the Petitioner reasonable and necessary, and has the Respondent paid all appropriate charges for all the reasonable and necessary medical services?

Section 8.7(i)(3) of the Act states "An employer may only deny payment or refuse to authorize payment of medical services rendered or proposed to be rendered on the grounds that the extent and scope of medical treatment is excessive and unnecessary in compliance with an accredited utilization review program under this Section."

Petitioner submitted outstanding medical bills and services totaling $62,179.84 (Px. #s 2, 3, 5, 6, 7, 8, 9, 10, 11, 13, 14, 15). Respondent claims to have paid $21,004.10 in reasonable and related medical bills and disputes liability for the remaining outstanding charges. (Arb. Ex #1) There are several Utilization Review reports providing Non-Certification decisions in evidence. Respondent's UR failed to certify a retrospective request for physical therapy of the lumbar spine once to twice per week for four weeks between October 2, 2012 and October 23, 2012. (Rx. #3) No other UR reports were submitted for all other physical therapy treatments before and after this period.

Respondent offered two Utilization Review reports in relation to a lumbar injection. In the first report by Dr. Rey Ximenes, the procedure was not certified because he opined that Petitioner's complaints of radiculopathy must be corroborated by either imaging studies or electrodiagnostic testing. (Rx. #4) At that time, the EMG test had not yet been performed. However, in the report following the appeal, Dr. Michael Skaredoff, offered a different standard than Dr. Ximenes' standard, and stated: "Electrodiagnostic studies are helpful in supporting the diagnosis of a compressive radiculopathy, but are not required and do not substitute for imaging studies." (Rx. #4) No other UR Non-Certification reports were submitted into evidence.

The Arbitrator concludes that all treatment that Petitioner received was reasonable, necessary and causally-related to his work injury. There were numerous reports on clinical examinations throughout the records documenting radicular symptoms. These symptoms were objectively confirmed by EMG testing. The MRI reports documented L5-S1 disc pathology and Dr. Sokolowski offered his opinion following a review of the April 23, 2013 MRI: "It is clearly demonstrated once again annular tear on the left at L5-S1. Specifically, T2 weighted axial image #14 of 15 demonstrates neural impingement on the left. Similarly T2 weighted sagittal image #6 of 13 demonstrates an annular tear quite clearly." (Px. #5)

The Arbitrator finds that the medical treatment and services to date have been reasonable, necessary and consistent with the diagnosis. The records suggest that the physical therapy and lumbar injections actually improved Petitioner's condition, although it became worse during strenuous work activities. Since the Arbitrator has concluded that Petitioner did sustain a compensable accident, and that his present condition is causally related to that injury, the Respondent is hereby found to be liable for those bills. Therefore, the Respondent shall pay to the Petitioner an amount equal to the medical bills submitted into evidence, pursuant to Section 8(a) and subject to Section 8.2 of the Act.

Respondent is entitled to a credit for medical bills that they have previously paid.

K. Is Petitioner entitled to any prospective medical care?

Dr. Sokolowski prescribed lumbar decompression surgery at L5-S1 based on the concordance between Petitioner's symptoms, the "clearly identifiable annular tear at L5-S1" on MRI and the positive EMG findings. (Px. #5) Dr. Hsu opined that Petitioner's current condition of ill being is due to a pre-existing condition, but offered no opinion as to whether the prescribed surgery was reasonable or necessary. (Rx. #2) There are no Utilization Review reports in evidence addressing surgery.

The Arbitrator finds that Dr. Sokolowski's prescribed treatment is reasonable, necessary and causally related to Petitioner's work injury. Therefore, the Arbitrator orders Respondent to pay for all reasonable and necessary costs associated with the prescribed surgery, pursuant to Section 8(a) and subject to Section 8.2 of the Act.

L. What temporary benefits are in dispute?

The Petitioner claims that he is entitled to temporary total disability benefits for the period between July 30, 2012 and October 8, 2012, and April 22, 2013 through the date of hearing, August 16, 2013. (Arb. Ex. #1) Respondent claims it paid temporary total disability benefits from July 30, 2012 through October 8, 2012, and April 22, 2013 through May 20, 2013, but denies further liability for any additional claimed temporary total disability benefits after May 20, 2013. (Arb. Ex. #1)

Petitioner remains off of work per Dr. Sokolowski's instructions, pending surgery. (Px. #5) Dr. Hsu opined that Petitioner may be a candidate for restrictions but could not determine what they would be without a physical examination. (Rx. #2) Respondent terminated temporary total disability benefits after May 20, 2013, based on Dr. Hsu's opinion that Petitioner's current condition is not work related. There is no opinion that Petitioner is able to return to full-duty work nor that Petitioner is capable and Respondent is offering work within a specific set of restrictions.

Since the Arbitrator has concluded that Petitioner did sustain a compensable accident, and that his condition is causally related to the injury, the Respondent is therefore liable to pay additional temporary total disability benefits to the Petitioner for 12-4/7 weeks for the period beginning May 21, 2013 through the date of hearing, August 16, 2013.

Since Petitioner has not yet reached a permanent state, this award in no instance shall be a bar to further hearing and determination of a further amount of temporary total compensation or of compensation for permanent disability.

M. Should penalties or fees be imposed upon Respondent?

Petitioner filed a petition seeking penalties and attorney fees under Sections 16, 19(k) and 19(l) of the Act. (Px. #1) Petitioner argues that penalties and fees are warranted where Respondent terminates benefits based on the Section 12 examiner's opinion which, based on the totality of the evidence, is unreasonable. In this case, the two opinions by Respondent's Section 12 examining physician, Dr. Wellington Hsu, are deficient for a number of reasons.

1. Dr. Hsu omits any reference to radicular symptoms throughout his review of the numerous records and reports, despite the multiple notations in the very records he reviewed. (Rx. #1)
2. Dr. Hsu's first report omits all of the references to scapula symptoms found throughout the medical records following the accident. (Rx. #1) He later provides an opinion in his second report that the scapula is not causally related because it is not referenced in the records he reviewed and outlined in his first report. (Rx. #2) His opinion is therefore based on his own misrepresentation of the facts.
3. Dr. Hsu's opinions in his first and second reports are at odds with each other. In his first report, Dr. Hsu interpreted the initial lumbar MRI films as showing evidence of "very mild L4-5 spondylosis." He specifically opined that Petitioner's complaints of back pain were not a manifestation of a pre-existing condition, but rather were "attributed to the lumbar strain." (Rx. #1) In his second report, which he issued without an examination, he opined that Petitioner's current symptoms "would be secondary to a pre-existing condition, which is lumbar spondylosis, which is easily seen on the MRI reports and films." (Rx. #2) He never explains how the "very mild L4-5 spondylosis" which he felt was not the cause of his symptoms at the time of the first examination suddenly became acute and symptomatic, even justifying work restrictions, by the time of his second report. There is no opinion from any other physician that Petitioner's current complaints are due to spondylosis. Nor is there any current treatment recommendations to the L4-5 disc level.

The burden is on the Respondent to show that any delay in paying benefits is reasonable. Respondent is permitted to rely on a qualified examiner, even if the Petitioner questions the opinions of the examiner. However, if the opinions are not logical or reasonable based on the totality of the evidence, penalties and attorney fees are justified. While the Arbitrator has determined that Dr. Hsu's opinions lack credibility due to his omissions and inconsistencies, Respondent's reliance on Dr. Hsu's inherently

contradicting opinions and misrepresentation of facts material to the evaluation of Petitioner's injuries warrants penalties and attorney fees.

The test is not whether there is some conflict in medical opinion. Rather, it is whether the employer's conduct in relying on the medical opinion to contest liability is reasonable under all circumstances presented. Continental Distributing v. Indus. Comm'n, 98 Ill.2d 407, 456 N.E.2d 847, 75 Ill. Dec. 26 at page 30 (1983)

Therefore, the Arbitrator awards penalties to the extent of $30 per day for a period of 12-4/7 weeks, or $2,640.00, which represents the amount of time that compensation has been unjustly withheld from Petitioner, pursuant to Section 19(l) of the Act.

Attorneys' fees may not be awarded when penalties are imposed pursuant to Section 19(l) alone. Boker v. Indus. Comm'n, 141 Ill.App.3d 51, 489 N.E.2d 913, 95 Ill. Dec. 351 (1986)

DATED AND ENTERED March 28, 2014

Brian T. Cronin

Brian Cronin
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 Accident	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☐ Modify	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

JOSE OLIVA,

Petitioner,

14IWCC1018

vs.

NO: 11 WC 28920

CITY OF CHICAGO,
DEPARTMENT OF STREETS AND SANITATION,

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, permanent partial disability (PPD) and being advised of the facts and applicable law, reverses the Decision of the Arbitrator and finds that Jose Oliva sustained bilateral carpal tunnel syndrome that arose out of and in the course of his employment on March 2, 2011.

The Commission has considered all of the testimony, exhibits, pleadings and arguments submitted by the parties. Based on the evidence, the Commission finds that Mr. Oliva sustained a repetitive work-related injury that manifested itself on March 2, 2011. As the result of the work-related accident, the Petitioner is entitled to medical expenses totaling $2,293.13 and 5% loss of use of each hand.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

The Commission makes the following findings:

1. Mr. Oliva filed an Application for Adjustment of Claim on August 1, 2011. He alleged injury to the bilateral hands and arms as the result of his repetitive work duties. The

manifestation date was March 2, 2011. Petitioner denied any prior hand/wrist issues. T.16. He is right handed and has never smoked. T.20.

2. Petitioner testified that he has been employed by the City of Chicago since 1990 and has worked in data entry for the last 6 years. He previously worked for the City as a Hoisting Engineer. However, on January 6, 2004, he sustained a right rotator cuff tear and bicep tendon rupture that resulted in permanent restrictions, which precluded him from returning to his position as a Hoisting Engineer. PX.3. Due to his restriction, Petitioner was given a light duty data entry position.

3. Petitioner testified that his work shift is 7.5 hours long and he spends 5 hours a day, 5 days a week working on a computer. He waits for sorting to come to him during the other 2.5 hours. T.18. He stated that his keyboard was high up and his chair was not adjustable. T.11. He would also answer phones and had a 30 minute lunch. T.18.

4. Petitioner does not recall when he first started complaining of hand pain. *Id.* He sustained a stroke unrelated to his work on November 26, 2011 and has not worked for the City since.

5. Petitioner was seen by Dr. Ashish Patel of Mercy Works on March 10, 2011 with complaints of bilateral wrist soreness and bilateral shoulder soreness. He reported that his symptoms have been occurring for many years since he has been employed as a typist. He reported occasional numbness in both wrists while typing. His past medical history included heart disease and diabetes. Examination revealed full range of motion of both wrists. He had a mildly positive Tinel's sign in both wrists and a negative Phalen's sign. He had no weakness. The assessment was bilateral wrist and shoulder strain. PX.4.

6. Mercy Works referred Petitioner to Dr. John Sonnenberg on March 21, 2011 for evaluation of his bilateral hand and shoulder pain that had been present for 8 month due to typing on a computer. According to his medical history form, Petitioner had a history of heart disease, high blood pressure, and diabetes. PX.5.

7. Mr. Oliva underwent an EMG on April 28, 2011. He was found to have bilateral median neuropathies at the wrist, electrophysiologically mild. There was borderline difference in F-wave latencies and medial antebrachial cutaneous amplitudes that were suggestive of, though not conclusive for, a right brachial plexopathy. There was no electrophysiologic evidence of ulnar palsy or cervical radiculopathy. PX.5.

8. On May 5, 2011, Trudy Sullivan of the Respondent contacted Mercy Works stating that Petitioner was not authorized to continue treatment with Mercy Works. PX.4.

9. Petitioner was seen by Dr. Sonnenberg on May 19, 2011. Dr. Sonnenberg noted that the EMG showed definite bilateral carpal tunnel syndrome and no significant diabetic

neuropathy. He assumed that the majority of Petitioner's problem was actually from repetitive use, probably data entry. He recommended injections. PX.1.

10. Petitioner underwent a Section 12 examination with Dr. Robert Wysocki of Midwest Orthopaedics Hand and Surgery Center on June 17, 2011. He noted that Petitioner quit smoking in the past and drank socially. Petitioner was 5'11" and 260 pounds. He opined that Petitioner's condition was insidious onset over the last year. There was no causal relationship between his occupation and symptoms. He noted that the literature regarding carpal tunnel was that sedentary work, even high frequency repetitive typing cannot consistently be linked in a causal fashion with carpal tunnel. Petitioner also had risk factors including diabetes and obesity. He diagnosed Petitioner with carpal tunnel syndrome and recommended bilateral carpal tunnel release. He could work full-duty and was at MMI as far as conservative treatment was concerned. RX.1.

11. Petitioner was seen by Dr. Sonnenberg on October 20, 2011. Petitioner underwent three prior injections with minimal relief. He had a positive Tinel's and Phalen's sign with numbness in the median nerve distribution. Petitioner did not want surgery and was content doing light duty work. He wanted another injection. Dr. Sonnenberg noted the ultimate goal was surgery. PX.1.

12. Petitioner underwent a Section 12 examination with Dr. Jeffrey Coe of Occupational Medicine Associates of Chicago on February 19, 2013. The examination was at the request of Petitioner's attorney. He opined that Petitioner suffered repetitive strain injuries to both hands in his work in data processing. The repetitive strains were a factor in causing development of symptomatic bilateral carpal tunnel syndrome. There was a causal relationship between the repetitive strain injury suffered at work and his current bilateral hand symptoms and state of impairment. Bilateral carpal tunnel release was warranted. He needed restrictions to include limitation of repetitive and forceful gripping, and limitation of repetitive use of the hands. He noted that Petitioner had a 15 year history of diabetes mellitus controlled with oral medication. Petitioner reported that he had not been diagnosed with diabetic neuropathy. PX.7.

13. Petitioner testified that his hands swell, tingle and hurt daily. They get stiff 2 to 3 times daily. T.15. He has not seen a doctor for his hand since 2011. He has unpaid medical bills totaling $2,293.00. T.16.

An injury is considered "accidental" even though it develops gradually over a period of time as a result of repetitive trauma, without requiring complete dysfunction, if it is caused by the performance of claimant's job. *Peoria County Belwood Nursing Home v. Industrial Comm'n* (1987), 115 Ill. 2d 524, 529-30, 505 N.E.2d 1026, 1028, 106 Ill. Dec. 235. Plaintiff must meet the burden of proving that the injury was work-related and not the result of normal degenerative aging processes. *Belwood*, 115 Ill. 2d at 530, 505 N.E.2d at 1028.

The Commission finds that the Petitioner established that his job duties were repetitive in nature. The Petitioner's unrebutted testimony was that he typed on a keyboard for 5 hours per day, 5 days per week. He sat in a chair that was not adjustable and his keyboard was located high on a table. The Respondent offered no evidence to rebut the Petitioner's assertion that his job was repetitive in nature, and that his workstation was not ergonomically correct. Petitioner performed a singular activity on a highly repetitive basis.

The Commission is cognizant of the fact that Petitioner had several co-morbid risk factors for the development of carpal tunnel. However, employers take their employees as they find them. *O'Fallen School District No. 90 v. Industrial Comm'n*, 313 Ill. App. 3d 413, 417, 729 N.E.2d 523, 246 Ill. Dec. 150 (2000). To result in compensation under the Act, a claimant's employment need only be a causative factor in his condition of ill-being; it need not be the sole cause or even the primary cause. *Sisbro Inc. v. Industrial Comm'n*, 207 Ill. 2d 193, 205, 797 N.E.2d 665, 278 Ill. Dec. 70 (2003).

The Commission notes that Petitioner was sent to Mercy Works by the Respondent. Mercy Works then referred Petitioner to Dr. Sonnenberg. Dr. Sonnenberg issued a causal connection opinion in favor of the Petitioner. The Respondent then cut off Petitioner's treatment with Mercy Works and obtained a Section 12 opinion from Dr. Wysocki finding no causal connection. The Commission finds the opinion of Dr. Sonnenberg more persuasive than the opinion of Dr. Wysocki. Dr. Wysocki's opinion ignores the Petitioner's statement that he did a significant amount of typing at work and that his symptoms would manifest themselves while typing at work. The Respondent offered no evidence to rebut this assertion. Further, Dr. Wysocki also noted that Petitioner had other risk factors for carpal tunnel including diabetes. However, Dr. Wysocki does not address the EMG finding of no significant diabetic neuropathy. Dr. Sonnenberg's opinion is persuasive as he considered the Petitioner's job duties along with the onset of his symptoms. While it is true that Petitioner had co-morbid risk factors for carpal tunnel, it is equally true that Petitioner's symptoms did not become manifest until after he began performing his data entry duties. The Petitioner proved that his employment was a causative factor in his condition of ill-being.

The Petitioner declined to undergo bilateral carpal tunnel surgery. Therefore, the Commission finds that the Petitioner is entitled to 5% loss of use of each hand. The Petitioner is entitled to medical expenses of $2,293.13.

IT IS THEREFORE ORDERED BY THE COMMISSION, that the Decision of the Arbitrator filed on February 19, 2014, is hereby reversed.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $669.64 per week for a period of 20.50 weeks, as provided in §8(e)(9) of the Act, for the reason that the injuries sustained caused the loss of use of 5% of the right hand and 5% of the left hand.

14IWCC1018

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $2,293.13 for medical expenses under Section 8(a) of the Act and subject to the medical fee schedule.

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

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

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

DATED: NOV 2 5 2014

Michael J. Brennan

MJB/tdm
O: 10-7-14
052

Thomas J. Tyrrell

Dissent

I respectfully dissent from the decision of the majority. I would affirm and adopt Arbitrator Williams' well reasoned decision in its entirety and without modification.

Kevin W. Lamborn

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

OLIVA, JOSE
Employee/Petitioner

Case# **11WC028920**

14IWCC1018

CITY OF CHICAGO
Employer/Respondent

On 3/6/2014, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

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

2559 BOWMAN & CORDAY LTD
JOHN T BOWMAN
20 N CLARK ST SUITE 500
CHICAGO, IL 60602

0113 CITY OF CHICAGO
STEPHANIE LIPMAN
30 N LASALLE ST SUITE 800
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

JOSE OLIVA
Employee/Petitioner

v.

CITY OF CHICAGO
Employer/Respondent

Case #11 WC 28920

14IWCC1018

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable Robert Williams, arbitrator of the Workers' Compensation Commission, in the city of Chicago, on February 19, 2014. After reviewing all of the evidence presented, the arbitrator hereby makes findings on the disputed issues, and attaches those findings to this document.

ISSUES:

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

B. ☐ Was there an employee-employer relationship?

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

D. ☐ What was the date of the accident?

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

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

G. ☐ What were the petitioner's earnings?

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

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

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

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

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

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

N. ☐ Is the respondent due any credit?

O. ☐ Prospective medical care?

FINDINGS

- On March 2, 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 $91,104.00; the average weekly wage was $1,752.00.
- At the time of injury, the petitioner was 65 years of age, married with no children under 18.

ORDER:

- All claims for compensation are denied and the claim is dismissed.

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

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

Robert E. Williams

Signature of Arbitrator

March 6, 2014
Date

MAR 6 - 2014

FINDINGS OF FACTS: 14IWCC1018

The petitioner sought medical care at MercyWorks on March 10, 2011, for bilateral wrist and shoulder soreness for many years since his employment as a typist. He reported occasional numbness in his wrists while typing and bilateral shoulder surgery six years earlier, heart disease and diabetes. The diagnosis was bilateral wrist and shoulder strain. He followed up at MercyWorks on the 18th and saw Dr. John Sonnenberg at Midland Orthopedics Associates on the 21st. Pursuant to Dr. Sonnenberg's request, an EMG/NCV study on April 28th was consistent with bilateral median neuropathies at the wrist. Dr. Sonnenberg opined on May 19th that the EMG definitely showed bilateral carpal tunnel syndrome but no significant diabetic neuropathy. The petitioner received injections into his wrists but with no satisfactory benefit. A second injection on June 9th provided six weeks of improvement. He reported a reoccurrence of his symptoms on October 20th after a third injection on August 18th and requested another injection instead of surgery.

FINDING REGARDING THE DATE OF ACCIDENT AND WHETHER THE PETITIONER'S ACCIDENT AROSE OUT OF AND IN THE COURSE OF HIS EMPLOYMENT WITH THE RESPONDENT:

Based upon the testimony and the evidence submitted, the petitioner failed to prove that he sustained an accident on March 2, 2011, arising out of and in the course of his employment with the respondent. Other than his testimony of typing on a computer the past six years, there was no evidence of the average number of documents and pages typed each hour, day and/or week, what his typing duties were or a description of the typing performed - reports, documents, data entry and/or field input, the output required to perform his duties and/or his average output or speed, and/or the continuity of his

typing absent breaks, interruptions, phone calls and mouse use. The petitioner failed to establish that his typing on a computer was a sufficient repetitive trauma that resulted in his bilateral carpal tunnel syndrome. All claims for compensation are 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 down	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Steven Dunteman,

Petitioner,

14IWCC1019

vs.

NO: 11 WC 40320

Caterpillar, Inc.,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by Petitioner herein and notice given to all parties, the Commission, after considering the issues of accident, causal connection, medical expenses, temporary total disability benefits, permanent disability, and Section 19(d) of the Illinois Workers' Compensation Act (hereinafter "Act"), reverses the Decision of the Arbitrator regarding causal connection, finds that Petitioner's current condition of ill-being is not casually related to the June 21, 2011 work accident, and vacates all awards of compensation.

So that the record is clear, and there is no mistake as to the intentions or actions of this Commission, we have considered the record in its entirety. We have reviewed the facts of the matter, both from a legal and a medical / legal perspective. We have considered all of the testimony, exhibits, pleadings and arguments submitted by the Petitioner and the Respondent.

One should not and cannot presume that we have failed to review any of the record made below. Though our view of the record may or may not be different than the Arbitrator's, it should not be presumed that we have failed to consider any evidence taken below. Our review of this material is statutorily mandated and we assert that this has been completed.

With the above in mind, the Commission notes that while it was stipulated to by the parties that Petitioner's blister was a result of Petitioner's work for Respondent, there is nothing in the record to indicate that the blister itself was in any way the cause of Petitioner's infection and/or ultimate amputation of Petitioner's left third toe in the left foot. The medical records indicate that Petitioner did not develop an infection in his left foot until after Petitioner had

lanced the blister at the bottom of his left foot. The Commission notes that Petitioner testified that following the lancing of the blister, his foot condition worsened and he developed redness and swelling, symptoms he did not have prior to the lancing. (T.36-37) The Commission further notes that Petitioner attributed the heat and humidity to his worsening condition. (T.34-35) Petitioner testified that his left foot condition became worse over time and as the temperature became hotter and more humid. (T.37)

On July 4, 2011, Petitioner went to the hospital, where he was diagnosed with lower extremity cellulitis and diabetes mellitus 2. The Commission notes that these are the same conditions Petitioner was diagnosed with back in 2009, except at that time the cellulitis was in the right lower extremity. (PX5,RX6) At the hospital on July 4, 2011, Dr. Smith noted that Petitioner noticed a blister formation on the plantar aspect of his left foot "approximately a week and a half" before this visit. (PX4) Dr. Smith further noted that Petitioner "used a hot needle that he seared on the stove along with peroxide to drain this abscess and/or blister at that time. He thought that this would be adequate. However, his foot got progressively red and painful." (PX4)

The Commission notes that on August 10, 2012, Petitioner's Section 12 examiner, Dr. Coe, testified that Petitioner's infection "arose from the penetration of the blister in his left foot with a needle that unfortunately became infected." (PX6-pg.34) Dr. Coe further admitted that he thought it was "correct to say that the infection arose after he drained the blister using the hot needle as he described it." (PX6-pg.48)

In *Vogel v. Illinois Workers' Compensation Commission*, 354 Ill. App. 3d 780, 786 (2005), the court explained that:

> "[e]very natural consequence that flows from an injury that arose out of and in the course of the claimant's employment is compensable **unless caused by an independent intervening accident that breaks the chain of causation between work-related injury and an ensuing disability or injury.**" (emphasis added)

As previously mentioned, the parties stipulated that Petitioner's work activities caused the development of the blister. However, the Commission notes that the infection did not come from the existence of the blister, but from Petitioner's lancing of the blister, which constitutes an intervening accident that breaks the causal chain between the development of the blister and Petitioner's current condition of ill-being. The blister, in and of itself, did not lead to the infection. Petitioner's actions lead to the infection, and the infection is what led to the amputation of Petitioner's left third toe.

There is nothing in the record to indicate that the infection was a result of Petitioner's work with Respondent. Instead, as explained above, the record points to Petitioner's lancing of the blister, and not the blister itself, as the cause of Petitioner's left foot infection. Therefore, based on the totality of the evidence, the Commission finds that the infection, and not the blister,

caused Petitioner's left foot condition and, ultimately, the amputation of Petitioner's left third toe. As a result, Petitioner failed to prove that the development of the blister at work is causally related to Petitioner's need for treatment of an infection, the amputation of his toe, and his current condition of ill-being. Therefore, the Commission reverses the Arbitrator's finding regarding causal connection and finds that Petitioner's current condition of ill-being is not causally related to the June 21, 2011 accident.

The Commission notes that in its Statement of Exceptions to Arbitrator's Decision and Supporting Brief, Respondent also argued, that Petitioner engaged in injurious practices under Section 19(d) of the Act when he lanced the blister on his left foot. The Commission finds that a complete reading of Section 19(d) establishes that it does not apply in this case.

Section 19(d) of the Act reads, in pertinent part:

> "If any employee shall persist in insanitary or injurious practices which tend to either imperil or retard his recovery or shall refuse to submit to such medical, surgical, or hospital treatment as reasonably essential to promote his recovery, the Commission may, in its discretion, reduce or suspend the compensation of any such injured employee." 820 ILCS 305/19(d) (2013).

The Commission notes that this section deals with a claimant negatively affecting his/her recovery. It does not deal with a claimant's actions as the cause of his/her injuries or a claimant's behavior severing the causal connection between a work accident and the claimant's condition of ill-being. Therefore, Section 19(d) of the Act does not apply to the case at bar.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed on August 8, 2013, is hereby reversed as stated above and all awards of compensation vacated.

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.

14IWCC1019

No bond is required for removal of this cause to the Circuit Court. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED:
MJB/ell
o-09/30/14
52

NOV 2 5 2014

Michael J. Brennan

Kevin W. Lamborn

DISSENT

Respectfully, I dissent from the majority's decision in finding that the condition of ill-being in Petitioner's left foot was not causally related to his June 21, 2011 work accident.

This finding was made despite the fact that it was undisputed that Petitioner sustained a work-related accident which caused a blister to form on the bottom of his left foot. The majority notes that the lancing of the blister by Petitioner led to an infection. The majority finds "that the infection, and not the blister, caused Petitioner's left foot condition and, ultimately, the amputation of Petitioner's left third toe."

The majority relies on *Vogel v. Illinois Workers' Compensation Commission*, 354 Ill. App 3d 780, 786 (2005), in determining that the lancing of the blister by Petitioner constituted an intervening accident that broke the causal chain between the work-related blister and Petitioner's current condition of ill-being.

Respectfully, I disagree with the reasoning of the majority. It is clear that the blister was work-related—that fact has been stipulated by both parties. I would find that Petitioner's action of lancing the blister in a sterile manner does not constitute an intervening accident or injurious practice. Petitioner's actions were not an intervening accident, but a natural consequence of the work-related injury. Petitioner was required to drive an old ten-gear truck with a clutch that required forceful application with the left foot. Combined with repetitive exiting of the truck while spinning on the same point of impact on the bottom of his left foot, Petitioner incurred the work-related blister. If Petitioner had not incurred the work-related blister, his foot would not have become infected. If Petitioner's foot had not become infected, no amputation would have been required. Hence, this work related injury is clearly causally connected to his current condition of ill-being.

In order for an intervening non-work related cause to relieve an employer of liability, the intervening incident must completely break the causal chain between the injury and the ensuing condition. Accidental injury need not be the sole causative factor, nor even the primary causative factor, as long as it was "a" causative factor in the resulting condition of ill-being. *Rock Road Construction Co. v. Industrial Comm'n*, 37 Ill.2d 123, 127, 227 N.E.2d 65 (1967). It is clear to this Commissioner in this case that the stipulated work-related accident which led to a blister forming on the bottom of the Petitioner's left foot was a causative factor in Petitioner's

resulting condition of ill-being. Also, it is a foreseeable consequence that a blister has a natural potential to become infected. To me this is a fact regardless of whether the blister popped naturally or was lanced by Petitioner.

The majority never fully addresses Respondent's argument that Petitioner engaged in injurious practices under Section 19(d) of the Act when Petitioner lanced the blister on his left foot because of their finding that the infection was not a work-related accident. The majority therefore correctly categorizes Section 19(d) as dealing with a claimant negatively affecting their recovery. Once the injury is found to be work-related, the argument needs to be addressed.

I would uphold the decision reached by Arbitrator Zanotti in finding that Petitioner did not commit an injurious practice pursuant to Section 19(d) of the Act. Section 19(d) infers a degree of intent to imperil or retard one's recovery. See *Global Products v. Workers' Comp. Comm'n,* 392 Ill. App. 3d 408 (2009). (Claimant's smoking did not constitute an injurious practice, even though it may have negatively impacted his recovery, because there was no evidence that the claimant smoked for the purpose of retarding his recovery). In the current case, there is no evidence that Petitioner was attempting to retard his recovery, on the contrary the record supports a finding that Petitioner lanced the blister in order to get some relief from the blister on the bottom of his foot that was a work related accident. As such, Petitioner's action was not an injurious practice and did not break the chain of causation.

As in most cases, there are different medical opinions, one offered by Petitioner's treating physician, Dr. Anderson and shared by Petitioner's Section 12 examiner, Dr. Coe. The differing opinion comes from Respondent's Section 12 examiner, Dr. Chiodo. Dr. Anderson, the treating surgeon, noted that Petitioner's activities at work most likely caused the original ulceration which developed into the infection. Dr. Anderson opined that Petitioner's job put him at risk for ulcerations to his feet and that such an ulceration ultimately led to Petitioner's infection. Dr. Coe agreed and opined that there was a causal relationship between the left foot repetitive strain injury suffered by Petitioner and his current left foot symptoms and state of impairment. Dr. Chiodo denied causation, asserting that the infection developed on the top of, as opposed to the bottom of, Petitioner's foot.

The Supreme Court of Illinois has ruled that the Commission may properly attach greater weight to the opinion of the treating physician, as the Arbitrator did in this case. See, *Holiday Inns of America v. Indus. Comm'n,* 43 Ill.2d 88, 89-90, 250 N.E.2d 643 (1969). The Arbitrator's decision to not rely on Dr. Chiodo's opinion regarding causal connection is justified and rationally reasoned. Dr. Chiodo's opinion has little basis for his conclusion. The medical records clearly indicate that the infection was focused in the plantar aspect of Petitioner's foot, and not on the top. Also, Dr. Chiodo based his causation opinion on Petitioner having improper foot care, as evidenced by his examination of Petitioner on May 25, 2012. This examination occurred nearly one year after the onset of the infection and subsequent to his three left foot surgeries. Dr. Chiodo's contention is uncorroborated by any medical record. Further, no treating

physician indicated that Petitioner had improper foot care or needed to improve his foot care regimen prior to his infection.

As all of Petitioner's testimony, medical records and Dr. Anderson's and Dr. Coe's opinions support the conclusion that Petitioner's condition of ill-being and surgeries are causally related to the accident, the Commission should affirm the Arbitrator's decision.

Therefore, I urge the Commission to reconsider. I would uphold the well-reasoned decision reached by Arbitrator Zanotti. I would insist on the employer paying all remaining and outstanding medical bills, and temporary total disability benefits from July 4, 2011 through September 4, 2011. Lastly, based upon all the medical records and testimony in this matter, a finding that Petitioner has sustained a 100% loss of his left third toe and 20% loss of his left foot is fair and just.

Thomas J. Tyrrell

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

DUNTEMAN, STEVEN
Employee/Petitioner

Case# **11WC040320**

CATERPILLAR INC
Employer/Respondent

14IWCC1019

On 8/8/2013, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.07% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

A copy of this decision is mailed to the following parties:

0293 KATZ FRIEDMAN EAGLE ET AL
PHILIP BARECK
77 W WASHINGTON ST 20TH FL
CHICAGO, IL 60602

2994 CATERPILLAR INC
MARK FLANNERY
100 N E ADAMS
PEORIA, IL 61629-4340

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

STEVEN DUNTEMAN
Employee/Petitioner

v.

CATERPILLAR, INC.
Employer/Respondent

Case # 11 WC 40320

14IWCC1019

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Brandon J. Zanotti**, Arbitrator of the Commission, in the city of **Springfield**, on **June 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: Did Petitioner commit an injurious practice pursuant to Section 19(d) of the Act?

14IWCC1019

FINDINGS

On **June 21, 2011**, Respondent *was* operating under and subject to the provisions of the Act.

On this date, an employee-employer relationship *did* exist between Petitioner and Respondent.

On this date, Petitioner *did* sustain an accident that arose out of and in the course of employment.

Timely notice of this accident *was* given to Respondent.

Petitioner's current condition of ill-being *is* causally related to the accident.

In the year preceding the injury, Petitioner earned **$37,117.88**; the average weekly wage was **$713.81**.

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 **$0** for TTD, **$0** for TPD, **$0** for maintenance, and **$3,464.28** for other benefits, for a total credit of **$3,464.28**.

Respondent is entitled to a credit of **$56,395.90** under Section 8(j) of the Act.

ORDER

Respondent shall pay reasonable and necessary medical services of $2,117.13, as provided in Section 8(a) of the Act, and subject to the medical fee schedule, Section 8.2 of the Act. (Note: The $2,117.13 figure is the amount due after Respondent's credit is taken into account).

Respondent shall pay Petitioner temporary total disability benefits of $475.87/week for 9 weeks, commencing July 4, 2011 through September 4, 2011, as provided in Section 8(b) of the Act.

Respondent shall pay Petitioner the sum of $428.29/week for a further period of 46.4 weeks, as provided in Sections 8(e)7 and 8(e)11 of the Act, because the injuries sustained caused the 100% loss of use of the third toe and the 20% loss of use of the left foot.

Petitioner did not commit an injurious practice pursuant to Section 19(d) 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

08/01/2013
Date

AUG 8 - 2013

STATE OF ILLINOIS)
) SS
COUNTY OF SANGAMON)

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

STEVEN DUNTEMAN
Employee/Petitioner

v.

CATERPILLAR, INC.
Employer/Respondent

14IWCC1019

Case # 11 WC 40320

MEMORANDUM OF DECISION OF ARBITRATOR

FINDINGS OF FACT

On June 21, 2011, Petitioner, Steven Dunteman, testified he worked for Respondent, Caterpillar, Inc., as an "outside driver." As an outside driver, Petitioner testified that he would drive trucks to various locations inside and outside the plant and that he was required to hook, dismantle and transport materials.

In 1999, Petitioner testified that he underwent a Department of Transportation (DOT) physical examination, and was found to have above-normal blood sugar levels. During that examination, the DOT doctor encouraged Petitioner to improve his dietary/eating habits, but never recommended medications, injections, or any follow-up evaluations with specialists. Petitioner testified that he followed the doctor's advice, improved his eating habits, and monitored his consumption.

Between 1999 and 2008, Petitioner testified that he felt good, continued monitoring his diet, and had no issue with his blood sugar. In October 2009, Petitioner testified that he was involved in a work accident (unrelated to the present claim), and was taken to the hospital, at which time he was first diagnosed with Type 2 Diabetes. At the emergency room doctor's recommendation, Petitioner followed-up with his primary care doctor, Dr. Daniel Smith for the condition. According to Dr. Smith's records, on November 9, 2009, Petitioner had elevated blood sugar levels and Dr. Smith noted that Petitioner was "trying to work on his diet" and "continues to be under a lot of stress." (Petitioner's Exhibit (PX) 5; Respondent's Exhibit (RX) 3). Petitioner testified that he began taking Metformin medication at Dr. Smith's recommendation in order to reduce his blood sugar levels. On January 26, 2010, Petitioner followed-up with Dr. Smith and was found to have fluctuating blood sugar levels. The doctor noted that Petitioner continued monitoring his diet. Dr. Smith noted that the diabetes was "under fair control." (PX 5; RX 3). Petitioner testified that he continued to take Metformin and also began testing his blood at home twice per day to monitor his blood sugar levels. Petitioner testified that he continued to follow-up with Dr. Smith, and noticed his blood sugar levels were dropping below normal. Petitioner testified that he felt it was affecting his personal life, so he contacted his doctor and it was decided to discontinue the Metformin. Petitioner testified that his blood sugar levels remained maintained between July 2010 and June 2011.

On June 21, 2011, the parties stipulated that Petitioner sustained an accidental injury to his left foot which arose out of and in the course of his employment. (See Arbitrator's Exhibit (AX) 1). Petitioner testified that the automatic truck that he was driving was being repaired, and it was replaced in May 2011 with an older ten-speed truck with a clutch. Petitioner testified that the clutch was on the left side of the truck and required him to strike it forcefully with the bottom of his left foot. Petitioner testified that he wore steel-toed shoes but the bottom was rubber with no additional protection. Petitioner testified that he was required to strike the steel clutch approximately 200 times per shift, and he spent approximately 70% of the day operating the truck and 30% of the day leaving the truck to perform tasks outside of the truck. When exiting the truck, he would step onto a steel, ridged corrugated step and spin on the left upper portion of his foot, in the same area where his foot struck the clutch. He exited the truck approximately 30 times per day, spinning on his left foot. After approximately four weeks of driving the ten-speed truck, Petitioner testified that he began noticing bruising on the bottom pad of his left foot under his second, third and fourth toes. Petitioner testified it was the same area in which he repeatedly struck the clutch and steel step.

Toward the end of June 2011, Petitioner testified that he was taking a bath and washing his feet, when he noticed a water blister under the callus formation on the bottom of his left foot between his third and fourth toes. He rubbed and loosened up his foot, stepped on a towel and walked to his kitchen. He sterilized a needle in order to pop the blister and relieve the pressure/pain in his foot. He testified that he boiled the needle in hot water and may have used a lighter flame as well for sterilization. He used peroxide and cotton, propped up his foot, and inserted the needle to relieve the blister. Petitioner testified that liquid immediately began to drain. When asked about popping the blister, Petitioner testified he was taught by his mother at a young age to sterilize a needle and use peroxide to pop blisters, and he had done so in the past without any complications.

Petitioner testified he continued to work wearing light, cotton socks in the work boots but continued to have pain and problems with his left foot. He noticed that striking the clutch with his left foot worsened the pain, and he began walking with a limp and noticed an ulcer on the bottom of his left foot where the blister formed. Petitioner testified he called Dr. Smith at this point. On July 1, 2011, Dr. Smith's records note that Petitioner had a sore on his foot which he was worried about getting infected, that he bruised his foot under his callus and was taking Metformin again because of elevated blood sugar levels. (PX 5; RX 3). Petitioner testified that neither Dr. Smith nor any other physician ever advised him against popping a blister himself.

On July 4, 2011, Petitioner testified that his left foot began to swell and redden around the blister. He marked on a photograph of his foot with the letter "R" where the redness occurred. (PX 8). Because it was the weekend, he was unable to see Dr. Smith and instead presented to St. Mary's Hospital. He was admitted and the triage notes indicate a two week onset of left foot problems, after he pushed on a pedal in a semi-trailer with his left foot and developed a bruise on the bottom of his foot which led to edema and redness. (PX 3, 4; RX 4). On July 5, 2011, Petitioner underwent surgery performed by Dr. Jason Anderson. The pre-operative diagnosis noted was cellulitis and abscess of the left foot. The surgery documents a two week history of a blister on the plantar aspect of the left foot, which Petitioner popped with a needle and subsequently had increased redness and darkening of the spot. The operative procedure consisted of an incision and drainage, deep abscess left foot 3rd interspace, a debridement including tendon and fascia, and delayed closure. According to the July 5, 2011 operative report, attention was focused on the plantar aspect of the foot where an ulceration was noted. The doctor performed incisions "encompassing" the ulceration. The doctor noted that it was directly beneath the third metatarsal head. (PX 3; RX 4). Petitioner made a line marking on a photograph depiction of the bottom of his foot indicating where the surgical incision occurred. (PX 8).

The following day, Petitioner underwent a second surgery performed by Dr. Anderson, which included irrigation debridement because of a delayed closure in the left foot. The pre- and post-operative diagnoses noted were "deep abscess left foot." (PX 3; RX 4).

On August 2, 2011, Dr. Anderson's notes indicate that Petitioner's third toe was completely "gangrenous" and "necrotic" and amputation of the third toe was recommended. On August 5, 2011, Dr. Anderson performed a third surgery, which was a left third toe amputation with medial based toe flat closure as well as deep interspace debridement in the left third interspace. The pre- and post-operative diagnoses noted were "left third toe necrosis and cellulitis." (PX 3; RX 4). It was also noted that Petitioner had a flexion contracture of his left second toe. Petitioner was taken off work per Dr. Anderson on July 4, 2011, and was released to return to work effective September 5, 2011. (PX 3).

On September 20, 2011, Dr. Anderson's medical records indicate that the redness and swelling resolved and there were no additional lesions or open ulcerations. Dr. Anderson went on to say that Petitioner's "job puts him at risk for these ulcerations as he has to use his left foot not only to clutch but also get in and out of the truck. This is most likely the cause of his original ulceration. ...there would have been no reason for him to suffer a large callus without the direct mechanism and repetitive mechanism." (PX 3; RX 4).

On February 7, 2012, Petitioner was examined at his attorney's request by Dr. Jeffrey Coe. Dr. Coe testified by evidence deposition. Dr. Coe found that Petitioner's diabetes condition was mild as he was not insulin-dependent with no known complications associated with the diabetes. (PX 6, p. 25). Dr. Coe testified, based upon a reasonable degree of medical certainty, that there was a causal relationship between the nature of Petitioner's work with Respondent involving the repetitive clutch depression and climbing in and out of the truck and his condition of ill-being regarding his left foot. (PX 6, pp. 32-33). Dr. Coe testified that diabetes places Petitioner at a higher risk for infections, but opined that the left foot condition and surgeries would not have developed if it was not for the blister (which occurred from the repetitive activities) penetration. (PX 6, pp. 33-34). Dr. Coe clarified on cross-examination that the infection arose after Petitioner drained the blister using the needle. (PX 6, p. 48). Dr. Coe also testified that Petitioner's post-operative, post-infectious flexion contracture of his left second toe and his ankle swelling was also causally related to the infection. (PX 6, pp. 52-53).

On May 25, 2012, Petitioner was examined at Respondent's request by Dr. Ernest Chiodo pursuant to Section 12 of the Illinois Workers' Compensation Act, 820 ILCS 305/1 *et seq.* (hereafter the "Act"). Dr. Chiodo testified by evidence deposition. Dr. Chiodo testified that Petitioner had diabetes and was not exercising proper foot care for his condition, which included medical supervision for his diabetic condition, medications to lower his blood sugar, diet, exercise and weight loss as the proper treatment. (RX 2, pp. 11-13, 19). Dr. Chiodo found no causal relationship between the surgeries and Petitioner's work duties, and asserted that Petitioner's infection "happened on the top of his foot, not on the bottom of his foot." (RX 2, pp. 16-18). Dr. Chiodo admitted that Petitioner's foot blister arose from repetitive use of the clutch at work resulting from the friction from the clutch use; he did not believe, however, that the foot infection had anything to do with the blister. (RX 2, pp. 14, 28-31). Dr. Chiodo agreed that once a blister has formed, complications can arise from a blister. (PX 2, p. 31).

Petitioner testified, and the medical records confirm, that he has had no problems with his right foot. Petitioner returned to work with a full duty release. He testified that he currently works a full 40-hour work week, with no restrictions or assistance. He returned to work with Respondent on September 5, 2011, keeping the same job title. His current job duties are similar to his duties before the work accident, but he currently drives a "jockey truck," which is automatic. He is in a different department now as well,

which requires transporting frames. He testified this is lighter duty work than his job before, and that he does not have to move as much.

Petitioner testified as to his hobby of working in his garage, and notices that following his foot surgeries it is harder to get up after being on his knees, as he cannot place much pressure on the amputation site of his foot due to the immense pain it causes. He has had to adjust the manner in which he gets up from this position. He testified to issues concerning his balance, in that he will wobble if he does not place pressure on his left foot, but that the pressure causes pain. He testified that cold temperatures cause discomfort in his foot, and that the scarred area will become numb.

At the time of trial, Petitioner testified that he no longer takes Metformin for his diabetes, and stopped doing so at the end of 2012. He testified that no doctor has recommended he resume taking this medication. He clarified that he was no longer taking Metformin because he had lost weight and had controlled his diet.

Petitioner offered into evidence invoices regarding medical expenses he incurred as a result of his foot treatment. (PX 7). He noted an outstanding balance of $2,117.13, and that the remaining medical bills were paid through Respondent's group insurance carrier.

CONCLUSIONS OF LAW

Issue (F): Is Petitioner's current condition of ill-being causally related to the injury?

In May 2011, Petitioner's truck was changed to an older ten-speed truck with a clutch. The evidence reveals that Petitioner repetitively and forcefully pressed on the steel clutch approximately 200 times per shift for about four weeks, at which time he developed bruising and a blister on the bottom of his left foot. Petitioner reported this to Respondent, as well as to all of the medical providers. The issue of "accident" is not in dispute. (See AX 1). Dr. Anderson, the treating surgeon, noted that Petitioner's activities most likely caused the original ulceration which developed into the infection. Dr. Coe agreed and found a causal relationship. Dr. Chiodo, Respondent's examining physician, denied causation asserting that the infection developed on the top as opposed to the bottom of Petitioner's foot where the blister occurred. Yet, he agreed the blister was work related. Petitioner lanced the blister himself after noticing it while bathing. He did so in a sterile manner. The lanced blister eventually led to an infection which necessitated three surgeries, one of which involved an amputation of Petitioner's third toe. The Arbitrator concludes that the opinions of Dr. Anderson and Dr. Coe outweigh the opinion of Dr. Chiodo. The evidence reveals that the infection and initial surgery was performed on the bottom of Petitioner's left foot in close proximity to the blister and ulceration which developed. Relying on the opinions of Dr. Anderson and Dr. Coe, the Arbitrator finds that Petitioner's current condition of ill-being is causally related to his repetitive work activities from May and June 2011.

Issue (J): Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?

Respondent denied liability in this case and the parties stipulated that the bills were processed through Respondent's group medical carrier pursuant to Section 8(j) of the Act. According to the medical bills offered into evidence, $2,117.13 remained outstanding. Therefore, after finding causation, the Arbitrator finds that Petitioner is entitled to $2,117.13 in reasonable and necessary medical services and allows Respondent a credit for the remaining bills paid by its group medical carrier pursuant to Section 8(j) of the Act. The individual bills, contained in Petitioner's Exhibit 7, are awarded are as follows:

- Clinical Radiologists - $89.24
- Central Illinois Associates - $204.35
- Infectious Disease Specialist - $246.00
- Lincolnland Home Care of SBL - $100.00
- Samuel Potts, M.D. - $146.00
- St. Mary's Hospital - $1,331.54

Issue (K): What temporary benefits are in dispute? (TTD)

Respondent denied liability for payment of temporary total disability (TTD) benefits in this case. The record indicates that Petitioner was off work per his treating physician from July 4, 2011 through September 4, 2011. Therefore, after finding causation, the Arbitrator awards nine weeks of TTD benefits at the rate of $475.87 per week. The Arbitrator further awards Respondent a credit in the amount of $3,464.28 representing non-occupational indemnity disability benefits paid in this case pursuant to Section 8(j) of the Act.

Issue (L): What is the nature and extent of the injury?

Petitioner underwent three surgeries for the ulceration/abscess and infection which developed in his left foot, which ultimately resulted in the amputation of the left third toe and a post-operative, post-infectious flexion contracture of his left second toe. This is noted in Dr. Anderson's records, the operative reports, as well as the reports of Dr. Coe and Dr. Chiodo. Dr. Coe noted swelling in the left ankle, a slight decrease in pulsation in Petitioner's left dorsalis pedis pulse, swelling in his left foot, weakness, and mild instability of the left foot related to the surgeries and injuries. (PX 6, pp. 29-31).

At trial, Petitioner testified that he returned to work in a full duty position, but now drives an automatic truck which does not require as much activity with the left foot or any clutch work. Petitioner testified to balance issues and difficulties kneeling and putting pressure on the left foot. Petitioner stated he notices numbness in the left foot and that weather conditions affect his sensitivity. The Arbitrator notes that Petitioner's third toe was amputated although he does have a small stump at the third digit area.

The Arbitrator finds that Petitioner testified in a credible, believable fashion consistent with the medical records. The Arbitrator concludes that Petitioner sustained the 100% loss to his third middle toe pursuant to Section 8(e)7 of the Act, as well as the 20% loss of use to his left foot pursuant to Section 8(e)11 of the Act as a result of the injuries. Petitioner is awarded permanent partial disability benefits accordingly.

Issue (O): Did Petitioner commit an injurious practice pursuant to Section 19(d) of the Act?

Pursuant to Section 19(d) of the Act, "If any employee shall persist in insanitary or injurious practices which tend to either imperil or retard his recovery or shall refuse to submit to such medical, surgical, or hospital treatment as is reasonably essential to promote his recovery, the Commission may, in its discretion, reduce or suspend the compensation of any such injured employee." 820 ILCS 305/19(d). Previously, the Appellate Court of Illinois has found that a claimant's inability to quit smoking which caused healing problems did not rise to a level of Section 19(d) injurious practice because the employer did not show that the claimant smoked cigarettes for the purpose of retarding his recovery. *See Global Products v. Workers' Comp. Comm'n.*, 392 Ill. App. 3d 408, 911 N.E.2d 1042 (1st Dist. 2009). In *Global*

Products, the Appellate Court noted that the claimant smoked in spite of its potential impact on his recovery, not because of it, thereby not justifying the triggering of Section 19(d) of the Act. Similarly, the Illinois Workers' Compensation Commission found that weight gain impacting on recovery did not justify reducing or suspending compensation pursuant to Section 19(d) of the Act when there was no evidence that the claimant refused any specific medical treatment, nor had the employer offer any weight loss program. *See Pignon v. Trumpf, Inc.*, 07 IWCC 184 (Feb. 26, 2007). Based upon the plain language of Section 19(d) of the Act, the employee must persist in an act which imperils or retards his recovery, and the reasonableness of the employee's conduct is the test when determining whether said employee has engaged in injurious practices. *Allied Chemical Corp. v. Industrial Comm'n*, 140 Ill. App. 3d 73, 488 N.E.2d 603 (1st Dist. 1986).

Section 19(d) of the Act, as supported by case law, infers a degree of intent to imperil or retard one's recovery. The Arbitrator does not find that Petitioner's conduct in this case rises to that level. The evidence in the record reveals that Petitioner was informed of a raised blood sugar level in 1999, and took reasonable measures to treat the condition, which included dietary changes, life style modifications and a reduction of his daily stresses. In 2009, after an injury, he was diagnosed with Type 2 Diabetes. He was recommended to begin treatment for his diabetic condition and immediately did so with Dr. Smith. There is nothing in Dr. Smith's medical records which indicates a failure to comply, treat or otherwise follow the appropriate protocol. To the contrary, Petitioner began taking medication, had regular follow-up appointments, daily monitoring of his blood sugar levels, and a continuation of his dietary monitoring. It was only after his levels lowered that he stopped taking the medication. The evidence indicates that his blood sugar levels spiked again after the left foot injury and he again followed-up with Dr. Smith. Dr. Chiodo testified that Petitioner was not exercising proper foot care, which the doctor testified included medical supervision, medications, diet, exercise and weight loss for the diabetes condition. (RX 2, p. 19). Contrary to Dr. Chiodo's opinion, the record indicates that Petitioner followed-up with medical supervision and medications, and monitored his diet, weight and blood sugar levels once he was diagnosed with Type 2 Diabetes. There is no indication that there was non-compliance or any failure to appropriately treat his diabetic condition. The Arbitrator finds that Petitioner's conduct in this regard did not rise to the level of an injurious practice pursuant to Section 19(d) of the Act.

The Arbitrator further finds that Petitioner lancing his blister at home does not rise to the level of an injurious or insanitary practice within the purview of Section 19(d) of the Act. The un-rebutted testimony establishes that Petitioner popped his foot blister utilizing a "home remedy" technique in a sanitary fashion. It is not unreasonable for a person to "pop" what appears to be a "water blister" with a sanitary needle. While Petitioner did suffer from diabetes, the un-rebutted testimony also establishes that he was never instructed from his treating physician, or any other doctor, to not engage in such a medical home remedy.

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

Christopher Reichardt,

Petitioner,

vs.

Thyssenkrup Safway, Inc. &
Brand Energy, Inc.,

Respondents.

14IWCC1020

NO: 10 WC 01654
(consol. 10 WC 01918)

DECISION AND OPINION ON REVIEW

This matter comes before the Commission on Petitioner's Petition for Review and on Respondent Thyssenkrup Safway, Inc.'s (hereinafter "Thyssenkrup") Motion to Dismiss Case 10WC01918. Notice was given to all parties. After considering the briefs provided by the parties, oral arguments, the record in its entirety, and the Arbitrator's Decision, filed on July 16, 2013 under case number 10WC01654, the Commission hereby denies Thyssenkrup's Motion to Dismiss Case 10WC01918 and reverses the Arbitrator's Decision under case number 10WC01654 and remands the matter back for a new hearing on all issues and before a new Arbitrator.

FACTS AND PROCEEDURAL HISTORY

On January 15, 2010, Petitioner's counsel filed an Application for Adjustment of Claim regarding its claim for compensation against Brand Energy, Inc. (hereinafter "Brand Energy") under case number 10WC01654. In the application, Petitioner alleged that he suffered a work related accident on November 5, 2009, in which he sustained injuries to his "Bilateral shoulders."

On January 19, 2010, Petitioner's counsel filed another Application for Adjustment of Claim for compensation, this time against Thyssenkrup under case number 10WC01918. In this application, Petitioner alleged that he suffered a work related accident on May 15, 2009, in

which he sustained injuries to his "Bilateral shoulders."

On April 7, 2010, Petitioner's counsel filed an Amended Application for Adjustment of Claim on 10WC01654 (Brand Energy). In the amended application, Petitioner claimed that on November 5, 2009, he sustained injuries to his "Bilateral shoulders; Bilateral hands, Bilateral upper extremities."

On November 10, 2010, Petitioner's counsel filed another Amended Application for Adjustment of Claim for 10WC01654 (Brand Energy). In this amended application, Petitioner alleged an accident date of September 9, 2009.

On September 2, 2011, Thyssenkrup's counsel filed a Motion to Consolidate cases 10WC01654 and 10WC01918. The Motion to Consolidate was granted on September 6, 2011.

On May 2, 2012, Petitioner proceeded to hearing before Arbitrator Simpson on case 10WC01654 only. Neither Thyssenkrup's counsel nor an agent for Thyssenkrup was present at the hearing. Likewise, neither Thyssenkrup's counsel nor agent received notice of Petitioner's intent to proceed on case number 10WC01654 only.

On July 16, 2013, Arbitrator Simpson issued her decision on case 10WC01654, finding that Petitioner failed to prove that he suffered a compensable injury under the Illinois Workers' Compensation Act (hereinafter "Act") on September 9, 2009.

On August 16, 2013, Petitioner's counsel filed a Petition for Review on case 10WC01654, as against Brand Energy.

On December 6, 2013, Thyssenkrup's counsel filed a Motion to Dismiss Case 10WC01918, based on the theory of election of remedy. Thyssenkrup argued that Petitioner "opted to proceed to hearing against only one defendant in consolidated matters, and thus opted to exclude evidence from consideration and elected a remedy against only Respondent Brand Energy....That the election of remedy by Petitioner to proceed to Arbitration against Respondent Brand Energy in 10 WC 1654 is a bar to any claim against Thyssenkrup Safway in 10 WC 1918."

Hearings were held before Commissioner Michael Brennan on January 14, 2014 and February 18, 2014 regarding Thyssenkrup's Motion to Dismiss case 10WC01918. All parties were present.

During the January 14, 2014 hearing, Thyssenkrup's counsel stated that he received no notice of the arbitration hearing held on May 2, 2012. (T.7) Counsel explained that he did not receive "a Motion for Trial for the case, a Stipulation Sheet or anything about the hearing. We had no knowledge that it went forward." (T.7) Counsel explained that the first notice he received of the hearing was through the Commission's website which had a copy of the Arbitrator's Decision. (T.7) Counsel argued that Thyssenkrup was denied the opportunity to defend itself. (T.8) Therefore, counsel argued, the Commission should find that the case against Thyssenkrup is "now over with" and grant its Motion to Dismiss. Petitioner's counsel testified that he did not

receive any notice that the cases had been consolidated. (T.9)

At the hearing held on February 18, 2014, Thyssenkrup's previous attorney testified that he sent the Motion to Consolidate to 5400 North Illinois, #101, Fairview Heights, Illinois and acknowledged that the address for Petitioner's counsel on the application for adjustment of claim was 5540 North Illinois, Suite 101, Fairview Heights, Illinois. (T.18)

On July 3, 2014, Thyssenkrup filed Respondent's Brief and Argument in Support of the Motion to Dismiss Case 10WC01918.

On July 18, 2014, Brand Energy filed its Brief and Argument in Opposition of Thyssenkrup Safway's Motion to Dismiss Case 10WC01918. On July 23, 2014, Petitioner's counsel filed Petitioner's Response to Respondent's Brief and Argument Regarding Motion to Dismiss Case Against Thyssenkrup Safway, Inc. (10WC01918), and on August 1, 2014, Thyssenkrup filed its Reply Brief and Argument in Support of the Motion to Dismiss Case 10WC01918.

After a complete review of the record in its entirety, it is clear to the Commission that there was a failure to provide proper notice of the Motion to Consolidate to and of the arbitration hearing to Thyssenkrup. Based on this lack of notice to the parties, the Commission finds Thyssenkrup's argument that Petitioner elected to go against Brand Energy instead of Thyssenkrup unpersuasive.

The Commission notes that Petitioner's counsel testified that he was unaware that the cases had been consolidated. The Commission further notes that Thyssenkrup's former counsel admitted that he sent the order consolidating the cases to an address different than what was listed as Petitioner's counsel's address on the application for adjustment of claim. Furthermore, Arbitrator Simpson, who had access to the file physically and via computer, failed to note or indicate at hearing or in her decision that the cases had been consolidated. Finally, there is nothing in the record to indicate that Brand Energy's counsel made any mention that the cases had been consolidated, though he was aware of same.

Arbitrator Simpson ultimately held a hearing for the case against Brand Energy, 10WC1654, and issued a decision solely on Petitioner's claim against Brand Energy. Aside from noting in her decision that Petitioner had previously worked for Thyssenkrup, she made no findings regarding Petitioner's claim against Thyssenkrup.

The Commission notes that nothing has occurred up to this point that has any effect on Petitioner's claim against Thyssenkrup. Due to lack of proper notice to the parties regarding the consolidation of the cases and the arbitration hearing, the Commission finds that the arbitration hearing should not have been held. Therefore, Thyssenkrup's Motion to Dismiss is hereby denied, the Arbitrator's Decision is vacated and reversed, and both cases are remanded back for a new hearing before a new Arbitrator.

14IWCC1020

IT IS THEREFORE ORDERED BY THE COMMISSION that Thyssenkrup's Motion to Dismiss Case 10WC01918 is denied and the Decision of the Arbitrator, filed on July 16, 2013, reversed and remanded back to a new Arbitrator for a new hearing on all issues.

DATED: NOV 2 5 2014
MJB/ell
o-09/29/14
052

Michael J. Brennan

Thomas J. Tyrrell

Kevin W. Lamborn

14IWCC1020

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

REICHARDT, CHRISTOPHER
Employee/Petitioner

Case# **10WC001654**

14IWCC1020
14IWCC1020

BRAND ENERGY
Employer/Respondent

On 7/16/2013, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.07% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

A copy of this decision is mailed to the following parties:

BROWN & BROWN LLP
DAVID JEROME
5440 N ILLINOIS SUITE 101
FAIRVIEW HTS, IL 62208

2674 BRADY CONNOLLY & MASUDA PC
MICHAEL K BRANDOW
705 E LINCOLN SUITE 313
NORMAL, IL 61761

14IWCC1020

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

Christopher Reichardt
Employee/Petitioner

v.

Brand Energy
Employer/Respondent

Case # **10** WC **01654**

Consolidated cases: _____

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Deborah L. Simpson**, Arbitrator of the Commission, in the city of **Mt. Vernon**, on **May 2, 2012**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. [ ] Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. [ ] Was there an employee-employer relationship?
C. [x] Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. [ ] What was the date of the accident?
E. [ ] 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. [ ] What is the nature and extent of the injury?
M. [ ] Should penalties or fees be imposed upon Respondent?
N. [ ] Is Respondent due any credit?
O. [x] Other **Prospective medical treatment**

14IWCC1020

FINDINGS

On **September 9, 2009**, Respondent ***was*** operating under and subject to the provisions of the Act.

On this date, an employee-employer relationship ***did*** exist between Petitioner and Respondent.

On this date, Petitioner ***did not*** sustain an accident that arose out of and in the course of employment.

Timely notice of this accident ***was*** given to Respondent.

Petitioner's current condition of ill-being ***is not*** causally related to the accident.

In the year preceding the injury, Petitioner earned **$61,623.12**; the average weekly wage was **$1,185.06**.

On the date of accident, Petitioner was **48** years of age, ***single*** with **1** dependent children.

ORDER

The Petitioner failed to prove a compensable injury. Benefits under the Act are denied.

In no instance shall this award be a bar to subsequent hearing and determination of an additional amount of medical benefits or compensation for a temporary or permanent disability, if any.

RULES REGARDING APPEALS Unless a party files a *Petition for Review* within 30 days after receipt of this decision, and perfects a review in accordance with the Act and Rules, then this decision shall be entered as the decision of the Commission.

STATEMENT OF INTEREST RATE If the Commission reviews this award, interest at the rate set forth on the *Notice of Decision of Arbitrator* shall accrue from the date listed below to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

Rebecca L. Simpson
Signature of Arbitrator

July 16, 2013
Date

JUL 16 2013

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Christopher Reichardt,	)	
	)	
Petitioner,	)	
	)	
vs.	)	14IWCC1020
	)	
Brand Energy,	)	
	)	
Respondent.	)	
	)	

FINDINGS OF FACTS AND CONCLUSIONS OF LAW

The parties agree that on September 9, 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. They further agree that the Petitioner gave the Respondent notice of the accident within the time limits stated in the Act.

At issue in this hearing is as follows: (1) Did the Petitioner sustain an accidental injury or was he last exposed to an occupational disease that arose out of and in the course of the employment on September 9, 2009; (2) Is the Petitioner's current condition of ill-being causally connected to this injury or exposure; (3) Were the medical services that were provided to Petitioner reasonable and necessary and has the Respondent paid for all reasonable and necessary medical expenses; (4) Is Petitioner entitled to TTD; (5) Is the Respondent due any credit for benefits already paid; and (6) Is the Petitioner entitled to any prospective medical care.

STATEMENT OF FACTS

The Petitioner testified that he was working for the Respondent on September 9, 2009, as a union carpenter. He started working for the Respondent on July 6, 2009. He worked for them until his employment ended on September 13, 2009. Prior to working for the Respondent, he had worked for Thyssen Safeway for about 7 – 8 months. Both jobs involved building scaffolding.

Plaintiff's position with Respondent was a full-time position that involved manipulation of metal piped scaffolding that was built many stories in the air. Petitioner testified that his job included the physical manipulation of the scaffolding materials and required lifting sections of the scaffolding below and raising them overhead to the next person above him as part of a

production line. Additionally, once the scaffolding was delivered, Petitioner would have to use a 22 ounce hammer to hammer the pipe into place; he used a ratchet wrench as well. He would also have to nail plywood down to the steel tubing by way of steel nails that were hammered into the pipes. He noted that each section of scaffolding required that he hammer in approximately 50 nails and he did several sections during his work shift. Petitioner testified that there were other times that he would have to dismantle the scaffolding. That required the removal of all of the nails and disassembly of the sections of scaffolding, again with the use of his hammer. The scaffolding that he was assembling and dismantling ranged in height from six feet high to two hundred feet high. He compared it to a big tinker toy set. He testified that they worked between forty and sixty hours per week.

While performing these work activities, Petitioner began to have problems with his right hand and elbow. He testified that he primarily noted these problems when hammering. As a result, he began using his opposite hand to perform this activity and shortly thereafter began to develop problems in his left hand and elbow as well. Petitioner noted that his problems began while he worked for the Respondent and that he had no problems prior to beginning employment with them.

Petitioner initially sought treatment with Dr. Jim Hong on November 5, 2009. Dr. Hong diagnosed bilateral carpal tunnel syndrome as well as elbow pain. The record from November 5, 2010, for chief complaint indicated that the Petitioner came to their office complaining of shoulder pain, hands numb while sleeping and right knee pain. Under the history section it indicates Petitioner complains of left shoulder, left elbow pain for long time. He described numbness in both hands that wakes him up at night with pain and numbness for at least one year. He indicated that he works as a carpenter and also has right knee pain, chronic. (P. Ex. 6) Dr. Hong recommended a nerve conduction study for both hands which was completed on November 18, 2009 at Anderson Hospital. The NCS revealed bilateral carpal tunnel syndrome as well as ulnar neuropathy worse on the left. At that time, the neurologist referred Petitioner for an orthopedic consultation. (P. Ex. 6) Dr. Hong also ordered x-rays of the left shoulder, left elbow and right elbow.

Petitioner chose to follow up with Dr. Paulo Bicalho who had already been treating him for problems with his shoulders. Dr. Bicalho ordered an MRI of the Right shoulder which was performed on November 7, 2009, indicating that Petitioner had a rotator cuff tear and impingement syndrome. (P. Ex. 7)

On December 2, 2009, the Petitioner had surgery in the form of a left shoulder rotator cuff repair, distal clavicle excision and subacromial decompression with Dr. Bicalho. He also had an injection in his right shoulder. (P. Ex. 7).

In March of 2010, Dr. Bicalho prescribed a right carpal tunnel release which was completed on March 10, 2010. Post-operatively, Petitioner reported improvement of his symptoms and stated that his numbness and tingling had greatly improved. By March 25, 2010, Dr. Bicalho's notes focused more on problems associated with a right rotator cuff injury. (P. Ex. 7)

On June 15, 2010, Petitioner was seen by Dr. David Brown, at the request of Petitioner's attorney David Jerome, for purposes of a medical evaluation. Dr. Brown diagnosed Petitioner with having bilateral cubital tunnel syndrome as well as bilateral carpal tunnel syndrome. He noted that Petitioner had recently undergone a right carpal tunnel release. Dr. Brown initially recommended conservative treatment but noted that surgery for the cubital tunnel syndrome and left carpal tunnel syndrome remained an option if the symptoms failed to improve. (P. Ex. 1, 2)

Dr. Brown reviewed Petitioner's description of his work as a carpenter and scaffold builder. Dr. Brown noted that Petitioner had a lack of medical problems such as diabetes, hypothyroidism, arthritis or increased body mass index that would be considered alternate risk factors in the development of either carpal tunnel syndrome or cubital tunnel syndrome. As a result, Dr. Brown concluded that Petitioner's work as a carpenter contributed or aggravated Petitioner's medical condition in causing the development of the bilateral cubital tunnel syndrome and bilateral carpal tunnel syndrome. Dr. Brown testified that Petitioner reported that he developed symptoms while working for the Respondent assembling and disassembling scaffolding that required beating the scaffolding with a hammer. (P. Ex. 1)

The insurance company for Respondent requested a medical examination pursuant to Section 12 of the Act and scheduled Petitioner for the evaluation with Dr. Evan Crandall. The exam took place on February 22, 2011. Following the examination, Dr. Crandall concluded that Petitioner's carpentry work at Respondent was a hand intensive activity that could cause carpal tunnel syndrome and/or ulnar neuropathy. However, he noted that there were records he was given to review that give a date of injury as May 15, 2009, which pre-dates the job with Respondent. He also noted that the NCS are consistent with neuropathy that had been present for a long period of time. Dr. Crandall noted that Petitioner's work at Respondent was his last exposure to hand intensive work prior to the nerve conduction study that took place on November 18, 2009. However, Dr. Crandall believed that one cannot develop a case of carpal tunnel syndrome or ulnar neuropathy with just two months of work. As a result, he concluded that he did not believe that it occurred as a result of the work at Respondent. (R. Ex. 1)

Dr. Brown examined Petitioner on February 9, 2011. Dr. Brown noted in his reports that he had been authorized to examine Petitioner. At that time, Dr. Brown diagnosed chronic bilateral cubital tunnel syndrome and bilateral carpal tunnel syndrome. Dr. Brown noted that due to the chronic nature of the compression neuropathies, his prognosis for successful resolution with conservative treatment was guarded. (P. Ex. 2)

On September 23, 2011, Dr. Brown performed surgery on Petitioner that consisted of a left cubital tunnel release with an anterior submuscular transposition of the ulnar nerve with myofacial lengthening of the flexor pronator tendon origin. Dr. Brown also completed a left carpal tunnel release. (P. Ex. 1, 2)

Similarly, on October 28, 2011, Dr. Brown performed the same surgical release on Petitioner's right elbow that consisted of a right cubital tunnel release with an anterior

submuscular transposition of the ulnar nerve with myofacial lengthening of the flexor pronator tendon origin. (P. Ex. 1, 2)

Post-operatively, Dr. Brown referred Petitioner for physical therapy of his right and left upper extremities. Initially, the therapist noted that Petitioner was able to complete the exercises but continued to report soreness, fatigue, and weakness. By November 11, 2011, Petitioner stated that he was approximately 50% better but was unable to pick up anything greater than 15 pounds and continued to report increased constant numbness in the fourth and fifth digits of both hands. (P. Ex. 5)

On November 23, 2011, Petitioner advised the therapist that his hands continued to cramp up when he tried to use them and that his hands were always cold. (P. Ex. 5)

On December 2, 2011, the therapist noted that Petitioner was complaining of a slight increase in pain and difficulty relating to performing the therapy activities. He complained of having ongoing numbness in the fourth and fifth digits of both hands and cramping with resisted wrist flexion in his left hand. (P. Ex. 5)

On December 12, 2011, Petitioner returned to Dr. Brown complaining of ongoing soreness in his elbow. Dr. Brown recommended two more weeks of physical therapy to concentrate on strengthening and work conditioning. At that time, he released Petitioner to return to work with a 10 pound lifting restriction of the left upper extremity with a full release effective January 2, 2012. (P. Ex. 2)

On January 3, 2012, the therapist noted that Petitioner was continuing to complain of numbness in the fourth and fifth digits of both hands. It was also noted that he continued to complain of ongoing cramping in the left hand with resisted flexion as well as burning in his right elbow at the incision site. (P. Ex. 5)

On January 17, 2012, the therapist noted that in addition to ongoing numbness, Petitioner's hand cramping with resisted wrist flexion had moved from the left hand to now include both hands. (P. Ex. 5)

On January 20, 2012, Petitioner was discharged from therapy but was noted to have ongoing problems. At the time of the last visit, Petitioner advised the therapist that he was continuing to have numbness in his fourth and fifth digits of both hands; cramping with resisted flexion of both hands; burning of the right elbow at the incision site; and locking up of his hands and wrists. Petitioner also reported that he continued to have symptoms of pain and tenderness in his right elbow as well as difficulty leaning on this elbow. (P. Ex. 5)

On January 31, 2012, a record review was prepared by Dr. Richard C. Lehman. In this report, he stated that his diagnosis was bilateral partial rotator cuff tears and acromioclavicular arthritis, recurrent instability of the left shoulder based on the records. Further, it was his opinion that the findings of an MRI on both shoulders from November 17, 2009 indicated that the conditions of the shoulders were not related to his employment at Thyssenkrup or

Respondent. They appeared to be long-term in nature and degenerative. The MRI of the left shoulder showed an impacted dislocation pattern and the patient's right shoulder evidenced long-term degenerative changes and breakdown in the rotator cuff. He provided his opinion that the patient's job activities while he was employed at Respondent were not sufficient to create the pathology as evidenced in the MRI and reports and that his work activities while at the Respondent for three months could not have possibly altered the natural progression of the condition of either of his shoulders. (R. Ex. 3)

On February 15, 2012, Petitioner returned to Dr. Brown reporting that he was still getting numbness in his little fingers bilaterally as well as spasms and cramping in his hands. Dr. Brown released him full duty but recommended that he continue his home therapy program. Additionally, Dr. Brown recommended that Petitioner be seen for follow up on May 16, 2012. (P. Ex. 2)

On February 29, 2012, Petitioner was again seen by Dr. Crandall for a medical evaluation at the request of Respondent. Dr. Crandall reported that the chance that Petitioner would require a repeat surgery was only 1 in 100 based upon his examination at the time. He indicated that Petitioner may still have numbness and tingling because the nerves grow over time and it could take as much as a year before all the symptoms go away. (R. Ex. 2)

Petitioner returned to Dr. Brown on April 2, 2012. At that time, Petitioner advised the doctor that he was continuing to have numbness in his little fingers bilaterally; numbness in the ulnar aspect of both hands; and cramping in both hands. Dr. Brown noted that Petitioner was still describing symptoms in the ulnar nerve distribution. He recommended a post-operative nerve conduction study to compare to the pre-operative studies. (P. Ex. 2)

Petitioner testified that the problems that he had in February of 2012, when he saw Dr. Crandall were similar to the complaints that he had when he saw Dr. Brown in April of 2012. Additionally, Petitioner testified that all of these problems continue up until today.

Petitioner testified that he continues to have cramping on the bottom side of both forearms. He also described cramping in both hands that will cause his hands to draw up. Petitioner testified that this cramping occurs daily but is more pronounced when he attempts to use his hands or forearms in a repetitive manner. In addition, Petitioner testified that he continues to have ongoing numbness in the pinky and ring finger of both hands that is always present and has continued in spite of the surgeries to his elbows.

Petitioner testified that since the surgeries to his elbows, he has perpetual soreness in the elbows that is on average a 4/10. Petitioner testified that as a result of all of the problems with his hands and elbows, he continues to be awakened at night. Petitioner testified that when he spoke with Dr. Crandall about all of these symptoms, the doctor made no further recommendations to help to reduce his symptoms.

Petitioner testified that after being released full duty by Dr. Brown on January 2, 2012, he has not been able to return to work anywhere and therefore has not been able to test his hands and elbows in a work environment. However, Petitioner testified that he did try to help a friend hang some drywall. He said that he had to stop working after only 20 minutes due to the problems with the cramping in his hands and forearms as well increased symptoms of pain in his elbows. Petitioner testified that these problems have continued in spite of the multiple surgeries to his hands and elbows. He testified also that he was afraid to go back to work with his hands in this condition since he could lose control of the hammer and hurt a co-worker or someone walking by.

Petitioner testified that he has had no new accidents or injuries to either of his hands or elbows. Additionally, Petitioner testified that since the surgeries, he has never had full resolution of the symptoms in either his hands or his elbows.

Petitioner noted that since the surgeries, he has noticed weakness in his hands and arms which causes problems in performing simple activities, such as opening a jar. Petitioner testified that he is unable to use tools such as hammers or drills as they increase his symptoms. Petitioner testified that he did not believe that he could return to his work as a carpenter building scaffolding since he would not feel safe lifting scaffolding to a co-worker or accepting scaffolding as part of the man line in getting the scaffolding up to the higher levels.

Petitioner testified that he is currently a member of a union that is unable to return him to work if he has any form of permanent restrictions or problems in completing his work activities. Petitioner testified that in spite of being released full duty by Dr. Brown, he does not feel that he can return to work as a carpenter due to ongoing problems with numbness in his pinky and ring finger; cramping in his hands and forearms; and an inability to grip or grasp due to weakness.

Petitioner's Exhibit 9 was a medical bill summary. This medical bill summary clearly reflects that the majority of the charges listed were not causally related to the Petitioner's carpal nor cubital tunnel syndrome.

It is noted specifically that the Carpenter Benefit Plan dated February 1, 2012, that was provided reflects that only the following treatment on the date of service was related to the carpal tunnel: March 10, 2010; November 5, 2009. The bills from Dr. Hong (Southern Illinois Family Medicine) all pre-dated the date of the alleged accident or there were no records or testimony relating to the charges.

The records from Anderson Hospital, with a cover letter of August 30, 2011, indicate that only a nerve conduction study from November 18, 2009 was related to the carpal tunnel. The remaining charges are related to treatment for Petitioner's shoulder, elbow or knee.

The records from Maryville Physicians Service indicate charges with different dates of treatment. The only charge related to the carpal tunnel was from March 10, 2010. The medical bills of Rehab Excel clearly are related to the Petitioner's shoulder as well as his bilateral carpal

tunnel the reports are broken down by body part, for the exercises, but the time devoted to each is difficult to determine.

The bill from Maryville Radiology was not supported by testimony or records.

The records from Millennium Anesthesiology Consultants contain bills from two dates of service. The only date of service related to the carpal tunnel was March 10, 2010.

The bill from Dr. Brown indicated an outstanding balance of $402.12. I note that the treatment, as reflected, was associated with the bilateral cubital tunnel or the right carpal tunnel syndrome and treatment.

CONCLUSIONS OF LAW

An injury is accidental within the meaning of the Worker's Compensation Act when it is traceable to a definite time, place and cause and occurs in the course of the employment unexpectedly and without affirmative act or design of the employee. *Matthiessen & Hegeler Zinc Co. v Industrial Board,* 284 Ill. 378, 120 N.E. 2d 249, 251 (1918)

An injury arises out of one's employment if it has its' origin in a risk that is connected to or incidental to the employment so that there is a causal connection between the employment and the accidental injury. *Technical Tape Corp. vs IndustrialCommission,*58 Ill. 2d 226, 317 N.E.2d 515 (1974) "Arising out of" is primarily concerned with the causal connection to the employment. The majority of cases look for facts that establish or demonstrate an increased risk to which the employee is subjected to by the situation as compared to the risk that the general public is exposed to.

The burden is on the party seeking the award to prove by a preponderance of credible evidence the elements of the claim, particularly the prerequisites that the injury complained of arose out of and in the course of the employment. *Hannibal, Inc. v. Industrial Commission,* 38 Ill.2d 473, 231 N.E.2d 409, 410 (1967)

An employee who suffers a repetitive trauma injury must meet the same standard of proof under the Act as an employee who suffers a sudden injury. See *AC & S v. Industrial Comm'n,* 304 Ill.App.3d 875, 879, 710 N.E.2d 837 (1st Dist. 1999)

For compensability of a claimed injury, where a pre-existing condition exists, recovery will depend on the employee's ability to show that a work-related injury aggravated or accelerated the pre-existing condition such that the employee's current condition of ill-being is said to have been causally connected to the work-related injury and not simply the natural sequela process of the pre-existing condition. *Sisbro Inc. v. Industrial Comm'n,* 207 Ill. 2d 193, 278 Ill. Dec.70, 797 N. E. 2d 665 (2003).

Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?

The Petitioner's testimony was not credible. The Petitioner's testimony on when he began noticing numbness and tingling in his hands was inconsistent with the medical records. He testified that he began noticing problems with his right hand while employed by the Respondent. After a period of time, he began using his left hand. He could not provide a date upon which he began switching to his left hand. After he switched to his left hand, he began noticing symptoms in both the left hand and elbow as well. His testimony is contradicted by the medical records from Dr. Hong dated November 5, 2009. At that time of his medical evaluation by Dr. Hong, Petitioer reported to Dr. Hong that he had pain in the left shoulder, left elbow for a long time. He described numbness bilaterally in the hands, **waking up at night with pain and numbness for at least one year**. He informed the doctor at that time that he was a carpenter and that he also had chronic right knee pain. The very next day, November 6, 2009, the Petitioner saw Dr. Bichalho, he reported to Dr. Bichalho that he was experiencing right and left shoulder pain, with the left shoulder being worse than the right. He did not recall specific trauma to both shoulders although he was involved in sports in the past. He described the pain as starting in the shoulder and radiating down the arm. He also reported that the pain wakes him at night. (P. Ex. 6)

Additionally, the history the Petitioner provided to Dr. Crandall was that the problems with his hands and elbows developed prior to coming to work for Respondent on July 6, 2009. I note he provided a different history to Dr. Brown. Both Dr. Brown and Dr. Crandall obtained detailed histories relating to the work the Petitioner performed as a union carpenter, both at Respondent, as well as his prior employer, Theyssenkrup. Dr. Brown stated that because the Petitioner developed symptoms while he was working at Respondent, that activity was an aggravating factor in the development of the symptomatic bilateral carpal and cubital tunnel syndrome. It is quite clear, that Dr. Brown was unaware that the conditions and complaints the Petitioner had with his hands and elbows that pre-dated his employment for Respondent and possibly even Theyssenkrup. Those conditions, pre-dating the Petitioner's employment with Respondent are contained in the records of Dr. Hong and Dr. Crandall. Further on this point, I note that Dr. Crandall stated in his records that it would be impossible for the Petitioner to develop carpal tunnel and/or ulnar neuropathy in just two months of working for Respondent. If it was impossible to develop the condition in two months, it would be even less likely that it could happen in the left hand and elbow. Petitioner's testimony was that the problems in his right hand and arm did not manifest themselves until some time after he began working for Respondent on July 6, and it was after he noticed the pain that he began using his left hand. Since he only worked from July 6, 2009, through September 13, 2009, two months and one week, that gives him less than two months for the condition to develop in the left elbow and hand. At any rate, this version of events does not match the descriptions provided to Dr. Hong or to Dr. Crandall.

Therefore, I find that the Petitioner's bilateral carpal and cubital tunnel syndromes were not causally related to his work activities with Respondent.

Further, I note that the Petitioner also had complaints regarding his shoulder. I note that Dr. Lehman provided his opinion in the report on January 31, 2012 stating that the Petitioner's bilateral partial rotator cuff tears and acromioclavicular arthritis were not related to the Petitioner's job activities while employed by Respondent and the Petitioner's work activities for the short period of time he worked there could not possibly have altered the natural progression of the condition in either of his shoulders. No causal connection opinion was provided indicating the shoulder conditions were related to the Petitioner's employment with Respondent.

The Petitioner related to Dr. Bicalho, that he has had the shoulder pain for quite some time. He had injured his right shoulder some time ago, he does not recall when and was told that he had a torn rotator cuff. He indicated that at the time surgery was recommended however he did not want surgery at that time because he could not stop working then. He never pursued surgical treatment. He admitted that he had injured both shoulders in the past when he played a lot of sports and did a lot of hard work. (P. Ex. 6)

Therefore, I further find that the petitioner's bilateral shoulder conditions were not causally related to his work activities with Respondent.

Is Petitioner's current condition of ill-being causally related to the injury?

Based upon the conclusions stated above, I find that the Petitioner's current condition was not causally related to his employment with Respondent.

Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services? Is Petitioner entitled to any prospective medical care? What temporary benefits are in dispute? Is Respondent due any credit?

Petitioner failed to prove a compensable injury, based upon that finding the other issues are moot.

ORDER OF THE ARBITRATOR

The Petitioner failed to prove a compensable injury. Benefits under the Act are denied.

Deborah L. Simpson
Signature of Arbitrator

July 16, 2013
Date

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 up	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Carol Bruley,

Petitioner,

14IWCC1021

vs.

NO: 12 WC 33009

Communities of Maple Lawn,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by Petitioner herein and notice given to all parties, the Commission, after considering the issues causal connection, medical expenses, temporary total disability benefits, and permanent disability benefits, 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.

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 in doing so, we find that Petitioner's current condition of ill-being and need for total right hip replacement surgery is causally related to the February 27, 2011 work accident.

The parties stipulated that Petitioner sustained a compensable work accident on February 27, 2011. (AX1) At hearing, Petitioner testified that as she was arising, the chair in which she had been sitting collapsed. (T.18) As the chair collapsed, she too began to fall and heard a snap in her right hip. (T.18-19) She caught herself from falling. (T.18-20) Petitioner further testified that she immediately felt right hip and back pain. (T.8-9) The Commission notes that the medical records are fairly consistent regarding Petitioner's history of the accident. The medical records also indicate that Petitioner's condition of ill-being did not improve or stabilize following the accident until she underwent right hip surgery. (PXC,PXD,PXE,PXF)

As explained by the court in *Organic Waste Systems v. Industrial Commission*, 241 Ill.App.3d 257, 260 (1993):

> "a chain of events which demonstrates a previous condition of good health, accident and subsequent injury resulting in disability may be circumstantial evidence to prove a causal nexus between the accident and claimant's injury. *International Harvester v. Industrial Comm'n* (1982), 93 Ill. 2d 59, 442 N.E.2d 908, 66 Ill. Dec. 347.

The medical records indicate that Petitioner had arthritis in her hip; however, as noted by Dr. Maurer (PXF), Petitioner's treating physician, and Dr. Rezin (RX1), Respondent's Section 12 examiner, Petitioner's right hip arthritis was essentially asymptomatic until the February 27, 2011 accident. The Commission finds that the difference between the opinions of Dr. Maurer and Dr. Rezin lie in the type of aggravation Petitioner suffered that day.

Dr. Maurer opined that Petitioner's need for a total right hip replacement is causally related to the February 27, 2011 accident. (PXF) Dr. Rezin opined that Petitioner suffered a temporary aggravation of her right hip arthritis on February 27, 2011, and that the need for a total right hip replacement was not causally related to the work accident. (RX1) The Commission notes, however, and as explained by Dr. Maurer in his August 20, 2013 report, that Petitioner's symptoms "did not subside until we replaced her hip so it would be difficult for me to assign a period of temporary pain to the injury and then the remaining pain to her hip arthritis, as I think her hip pain continued from her injury until we replaced her hip." (PXB) The Commission notes that Dr. Maurer's findings and opinions are supported by the medical records and Petitioner's testimony.

The Commission further notes that while Petitioner did not treat for about a year, it was not for lack of symptoms or problems with her right hip. Petitioner testified, and the medical records support her testimony, that she did not undergo treatment for about a year due to a lack of medical insurance. (T.20-21,PXF) The record further establishes that Petitioner never stopped complaining of ongoing and worsening right hip problems following the work accident.

Therefore, based on the totality of the evidence, the Commission finds that Petitioner's condition of ill-being and need for a total right hip replacement and current was causally related to the February 27, 2011 accident. The Commission further finds that Petitioner is entitled to temporary total disability benefits from January 9, 2013, the date of Petitioner's right hip surgery, through April 18, 2013, when Dr. Maurer released Petitioner to return to work with restrictions. (PXF,PXH) The Commission also finds that Petitioner is entitled to medical expenses incurred in the treatment of her injuries stemming from the February 27, 2011 accident, totaling $1,091.27. Respondent shall hold Petitioner harmless for amounts paid by ACS Recovery, totaling $13,931.41, towards Petitioner's medical expenses.

Regarding permanent disability benefits, the Commission notes that Petitioner has undergone a total right hip replacement and has returned to work full duty. The Commission

further notes that Petitioner continues to have right hip issues. During Petitioner's last visit with Dr. Maurer on August 1, 2013, Dr. Maurer noted that Petitioner was doing very well and felt that Petitioner had "pretty much reached maximum medical improvement." (PXF) However, Dr. Maurer noted that Petitioner continued to have limitations regarding her right hip after working about eight hours or more and noted that "her whole body starts to bother her....I think that she probably still needs an eight-hour restriction." Therefore, based on Petitioner's testimony and the medical records, the Commission finds that Petitioner has suffered a 45% loss of use of the right leg under Section 8(e)12 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 Decision of the Arbitrator filed on April 3, 2014, is hereby modified as stated above, and otherwise affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $446.67 per week for a period of 14-2/7 weeks, from January 9, 2013 through April 18, 2013, that being the period of temporary total incapacity for work under Section 8(b) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $402.00 per week for a period of 96.75 weeks, as provided in Section 8(e)12 of the Act, for the reason that the injuries sustained caused the 45% loss of use of the right leg.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner $1,092.27 in medical expenses, pursuant to Sections 8(a) and 8.2 of the Act. Respondent shall hold Petitioner harmless for amounts paid by ACS Recovery of Petitioner's medical expenses, totaling $13,931.41.

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.

14IWCC1021

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $61,200.00. 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: NOV 2 5 2014
MJB/ell
o-09/30/14
52

Michael J. Brennan

Thomas J. Tyrrell

Dissent

I respectfully dissent from the decision of the majority. I would affirm Arbitrator Mathis' thorough and well reasoned decision in its entirety and without modification.

Kevin W. Lamborn

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

BRULEY, CAROL
Employee/Petitioner

Case# **12WC033009**

14IWCC1021

COMMUNITIES OF MAPLE LAWN
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:

0651 LAW OFFICE OF MIKE McELVAIN
234 E FRONT ST
PO BOX 3007
BLOOMINGTON, IL 61701

2284 LAW OFFICE OF LAWRENCE COZZI
KATERINA ROBINSON
27201 BELLA VISTA PKWY #410
WARRENVILLE, IL 60555-1619

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

Carol Bruley
Employee/Petitioner

v.

Communities of Maple Lawn
Employer/Respondent

Case # 12 WC 33009

14IWCC1021

An *Application for Adjustment 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 **December 30, 2013**. After reviewing all of the evidence presented, the arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was 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

14IWCC1021

- On **February 27, 2011**, the respondent *was* operating under and subject to the provisions of the Act.
- On this date, an employee-employer relationship *did* exist between the petitioner and respondent.
- On this date, the petitioner *did* sustain injuries that arose out of and in the course of employment. However, for reasons set forth in the attached decision, the workplace accident was causally related to the petitioner's muscular strains, but not to her arthritic right hip condition.
- Timely notice of this accident *was* given to the respondent.
- In the year preceding the injury, the petitioner earned $ **34,840** ; the average weekly wage was $**670.00**.
- At the time of injury, the petitioner was **62** years of age, ***married*** with **0** children under 18.
- Necessary medical services ***have*** been provided by the respondent.
- To date, $**0** has been paid by the respondent for TTD and/or maintenance benefits.

ORDER

- The respondent shall pay the petitioner the sum of $**402.00**/week for a further period of **10.75** weeks, as provided in Section **8(e)** of the Act, because the injuries sustained caused **5% loss to the right leg**.
- The respondent shall pay the petitioner compensation that has accrued from **April 28, 2011 (MMI)** through **the present**, and shall pay the remainder of the award, if any, in weekly payments.

RULES REGARDING APPEALS Unless a party files a *Petition for Review* within 30 days after receipt of this decision, and perfects a review in accordance with the Act and Rules, then this decision shall be entered as the decision of the Commission.

STATEMENT OF INTEREST RATE If the Commission reviews this award, interest at the rate set forth on the *Notice of Decision of Arbitrator* shall accrue from the date listed below to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

Signature of arbitrator

27 March 2014
Date

APR 3 - 2014

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

CAROL BRULEY,	)	14IWCC1021
	)	
Petitioner,	)	
	)	
vs.	)	No. 12 WC 33009
	)	
COMMUNITIES OF MAPLE LAWN,	)	
	)	
Respondent.	)	

ADDENDUM TO ARBITRATION DECISION

This matter was tried before Arbitrator Stephen Mathis. Following the hearing, but before the decision could be authored, Arbitrator Mathis was appointed as a Commissioner. This matter was therefore reassigned for authorship of the decision.

STATEMENT OF FACTS

The petitioner, 62 years of age as of the date of loss, February 27, 2011, worked as a night shift charge nurse for the respondent, a nursing home. She asserts a right hip injury when, while rising from a chair, a pin in the bottom of the chair "disengaged" and it collapsed. On cross-examination, she testified that while she was still in the chair at the time, she rose from the chair as it collapsed and she did not fall or strike the ground. See Tr.18-19. She further testified that she caught herself while standing up and did not strike her right hip, and she did not recall providing such a history to her medical provider. See Tr.20.

On March 7, 2011, the petitioner presented for an initial appointment at IWIRC for a right groin injury. She reported no prior care but had taken OTC meds for symptom relief. Following examination, she was assessed with a right groin strain, given medication and instructed on use of heat and ice, given light duty with no frequent lifting over 50 pounds and told to follow up. PX "D." Her work restrictions were honored and she continued working on light duty at that time.

On March 14, 2011, the petitioner reported to IWIRC reporting improved symptoms. X-rays noted no fracture but some degenerative joint disease. She was recommended to see a physical therapist. PX "D."

On March 23, 2011, the claimant presented to the IWIRC physical therapist. He noted "the mechanism of injury was incident to routine activity," instructed her on a home exercise program and recommended 3-6 appointments with him. PX "D."

On March 28, 2011, the petitioner presented at IWIRC noting improved symptoms. She was instructed to continue over the counter medications as needed and

released to unrestricted work, but told to follow up in two weeks. She also saw the physical therapist that day. PX "D."

On March 29, 2011, the petitioner presented to Dr. Christopher Hughes for her yearly physical. She reported this incident, and noted she was seeing a separate provider for it but wanted Dr. Hughes' opinion. She reported having been told it was a muscle strain but the pain was not well controlled. Examination noted pain with flexion but no masses or bulges and she reported the x-ray had been negative. Dr. Hughes assessed a flexor strain and prescribed medication as well as instructing her to follow up with the workers' compensation provider. Further treatment for her unrelated issues was also prescribed. See PX "C."

On April 1, 2011, the petitioner presented to the IWIRC physical therapist, asserting she felt no better and had difficulty scheduling appointments. She was noted to be non-compliant with home exercise and it was noted she had "lack of engagement in rehab." The claimant declined to schedule follow-ups at that point, and the petitioner advised that she would see her primary care physician. PX "D."

On April 7, 2011, the petitioner returned to Dr. Hughes, reporting ongoing hip pain. Following examination, Dr. Hughes noted either a strain or possible labral tear and recommended an MRI scan. He did not impose work restrictions. PX "C."

On April 12, 2011, X-rays and MRI were conducted on the petitioner. X-rays noted no fracture or dislocation, but degenerative changes were observed. The MRI noted a joint effusion and a possible small chip avulsion, which was unclear. The results were consistent with a muscle strain. PX "G."

On April 19, 2011, Dr. James Maxey, an orthopedist, saw the claimant on referral from Dr. Hughes. She reported a history of right hip pain following a fall from a chair which had broken, striking her hip. X-rays had been normal, and MRI showed some fluid and edema, which Dr. Maxey opined was consistent with a hip contusion. He opined it should be followed by clinical observation but did not believe anything else was required at that time, noting that if her symptoms did not improve he would repeat the MRI, since the findings at that point "are fairly nonspecific." PX "E." He authored a letter to Dr. Hughes relating the evaluation results. See PX "C."

On April 28, 2011, she saw Dr. Hughes in a follow-up appointment. She noted she was no longer in therapy. Dr. Hughes noted the MRI showed a subtle fracture and the petitioner reported she was seeing Dr. Maxey. Dr. Hughes prescribed monitoring of her unrelated issues and noted the right hip was "stable at this time." He instructed her to follow up in a year for her annual physical. PX "C."

On May 17, 2011, the petitioner saw Dr. Maxey. She reported persistent pain. New x-rays noted a small indistinct area and Dr. Maxey questioned if early avascular necrosis or arthritis might in fact be causing the symptoms. He noted she was improving and instructed her to return in six weeks with full duty work in the interim. On June 28,

2011, the petitioner reported increased groin pain and Dr. Maxey recommended a repeat MRI. See PX "E."

On July 2, 2011, the petitioner underwent the repeat MRI. However, the new MRI was not compared to the prior study by the radiologist. The MRI demonstrated osteoarthritic narrowing in the joint but no effusion or tendon damage. See PX "G." On July 6, 2011, Dr. Maxey's records contain handwritten notes indicating that the petitioner had an MRI and that she could consider seeing a total joint doctor. She noted she would consider it and call for an appointment if she desired such. PX "E."

On July 13, 2012, the petitioner presented to Dr. Hughes' office for unrelated issues but reported pain down the right leg with catching in the knee, and noted a fall at work a year prior to the appointment. However, the only treatment recommendations at that appointment were for unrelated concerns. PX "C."

On July 19, 2012, the petitioner saw Dr. Maxey. He noted a repeat MRI on July 11, 2012 demonstrated hip joint narrowing. X-rays that day also noted narrowing of the hip joint with bone spur formation. He opined that her hip pain "is all secondary to osteoarthritis of the hip" and believed she would likely require hip arthroplasty. At her request, he provided her a referral to his colleague, Dr. Maurer. PX "E."

On August 30, 2012, she saw Dr. Ted Maurer. He noted new x-rays that day demonstrating "significant to almost complete obliteration of the joint space" with osteophytic formation and degenerative changes. No evidence of avascular necrosis, fracture or tumor was notable on x-ray or on the MRI from 2011. He assessed her with "clinically severe arthritis of the right hip" and opined she would not be a candidate for joint preservation surgery given the extent of the disease. He opined she could have injections and therapy but thought she would ultimately require hip replacement surgery. He provided her an opinion that this was pre-existing arthritis which was minimally symptomatic and aggravated by her fall at work. See PX "F."

On October 25, 2012, Dr. Maurer saw the petitioner and recommended diagnostic injections to distinguish trochanteric irritation from arthritis. Injection was conducted that day and November 7. PX "F" and "H." On November 29, 2012, Dr. Maurer noted some relief from the injection which proved transient, and opined the symptoms were intraarticular. Following discussion of options she wished to proceed with hip arthroplasty. PX "F."

On December 26, 2012, the petitioner saw Dr. Maurer pre-operatively. She noted a motor vehicle accident on December 11, 2012, which had resulted in right thigh bruising, but no significant injury per his evaluation. Surgery was scheduled for January 9, 2013. PX "F."

On December 27, 2012, the claimant saw Dr. Hughes pre-operatively. He noted "a long-standing history of severe and chronic pain in the right hip" which had worsened following a work accident several years prior, and noted she had significant degenerative

changes in the right hip. He instructed her to restart her antidepressant medications, which had been stopped pursuant to the orthopedist's orders, but Dr. Hughes opined they would not conflict with the surgery. PX "C." Notably, the petitioner testified she did not know she had arthritis in her hip before this incident. Tr. 14-15.

On January 9, 2013, the petitioner underwent the right hip arthroplasty. Intra-operative findings demonstrated "completely eburnated bone of the femoral head with severe degenerative change throughout the remainder." PX "H." Postoperative x-rays demonstrated good positioning of the hardware. PX "G."

On January 31, 2013, the petitioner was seen in post-operative evaluation. X-rays showed the implant in good position and no infection was apparent. No complaints were noted and physical therapy was prescribed. PX "F."

On March 14, 2013, Dr. Maurer noted good progress in therapy and instructed her to follow up in a month. He kept her off work at that time, as she reported no light duty was available. On April 18, 2013, she reported doing well and x-rays showed stable placement. He released her to work and told her to follow up in three months. PX "F."

The respondent secured a Section 12 medical review of the claimant's records by Dr. Keith Rezin, an orthopedist. On June 19, 2013, Dr. Rezin noted the x-rays noted progressive worsening of the joint space over time and concluded that the petitioner had pre-existing and progressive arthritis in the right hip. He noted the MRI findings of edema were consistent with a muscle strain only and opined the accident had caused a flareup of symptoms but did not cause the need for the hip replacement surgery. He felt the surgery was related to age and progressive degeneration, and any result of the workplace injury would have resolved within no more than two to three months. RX1.

On August 1, 2013, Dr. Maurer opined she was doing "very well" and was effectively at MMI, but noted conditioning could improve over the next one to three years. He limited her to eight hour days pending a follow-up in January 2014. PX "F."

On August 20, 2013, Dr. Maurer authored an opinion report at the request of petitioner's counsel, opining that the injury made the degenerative changes in the petitioner's hip clinically relevant. See PX "B."

OPINION AND ORDER

Causal Relationship to the Accident

A claimant has the burden of proving by the preponderance of credible evidence all elements of the claim, including a causal relationship between the original injury and any condition of ill-being. See, e.g., *Orsini v. Industrial Commission*, 117 Ill.2d 38 (1987). The petitioner submits this matter on an aggravation theory. To demonstrate aggravation, an accident need not be the sole factor, primary factor, or even a substantial factor, so long as it was a factor in the development of the injurious condition. See, e.g.,

Sisbro, Inc., v. Industrial Commission, 207 Ill.2d 193 at 205 (2003), citing *Rock Road Construction Co. v. Industrial Commission*, 37 Ill.2d 123, 127 (1967). Therefore, a degenerative or pre-existing condition which is nevertheless aggravated or accelerated by the workplace accident is considered medically caused by the workplace accident for purposes of the Act. However, depending on the extent of the degenerative condition, it may still be shown that the condition of ill-being was not caused by work. *Sisbro* at 212.

In this case, the accident clearly caused a muscular strain, as identified by the MRI scan of April 2011. However, while this otherwise fairly minor physical incident provoked symptoms, Dr. Hughes' preoperative note clearly indicates that significant symptoms pre-existed the accident. Moreover, Dr. Maxey noted nonspecific findings on the MRI regarding anything more than a muscle strain and later noted the hip pain was secondary to degenerative processes. The intraoperative findings, showing denuded bone and substantial degeneration, clearly bear this out. Dr. Rezin's credible assessment supports this conclusion as well.

The Arbitrator finds that the accident caused the muscular strain, resulting in the medical treatment through the April 28, 2011 appointment with Dr. Hughes, when he opined the hip was stable. She had been released to full duty work by that point. That is also two months following the accident, when Dr. Rezin opined she would likely approach or attain MMI. Lastly, it was at the next appointment in May 2011 when Dr. Maxey assessed her symptoms as likely being caused by arthritis. Accordingly, treatment thereafter is deemed related only to her preexisting and naturally progressing degenerative condition.

Medical Services Provided

The Arbitrator's review of the medical bills submitted by the petitioner show expenses incurred for related treatment have zero balances, with the unpaid balances remaining relating to treatment not causally related. As such, these are denied.

Temporary Total Disability

The petitioner was initially prescribed light duty, which was accommodated. She was thereafter released to full duty and worked her regular job until the surgery, which was not related. As such, TTD is not causally related, rendering this issue moot.

Nature and Extent of the Injury

The petitioner's work-related accident was causally related to the muscular strain to the petitioner's right leg, hip and groin. The petitioner having reached maximum medical improvement, respondent shall pay the petitioner the sum of $402.00/week for a further period of 10.75 weeks, as provided in Section 8(e) of the Act, as the injuries sustained caused permanent loss to the petitioner's right leg to the extent of 5% thereof.

STATE OF ILLINOIS)
) SS.
COUNTY OF)
WILLIAMSON

☒ Affirm and adopt (no changes)	☐ Injured Workers' Benefit Fund (§4(d))
☐ Affirm with changes	☐ Rate Adjustment Fund (§8(g))
☐ Reverse Choose reason	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☐ Modify Choose direction	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Rhonda Bowman,

Petitioner,

vs.

NO: 12 WC 21414

14IWCC1022

Gateway Regional Medical 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, temporary total disability, prospective medical expenses, and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof. The Commission further remands this case to the Arbitrator for further proceedings for a determination of a further amount of temporary total compensation or of compensation for permanent disability, if any, pursuant to Thomas v. Industrial Commission, 78 Ill.2d 327, 399 N.E.2d 1322, 35 Ill.Dec. 794 (1980).

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed 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.

14IWCC1022

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: NOV 25 2014
TJT:yl
o 9/29/14
51

Thomas J. Tyrrell

Kevin W. Lamborn

Michael J. Brennan

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF 19(b) DECISION OF ARBITRATOR

BOWMAN, RHONDA
Employee/Petitioner

Case# **12WC021414**

GATEWAY REGIONAL MEDICAL CENTER
Employer/Respondent

14IWCC1022

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:

0969 THOMAS C RICH PC
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FAIRVIEW HTS, IL 62208

0560 WIEDNER & McAULIFFE LTD
MATTHEW J ROKUSEK
ONE N FRANKLIN ST SUITE 1900
CHICAGO, IL 60606

14IWCC1022

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)

Rhonda Bowman
Employee/Petitioner

v.

Gateway Regional Medical Center
Employer/Respondent

Case # 12 WC 21414

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 **Joshua Luskin**, Arbitrator of the Commission, in the city of **Herrin**, on **October 11, 2013**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☐ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☐ What was the date of the accident?
E. ☐ Was timely notice of the accident given to Respondent?
F. ☒ Is Petitioner's current condition of ill-being causally related to the injury?
G. ☐ What were Petitioner's earnings?
H. ☐ What was Petitioner's age at the time of the accident?
I. ☐ What was Petitioner's marital status at the time of the accident?
J. ☒ Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for 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, **5/19/2012**, 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 **$12,387.04**; the average weekly wage was **$495.48**.

On the date of accident, Petitioner was **58** years of age, ***married*** with **0** dependent children.

Respondent ***has not*** paid all reasonable and necessary charges for all reasonable and necessary medical services.

Respondent shall be given a credit of **$18,397.32** for TTD, $-- for TPD, $-- for maintenance, and **$1,528.56** for other benefits, for a total credit of **$19,925.88**.

Respondent is entitled to a credit of $-- 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

12-19-13
Date

ICArbDec19(b)

DEC 20 2013

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

RHONDA BOWMAN,	)	14IWCC1022
	)	
Petitioner,	)	
	)	
vs.	)	No. 12 WC 21414
	)	
GATEWAY REGIONAL MEDICAL CENTER,	)	
	)	
Respondent.	)	

ADDENDUM TO ARBITRATION DECISION

This matter was heard pursuant to Sections 8(a) and 19(b) of the Act. The parties had originally disputed the Average Weekly Wage, but thereafter advised that the dispute was withdrawn and the parties concurred that the AWW pursuant to Section 10 was $495.48 per week based on part-time earnings of $12,387.04.

STATEMENT OF FACTS

The claimant, fifty-eight years old on the date of loss, is a clinical interventionist for Gateway Regional Medical Center. On May 19, 2012, she was injured when an unruly patient pushed her up against a door, causing her to strike her neck and back. She advised the respondent of the incident, and accident was not disputed.

Prior to her injury, the petitioner had a five-year history of low back complaints. At the time of her injury, she was under the active care of Dr. Gunapooti, who had previously performed spinal injections and had referred her for a neurosurgical consultation, a prescription she had not pursued at the time of the instant injury.

On September 13, 2007, an MRI of the petitioner's lumbar spine demonstrated multilevel degenerative disc disease producing mild stenosis at the lower three levels of the lumbar spine. RX2. Dr. Gornet testified in his deposition that he had seen the petitioner in 2007 for a work-related injury, and recommended conservative care at that point. Following physical therapy, he discharged her from treatment in 2008 and did not himself see her until after the accident at issue in this case. See PX11.

On September 9, 2011, the petitioner saw Dr. Gunapooti at Interventional Pain Management Services. That visit is noted to be a follow-up examination, but earlier records are not present. RX4. She reported chronic low back pain radiating down the right leg for several years. She had undergone nerve blocks and conservative care without relief. Dr. Gunapooti prescribed an MRI of the lumbar spine and a neurosurgical

consultation. RX4. The MRI of the lumbar spine was obtained on September 28, 2011. It demonstrated multilevel disc bulging from L3 through S1, with possible herniation at L3-4 and annular tear at L4-5; multiple references to arthritic findings are also apparent. RX3. Dr. Gunapooti thereafter reviewed the MRI, recommended injection therapy and renewed his recommendation for a surgical consultation. The petitioner desired to undergo the injections but declined the surgical evaluation. RX4.

The petitioner returned to Dr. Gunapooti on January 16, 2012. The first set of injections had provided some relief, and Dr. Gunapooti performed repeat injections. RX4. On March 30, 2012, she reported ongoing significant pain though she advised the injections had helped her. RX4. Dr. Gunapooti discussed treatment options and the claimant wished to defer neurosurgical consultation. On April 16, 2012, the petitioner saw Dr. Gunapooti with ongoing symptoms. Dr. Gunapooti performed a sacroiliac joint injection, prescribed physical therapy and instructed her to follow up. RX4.

The accident presently under discussion occurred before the petitioner's scheduled follow-up with Dr. Gunapooti. On the morning of May 22, 2012, she presented to Alton Memorial Hospital for a back injury incurred at work. She was prescribed a muscle relaxant and instructed to follow up with Dr. Gornet or occupational health care. PX3. Later that day, she presented to Gateway Occupational Health Services. See PX4. She gave a consistent history and Dr. Knapp noted a new onset of neck pain with right hand numbness and aggravation of low back pain, the extent of which was unclear. He prescribed her off work pending Dr. Gornet's evaluation. PX4.

On June 7, 2012, the petitioner saw Dr. Gornet. She provided a consistent history of accident. He noted low back pain with radiation, as well as neck pain radiating into the shoulders and tingling in the hands. He recommended a new MRI scan, expressed a desire to review Dr. Gunapooti's notes, and opined there had been an aggravation of her prior condition. His notes relative to work are inconsistent; the transcribed report states he placed her off work, but the off work slip he wrote shows light duty. PX5.

The MRI was performed on August 8, 2012. It suggested multilevel disk bulges as previously reported with herniation at L3-4 and stenoses from L4-S1. PX6. Dr. Gornet reviewed the MRI that day. He interpreted it as showing a herniation at L5-S1 and recommended lumbar steroid injections, physical therapy and light duty. PX5.

On October 4, 2012, the petitioner saw Dr. Gornet. He noted she was working light duty and reported the injections had proven of use. Due to ongoing neck pain he recommended a cervical spine MRI and maintained the light duty restrictions. PX5.

On November 12, 2012, the petitioner underwent another MRI of the lumbar spine. It demonstrated disk pathology generally consistent with the prior MRI of Augsut 2012. PX6. That day the petitioner saw Dr. Gornet and complained of difficulty with weightbearing and weakness in the right leg. He opined the MRI correlated with her symptoms and placed her off work. He also prescribed medication. PX5.

The respondent secured a Section 12 evaluation with Dr. Petkovich, who authored an initial report on October 22, 2012. At that time, following his examination, he assessed her with cervical and lumbar strains, and had possibly aggravated her underlying condition, but would need to see radiographic films before making a determination. He thereafter reviewed objective films and issued a supplemental report on November 7, 2012. He opined that the lumbar spine pathology had preceded the event of May 2012 and therefore the petitioner had a temporary aggravation to that area but was at MMI. With regard to the cervical spine, he believed she was in need of further evaluation, and recommended MRI evaluation. Dr. Petkovich later testified in deposition in support of those conclusions on March 25, 2013. RX5.

Dr. Gornet performed a discogram with post-discogram CT on December 12, 2012. He interpreted the results as showing provocative pain at L5-S1 and an annular tear and disk bulge at that level. PX9-10. On December 20, 2012, Dr. Gornet reviewed the October 22, 2012 report of Dr. Petkovich, placed neck treatment on hold and noted the results of the CT discogram; he thereafter recommended L5-S1 fusion surgery. PX5. He has since prescribed her off work pending surgery. PX5.

Dr. Gornet thereafter testified in support of his causal connection opinion and proposed treatment course, specifically the anterior-posterior one level fusion at L5-S1, on August 19, 2013. PX11.

The respondent obtained a second Section 12 examination, which was conducted on August 20, 2013, by Dr. Bernardi. Following his examination, he diagnosed her with L3-4, L4-5 and L5-S1 degenerative disc/facet disease, right meralgia paresthesia, as well as cervical degenerative disc disease and neck pain of undetermined etiology. Dr. Bernardi recommended that the cervical spine MRI be conducted if it had not been so, and that any determination of MMI would be able to be made after that point. Relative to the low back, he concluded that the injury described could have provoked symptoms, but did not believe the structural pathology had been affected by the May 2012 accident. He testified in support of his conclusions on September 24, 2013. RX6.

OPINION AND ORDER

Causal Relationship to the Injury

There is no current dispute over the causal relationship between the cervical complaints and the work injury, as both the treating and examining physicians agree that the petitioner requires further evaluation of her cervical spine including an MRI. The present issue is the work accident's causal relationship to the current lumbar spine complaints and the recommended treatment for same.

While Dr. Bernardi and Dr. Petkovich testified credibly, and based their reasonable findings on the objective studies available to them, in this case the Arbitrator is persuaded by the fact that while the petitioner had been recommended to have a

surgical consultation, she had attempted to avoid pursuing such and had certainly been capable of engaging in full duty work prior to this incident. Moreover, there is no dispute as to the significance of the accident, as Drs. Bernardi and Petkovich both suggested further evaluation of the cervical spine was warranted.

The respondent's position is certainly understandable given that she was under active care from Dr. Gunapooti at the time of the instant incident. However, by all accounts Dr. Gunapooti had not exhausted conservative measures at that time. As such, while the Arbitrator finds the assessment of the examining physicians to be both credible and well supported, it does appear that an acceleration of the recommended treatment did in fact occur, inevitable though such treatment may well have been.

Medical Services – Past and Prospective

The medical services provided appear generally medically reasonable. However, the Arbitrator concurs with Dr. Bernardi's assessment when he states "I don't think she needed both physical therapy and chiropractic treatment. I think they are – In the management of low-back pain, I think they are essentially equivalent. One or the other is appropriate..." See RX6 p.38. Accordingly, the Arbitrator finds that the chiropractic charges from Dr. Eavenson are not reasonable and necessary. The respondent is directed to pay the other medical bills identified in PX1 pursuant to Sections 8(a) and 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.

Prospectively, the respondent shall authorize and pay for the L5-S1 lumbar fusion recommended by Dr. Gornet, as it appears reasonably targeted at curing or relieving the effects of the instant injury.

Relative to the cervical spine, Dr. Gornet has suspended care relative to that anatomy. As such, any request for treatment targeted at that section is speculative. The Arbitrator defers any such request under 8(a) to a future hearing, if needed.

Temporary Total Disability

In light of the above causal findings, the Arbitrator finds TTD to have been established from May 22, 2012, when she was prescribed off work by Dr. Knapp, through June 7, 2012, when she saw Dr. Gornet for the first time. At that point she was apparently released on light duty, and both Dr. Gornet and Dr. Petkovich noted she was in fact working during that period thereafter. See PX5 on 10-4-12, "is working" and RX5 p.13, "...Ms. Bowman told me that she was working at the time that I saw her...". The petitioner was later taken off work beginning November 12, 2012, extending through the trial date of October 11, 2013.

As such, the petitioner has established TTD eligibility for a total of 351 days, or 50 & 1/7 weeks. At the appropriate average weekly wage of $495.48, a correspondent TTD rate of $330.32 results. This produces a total TTD liability of $16,563.19. The respondent has paid $19,925.88 to date. As such, the respondent is entitled to $3,362.69 credit in overpaid disability benefits, to be applied against future disability benefits of either temporary or permanent nature.

STATE OF ILLINOIS)
) SS.
COUNTY OF)
WILLIAMSON

☐ Affirm and adopt (no changes)	☐ Injured Workers' Benefit Fund (§4(d))
☐ Affirm with changes	☐ Rate Adjustment Fund (§8(g))
☒ Reverse Accident	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☐ Modify	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

RONALD E BANDY, SR.,

Petitioner,

vs. NO: 10 WC 42611

IDOT,

14IWCC1023

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of accident, causal connection, medical expenses, and permanent partial disability benefits, and being advised of the facts and law, reverses the Decision of the Arbitrator as stated below.

FINDINGS OF FACT

Petitioner worked for Respondent for 18.5 years and previously injured his left knee in March 2007.

Petitioner said in November 2009 he was working at Respondent's lab where various tests on asphalt and other materials were performed, and where timers were set to alert one when the material reached various temperatures. Petitioner said his job duties were time sensitive. He testified the timers were urgent, rushing was necessary, and assumed that the timer was important because subsequent steps and tests need to occur once the material reached a certain temperature.

14IWCC1023

Bruce Peebles testified on behalf of Respondent. He is a materials and civil engineer and supervises the D-9 material lab, where Petitioner was working when he allegedly injured himself. Peebles explained there are multiple ovens in the lab that heat materials to the test temperature required. He said the lab is not large so all of the ovens are probably within 30 feet of one another and the adjacent room with additional ovens is only a short walk. Peebles explained there are timers for each oven that go off when the test has been completed or a measurement needs to be taken. Peebles explained that when a timer goes off, one must respond but it is not an emergency or immediate. Peebles agreed timely action is required, otherwise there is risk the materials could over heat and not be at the proper test temperature when removed from the oven. But Peebles would not equate a timely manner to rushing.

Petitioner alleged he re-injured his left knee while pivoting around a tight corner. Petitioner said when he walked through the doorway to the lab, he had to make a tight turn because of the location of two counters. Petitioner said the majority of the floor is tile and while turning, he had to watch for trash cans. Petitioner said he was walking a little faster than usual when his knee popped. Petitioner testified it made him nauseous and he felt immediate pain. Peebles testified he had no recollection of Petitioner injuring himself and does not know how fast Petitioner was walking at the time.

Petitioner sought medical treatment with Dr. Austin at WorkCare. On November 6, 2009, Petitioner saw Dr. Austin. Petitioner gave a history of an injury in March 2007 that has gotten worse in the last six to eight months. Petitioner said he told Dr. Austin about his March 2007 injury because Petitioner thought Dr. Austin needed to know he was injured before. He reported his left knee joint actually locked up when he bent down on his knees and he used his hands to manually straighten his leg. He denied radiating pain, numbness or tingling. During the physical exam, Petitioner had mild swelling and joint line tenderness. Dr. Austin wrote his impression was left knee hypertension injury over two and a half years ago with persistent pain and occasional locking. He noted the exam findings were consistent with probable anterior horn lateral meniscal tear and small Baker's cyst. Petitioner also had an x-ray that showed moderate patellofemoral osteoarthritis.

On November 30, 2009, Petitioner had a left knee MRI. The impression included lateral meniscal tear; marked patellofamoral compartment chondrosis; moderate distal quadriceps and proximal patellar tendinosis; and Baker's cyst.

On December 2, 2009, Petitioner saw Dr. Austin again. Subjectively, Petitioner reported spasms but overall was unchanged. He reported no pain at rest and when sitting but increased pain with more use and as the day progressed. On the physical exam, Petitioner had swelling in his knee and moderate joint line tenderness and some weakness. Dr. Austin's impression was the same. He noted the exam and MRI findings were consistent with posterior lateral meniscal tear, small Baker's Cyst, quad patellar tenderness and patelloforminal echondrosis. He also referred Petitioner to Dr. Davis.

14IWCC1023

On January 11, 2010, Petitioner saw Dr. Davis, an orthopedic surgeon. He completed a patient intake form, on which he indicated his chief complaint was left knee pain and that the injury occurred in March 2007 – there is no mention of the November 2009 injury. Petitioner said he told Dr. Davis about the March 2007 injury because he thought Dr. Davis needed to know Petitioner had previously injured the same knee. Dr. Davis noted that Petitioner complained of left knee giving way, pain and swelling, and rated his pain at 8/10.

Petitioner said he eventually stopped treating for this injury. Petitioner testified that Dr. Davis told him that Petitioner could have surgery or put up with the pain, and he chose to deal with the pain. Petitioner said he did not miss any work as a result of the injury. Petitioner testified he has problems and pain with squatting, stairs, sitting in soft furniture where his knee bends past 90 degrees, and getting down on the floor. Petitioner also said he lost some flexibility and range of motion in his left leg.

CONCLUSIONS OF LAW

We hold that Petitioner did not prove he suffered an accident arising out of and in the course of his employment. We find that Petitioner did not show that his injury derived from a risk connected with, or incidental to, his employment. There are three categories of risk an employee may be exposed to: (1) risks distinctly associated with the employment; (2) risks personal to the employee; and (3) neutral risks which have no particular employment or personal characteristics. *Ill. Institute of Technology Research Institute v. Indus. Com'n*, 314 Ill.App.3d 149, 162 (2000). However, "the mere fact that claimant was present at the place of injury because of his employment duties will not by itself suffice to establish that the injury arose out of the employment." *Brady v. Louis Ruffolo & Sons Const. Co.*, 143 Ill.2d 542, 551, 578 N.E.2d 921, 924 (1991). If the accident resulted from a risk that Petitioner would have been equally exposed to apart from his employment, the injury does not arise out of the employment. *Id.* Walking on a normal surface is not a risk incidental to employment. *Tinley Park Hotel and Convention Center v. Indus. Com'n*, 356 Ill.App.3d 833, 839, 826 N.E.2d 1043, 1048 (1st Dist. 2005).

The record as a whole reflects that Petitioner sustained his injury as a result of a neutral risk and that he was not exposed to a risk of injury to a greater extent than the general public. In this case, Petitioner experienced pain in his left knee when he rounded a corner to respond to a timer. The record does not reflect, and Petitioner did not allege, a defect in the laboratory floor. We find this was a neutral risk.

While Petitioner testified he was "rushing" while walking around the corner, the rest of the record does not contain any comments about Petitioner rushing. Petitioner even admitted on cross examination that he did not tell any of his doctors or mention on any form that he was rushing while completing this task. Further, Dr. Austin's and Dr. Davis' records are void of any mention of an injury occurring in November 2009. Moreover, Respondent's witness, Bruce Peebles, testified the timers would go off several times a day and did not indicate an emergency

14IWCC1023

situation. Peebles testified that when the timers go off, one is only required to move at a normal – not rushed – pace to respond. We find that Petitioner did not present evidence to find an increased risk as a result of his employment. Therefore, Petitioner failed to meet his burden of proof that he was exposed to a risk greater than the general public and failed to prove he suffered an accident arising out of and in the course of his employment with Respondent.

Because we find Petitioner did not prove he suffered an injury arising out of and in the course of his employment with Respondent, all other issues are moot and any claimed benefits are denied.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Arbitrator's decision is reversed. We hold Petitioner did not suffer a work related injury and do not award him any benefits.

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: NOV 25 2014
TJT: kg
R: 9/30/14
51

Thomas J. Tyrrell

Michael J. Brennan

Kevin W. Lamborn

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

Cynthia Thomas-King,
Petitioner,

vs.

University of Chicago,
Respondent.

14IWCC1024

NO: 10 WC 5008

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 December 17, 2013 is hereby affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that the Respondent pay to Petitioner interest under §19(n) of the Act, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that the Respondent shall have credit for all amounts paid, if any, to or on behalf of the Petitioner on account of said accidental injury.

The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: NOV 25 2014
KWL/vf
O-11/18/14
42

Kevin W. Lamborn

Thomas J. Tyrrell

Michael J. Brennan

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

14IWCC1024

Case# 10WC005008

THOMAS-KING, CYNTHIA
Employee/Petitioner

UNIVERSITY OF CHICAGO
Employer/Respondent

On 12/17/2013, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.09% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

A copy of this decision is mailed to the following parties:

0006 LAW OFFICES OF LEO ALT
221 N LASALLE ST
SUITE 2014
CHICAGO, IL 60601-1413

1401 SCOPELITIS GARVIN LIGHT ET AL
GREGORY AHERN
30 W MONROE ST SUITE 600
CHICAGO, IL 60603

STATE OF ILLINOIS)
)SS.
COUNTY OF COOK)

☐ Injured Workers' Benefit Fund (§4(d))
☐ Rate Adjustment Fund (§8(g))
☐ Second Injury Fund (§8(e)18)
☒ None of the above

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

14IWCC1024

CYNTHIA THOMAS-KING
Employee/Petitioner

v.

UNIVERSITY OF CHICAGO
Employer/Respondent

Case # 10 WC 05008

Consolidated cases: ___

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **BRIAN CRONIN**, Arbitrator of the Commission, in the city of **CHICAGO**, on **JUNE 20, 2013**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☐ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☐ What was the date of the accident?
E. ☐ Was timely notice of the accident given to Respondent?
F. ☒ Is Petitioner's current condition of ill-being causally related to the injury?
G. ☐ What were Petitioner's earnings?
H. ☐ What was Petitioner's age at the time of the accident?
I. ☐ What was Petitioner's marital status at the time of the accident?
J. ☒ Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. ☒ What temporary benefits are in dispute?
☒ TPD ☐ Maintenance ☐ TTD
L. ☒ What is the nature and extent of the injury?
M. ☐ Should penalties or fees be imposed upon Respondent?
N. ☐ Is Respondent due any credit?
O. ☐ Other ___

14IWCC1024

FINDINGS

On **DECEMBER 21, 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 partially* causally related to the accident.

In the year preceding the injury, Petitioner earned **$36,777.00**; the average weekly wage was **$707.25**.

On the date of accident, Petitioner was **59** years of age, *single* with **0** dependent children.

Petitioner *has* received all reasonable and necessary medical services.

Respondent *has not* paid all appropriate charges for all reasonable and necessary medical services.

Respondent shall be given a credit of **$13,875.50** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$13,875.50**.

Respondent is entitled to a credit of **$0** under Section 8(j) of the Act.

ORDER (SEE ATTACHMENT)

RESPONDENT SHALL PAY PETITIONER TEMPORARY TOTAL DISABILITY BENEFITS OF $471.50/WEEK FOR 27 WEEKS, FROM 12/22/2009 THROUGH 6/28/2010 AS PROVIDED IN SECTION 8(B) OF THE ACT.

RESPONDENT SHALL PAY PETITIONER TEMPORARY PARTIAL DISABILITY BENEFITS OF $118.12/WEEK FOR 9-2/7 WEEKS, COMMENCING JUNE 29, 2010 THROUGH SEPTEMBER 1, 2010, AS PROVIDED IN SECTION 8(A) OF THE ACT.

RESPONDENT SHALL PAY $628.00 FOR THE REASONABLE AND NECESSARY MEDICAL SERVICES FOR PETITIONER'S RIGHT KNEE, AS PROVIDED IN SECTION 8(A) AND SUBJECT TO SECTION 8.2 OF THE ACT.

RESPONDENT SHALL PAY PETITIONER PERMANENT PARTIAL DISABILITY BENEFITS OF $424.35/WEEK FOR 75.25 WEEKS, BECAUSE THE INJURIES SUSTAINED CAUSED THE 35% LOSS OF USE OF PETITIONER'S RIGHT LEG, AS PROVIDED IN SECTION (E)12 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 16, 2013
Date

DEC 17 2013

14IWCC1024

CYNTHIA THOMAS-KING V. UNIVERSITY OF CHICAGO

10 WC 05008

FINDINGS OF FACT:

Cynthia Thomas-King was employed by the University of Chicago as an Operations Assistant. On December 21, 2009, while in the scope and course of her job, Petitioner was pinning putting posters on a cabinet when the cabinet fell on top of her.

Petitioner sought treatment at the University of Chicago Medical Center on December 21, 2009, at which time she complained of back pain and knee pain. (P. Ex. 6)

According to the Employee Statement of Injury or Illness, which Petitioner signed and dated on December 28, 2009, the Petitioner wrote:

"While trying to pin up poster, cabinet fell on top of me, first hitting me in the top of the head (when I lifted my hands to block (over) the cabinet, it was too heavy and when it hit me, I felt a 'pop' in my knee and the next thing I remember is hitting the floor.) I remember calling out for help." (P. Ex. 5)

At arbitration, Petitioner testified that she put up her arms to stop the cabinet from falling, but the cabinet was unbelievably heavy and she felt pain in her arms and shoulders and a 'pop' in her leg.

Ms. Thomas-King went on her own to treat with Michael G. Maday, M.D., of Midland Orthopedic Associates. Petitioner completed a Medical History intake form that she signed and dated December 30, 2009. In answer to the question "Describe your problem (where does it hurt)", Petitioner wrote: "knee injury." (P. Ex. 7) Petitioner completed a "Work–Related Injury" form that she signed and dated December 30, 2009. In explaining, "why this injury is work-related," Petitioner wrote, in pertinent part, the following:

"Posting poster in bulletin board cabinet, cabinet fell off wall (I was told it weighed about 400 lb.) onto me. When the paramedics arrived, I let them know I was having knee & back pain." (P. Ex. 7)

In Dr. Maday's narrative report dated December 22, 2010, he wrote that on December 30, 2009, he first saw Petitioner for a left (sic) knee injury that occurred on December 21, 2009. In that report, he makes no mention of any right shoulder complaints. (P. Ex. 10)

Due to her failure to respond to conservative care, Petitioner underwent arthroscopic surgery and manipulation on her right knee on April 12, 2010. Petitioner sustained a medial patellar fracture. Dr. Maday performed the arthroscopic surgery. He found that Petitioner had fibrotic scar tissue, a complex tear of the posterior horn of the lateral meniscus, grade-4 chondrosis of the lateral tibial plateau and a complex tear of the posterior horn of the medial meniscus. (P. Ex. 11, R. Ex. 1)

Subsequent to the surgery, Petitioner underwent therapy and viscous supplementation injections. Dr. Maday then opined:

"Despite medication, injection, and surgical intervention she has continued to complain of pain and based on the findings at arthroscopic surgery, I would anticipate at some point in her life she would need a total knee replacement. Although she did have an underlying degenerative condition, I believe that her injury did aggravate this condition." (P. Ex. 11)

In his April 29, 2011 chart note, Dr. Maday wrote:

"Cynthia Thomas-King returns today and overall her knee is doing somewhat better. She is still having pain. She is still limited with her walking. Furthermore, she has noted right shoulder pain which she states was present since the time of her injury when she was struck. Apparently she did not report this at the time of injury and I have asked her to confirm this." (P.Ex. 7)

In Dr. Maday's report dated March 20, 2012, he wrote that he first evaluated Petitioner for her shoulder symptoms on June 10, 2011. (P. Ex. 10)

On the Medical History intake form, which Petitioner signed and dated June 10, 2011, Petitioner answered the question "Describe your problem (where does it hurt)" as follows: "Pain in right shoulder and back." In answer to "How long has it bothered you", Petitioner wrote a number that was either 6 or 8 months. The Arbitrator notes that the number was changed. Significantly, in answer to the question "Explain how this happened", Petitioner answered "unknown." (P. Ex. 7)

At the arbitration hearing, Petitioner insisted that in 2010, she did mention to Dr. Maday that she had pain in her back and shoulder, but that she was focused on the knee, and she assumed Dr. Maday was focused on the knee. Petitioner testified that her shoulder had been bothering her prior to her April 12, 2010 knee surgery, and that when she returned to work on June 28, 2010, she mentioned her shoulder problem to Julie Stephan and other office co-workers. However, Petitioner was not sure if the co-workers heard her complaints. On redirect examination, Petitioner testified that when she complained of back pain, she meant upper back pain, and further that she did not know if it was the shoulder or her spine.

On August 11, 2010, at the request of Respondent and pursuant to Section 12 of the Act, Petitioner submitted to an examination by Ira B. Kornblatt, M.D. The history contained in this report indicates that Ms. Thomas-King told him that she was trying to hold a cabinet from falling and her right knee buckled and she sustained an injury to the right knee. There is no mention in Dr. Kornblatt's report that Petitioner alleged injuries to her shoulder on December 21, 2009 or any time thereafter. Dr. Kornblatt only conducted an examination of Petitioner's lower extremities. Dr. Kornblatt opined that it appears that Petitioner had a significant aggravation of her pre-existing osteoarthritis. (R. Ex. 1)

The June 23, 2011, MRI of the right shoulder was negative for a full thickness tear of the supraspinatus, but did reveal minimal supraspinatus

tendinopathy and with a probable non-displaced tear of the anterior/inferior labrum.

Petitioner underwent injections for the shoulder.

In Dr. Maday's report dated March 20, 2012, he wrote:

"Therefore, I feel that if she did use her arm to try to prevent the file cabinet from falling, her mechanism of injury would be consistent with a rotator cuff injury as well as a labral injury. In that respect if she was asymptomatic prior to the injury, I feel that this injury would be responsible for the partial thickness tear of the rotator cuff and labral pathology."

CONCLUSIONS OF LAW:

In support of his decision with regard to issue (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:

The burden is on the party seeking an award to prove by a preponderance of credible evidence the elements of the claim. *Hannibal, Inc. v. Indus. Comm'n*, 231 N.E.2d 409, 410 (1967); *Illinois Institute of Technology v. Indus. Comm'n*, 369 N.E.2d 853, 12 Ill. Dec. 146 (1977).

Based on the opinions of Doctors Maday and Kornblatt, as well as on the medical records, the Arbitrator finds that Petitioner's right knee condition of ill-being is causally related to the accidental injury of December 21, 2009.

However, the Arbitrator finds, by a preponderance of he weight of the credible evidence, that Petitioner failed to prove that the current condition of ill-being of her right shoulder is causally related to the accident of December 21, 2009. There is no mention in the medical records of any right shoulder complaints until April 29, 2011. Then, on June 10, 2011, Petitioner completes, signs and dates a Medical History intake form. Petitioner answered the question "Describe your problem (where does it hurt)" as follows: "Pain in right shoulder and back." In answer to "How long has it bothered you", Petitioner wrote a number of months that was either 6 or 8. The Arbitrator notes that

this handwritten number was changed. Significantly, in answer to the question "Explain how this happened", Petitioner answered "unknown." (P. Ex. 7)

The Arbitrator notes that Petitioner's first documented complaint of right shoulder pain began more than 1 year and 3 months after the accident and 10 months after she returned to work following the right knee surgery.

Petitioner did provide unrebutted testimony that upon returning to work post-knee surgery, on June 28, 2010, she told Julie Stephan that she was having problems with her shoulder. Yet, there is no evidence that she told Julie Stephan when and how such shoulder problems began.

In support of his decision with regard to issue (K) "What temporary benefits are in dispute? (TPD)", the Arbitrator makes the following findings of fact and conclusions of law:

The parties have stipulated that Petitioner was temporarily totally disabled for 27 weeks (from December 22, 2009 through June 28, 2010).

Respondent is entitled to a credit of $13,875.50 for TTD benefits previously paid.

Petitioner was released to return to limited duty, part-time, half days and received half pay from June 29, 2010 until September 1, 2010. The difference amounts to $118.12 per week.

The Arbitrator awards $118.12 per week for 9-2/7 weeks for the period June 29, 2010 to September 1, 2010, that being the period that Petitioner worked on a part-time basis per her doctor's instructions and the Respondent's accommodations.

In support of his decision with regard to issue (J) "Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?", the Arbitrator makes the following findings of fact and conclusions of law:

The Arbitrator finds that Respondent is responsible for payment of the ambulance bill in the amount of $613.00, pursuant to Section 8(a) and subject to Section 8.2 of the Act. (P. Ex 1) The parties stipulated that if the University of Chicago has already paid the bill, then Respondent shall receive a credit for such payment. The Arbitrator finds that Respondent is liable for reimbursing Petitioner $15.00 in out-of-pocket costs for prescription pain medication for her right knee, pursuant to Section 8(a) and subject to Section 8.2 of the Act. (P. Ex 2)

As the Arbitrator has found that Petitioner's current condition of ill-being of her right shoulder is not causally related to the December 21, 2009 accident, the Arbitrator denies any bills for treatment of Petitioner's right shoulder.

In support of his decision with regard to issue (F) "What is the nature and extent of the injury?", the Arbitrator makes the following findings of fact and conclusions of law:

The Arbitrator finds that as a result of the accidental injury of December 21, 2009, Petitioner sustained substantial damage to her right knee.

Ms. Thomas-King was found to have a medial patellar fracture. Dr. Maday performed the arthroscopic surgery. He found that Petitioner also had fibrotic scar tissue, a complex tear of the posterior horn of the lateral meniscus, grade-4 chondrosis of the lateral tibial plateau and a complex tear of the posterior horn of the medial meniscus. (P. Ex. 11, R. Ex. 1)

In his March 20, 2012 report, Dr. Maday wrote that he would anticipate that at some point in Petitioner's life, she would need a total knee replacement. Respondent's Section 12 examining physician, Dr. Kornblatt, concurred with this prognosis. Dr. Kornblatt wrote: "I believe the claimant will continue to have significant disability until the total knee is performed."

Petitioner testified that due to the pain from her right knee injury, she is unable to do a lot of things that she used to do: shopping, going for walks, being on her feet a lot. She can walk 1-1/2 blocks without a rest. Petitioner finds that it is very painful walking downstairs. Petitioner further testified that she does not kneel at church anymore because it is too painful.

Based on the foregoing, the Arbitrator finds that as a result of the accident of December 21, 2009, Petitioner sustained a permanent loss of use of her right leg to the extent of 35% thereof.

STATE OF ILLINOIS	)	☒ Affirm and adopt	☐ Injured Workers' Benefit Fund (§4(d))
	) SS.	☐ Affirm with changes	☐ Rate Adjustment Fund (§8(g))
COUNTY OF LAKE	)	☐ Reverse	☐ Second Injury Fund (§8(e)18)
			☐ PTD/Fatal denied
		☐ Modify	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Brian Barna,

Petitioner,

14IWCC1025

vs.

NO: 13 WC 6903

Buffalo Grove Fire Department,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of accident, 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 July 9, 2013 is hereby affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that this case be remanded to the Arbitrator for further proceedings consistent with this Decision, but only after the latter of expiration of the time for filing a written request for Summons to the Circuit Court has expired without the filing of such a written request, or after the time of completion of any judicial proceedings, if such a written request has been filed.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner interest under §19(n) of the Act, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall have credit for all amounts paid, if any, to or on behalf of Petitioner on account of said accidental injury.

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $100.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: NOV 25 2014
KWL/vf
O-11/18/14
42

Kevin W. Lamborn

Thomas J. Tyrrell

Michael J. Brennan

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF 19(b) DECISION OF ARBITRATOR

14IWCC1025

BARNA, BRIAN
Employee/Petitioner

Case# **13WC006903**

BUFFALO GROVE FIRE DEPT
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:

2208 CAPRON & AVGERINOS PC
DANIEL F CAPRON
55 W MONROE ST SUITE 900
CHICAGO, IL 60603

0507 RUSIN MACIOROWSKI & FRIEDMAN LTD
GREG RODE
10 S RIVERSIDE PLZ SUITE 1530
CHICAGO, IL 60606

STATE OF ILLINOIS)
)SS.
COUNTY OF LAKE)

☐ Injured Workers' Benefit Fund (§4(d))
☐ Rate Adjustment Fund (§8(g))
☐ Second Injury Fund (§8(e)18)
☒ None of the above

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

14IWCC1025

Case # 13 WC 6903

Brian Barna
Employee/Petitioner

v.

Buffalo Grove Fire Department
Employer/Respondent

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Anthony C. Erbacci**, Arbitrator of the Commission, in the city of **Rockford**, on **May 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

14IWCC1025

FINDINGS

On the date of accident, **May 30, 2012**, Respondent ***was*** operating under and subject to the provisions of the Act.

On this date, an employee-employer relationship ***did*** exist between Petitioner and Respondent.

On this date, Petitioner ***did*** sustain an accident that arose out of and in the course of employment.

Timely notice of this accident ***was*** given to Respondent.

Petitioner's current condition of ill-being ***is*** causally related to the accident.

In the year preceding the injury, Petitioner earned **$110,932.12**; the average weekly wage was **$2,133.31**.

On the date of accident, Petitioner was **45** years of age, ***single*** with **2** dependent children.

Respondent ***has not*** paid all reasonable and necessary charges for all reasonable and necessary medical services.

ORDER

Respondent shall authorize and pay the reasonable, necessary and causally related expenses of the repeat arthroscopy prescribed for the petitioner by his treating physician, Dr. Farrel.

As the petitioner was paid full salary during his period of Temporary Total Disability, no Temporary Total Disability benefits are awarded herin.

In no instance shall this award be a bar to subsequent hearing and determination of an additional amount of medical benefits or compensation for a temporary or permanent disability, if any.

RULES REGARDING APPEALS Unless a party files a *Petition for Review* within 30 days after receipt of this decision, and perfects a review in accordance with the Act and Rules, then this decision shall be entered as the decision of the Commission.

STATEMENT OF INTEREST RATE If the Commission reviews this award, interest at the rate set forth on the *Notice of Decision of Arbitrator* shall accrue from the date listed below to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

Arbitrator Anthony C. Erbacci

July 3, 2013
Date

13 WC 6903
ICArbDec19(b)

JUL 9 - 2013

FACTS:

The petitioner has been employed by the respondent since 1990, initially as a firefighter, then as a lieutenant and, for the past 12 years, as a battalion chief. His duties require him to supervise department personnel at fires and accident scenes.

The petitioner testified that on May 30, 2012, he was washing his department vehicle, an F350 cargo van. While standing on the running board and attempting to wipe the front windshield of the vehicle, the petitioner slipped, fell approximately two feet to the ground, landed on his right foot and felt a "pop" and immediate pain in his right knee.

The petitioner was seen in the emergency room of Northwest Community Hospital at 10:34 a.m. on May 30, 2012. He gave a history of right knee pain after he slipped on a wet running board while washing a van, landing on his feet and feeling a "pop" in his knee. X-rays of the right knee were within normal limits. The petitioner was discharged with a diagnosis of a right knee sprain.

On June 1, 2012, the petitioner was seen by his primary care physician at Lincolnway Medical Associates. The dictated history reflects that the petitioner had injured his right knee at work three days earlier, but the handwritten form completed by the petitioner reflects the date of accident as "5/30/12." Dr. James Niemeyer, the attending physician, prescribed an MRI and referred the petitioner to an orthopedic surgeon.

The petitioner underwent an MRI on June 15, 2012. The radiologist's report reflects that the study revealed a likely Baker's cyst and oblique tear of the medial meniscus with superimposed degenerative fraying.

On June 22, 2012, the petitioner was seen by Dr. William Farrell of Parkview Orthopaedic Group. Dr. Farrell had previously performed surgery on the petitioner's left hip. The petitioner gave a history of having sustained a rotational injury to his right knee after slipping while washing a work vehicle. Dr. Farrell diagnosed a torn medial meniscus and performed arthroscopic surgery on July 6, 2012. The operative report reflects a debridement of Grade 3 chondromalacia of the medial and lateral femoral condyle. Post-operative physical therapy began on July 18, 2012 and continued until November 5, 2012.

When the petitioner returned to Dr. Farrell on August 21, 2012, it was noted that he had persistent swelling and difficulty with terminal flexion of the right knee. On October 2, 2012, Dr. Farrell injected the petitioner's right knee with a steroid. When the petitioner returned to Dr. Farrell on December 4, 2012, he still had swelling of the right knee so another steroid injection was administered. On January 15, 2013, Dr. Farrell found "definite objective swelling in the medial pre-patellar area" of the petitioner's right knee. Due to the persistent symptoms, unrelieved by therapy or steroid injections, Dr. Farrell prescribed a new MRI.

On January 17, 2013, the petitioner underwent another MRI of his right knee. The attending radiologist reported a large, full-thickness, articular cartilage defect at the central

weight bearing portion of the medial femoral condyle as well as at the posterior aspect of the lateral femoral condyle. Other findings were suggestive of early osteoarthritis.

On January 29, 2013, Dr. Farrell recommended repeat arthroscopy and renewed the petitioner's medications, Flexeril and Vicodin.

The petitioner was examined at the request of the respondent by Dr. Lawrence Lieber of M & M Orthopaedics on January 30, 2013. Dr. Lieber opined that the petitioner had pre-existing degenerative chondromalacia of his right knee, and that the work accident had resulted in a minor strain resulting in, at most, a temporary aggravation of that underlying degenerative condition. Based on the operative findings, Dr. Lieber felt that the petitioner should have attained MMI as of October 15, 2012, or approximately three months post-op.

On February 22, 2013, the petitioner returned to Dr. Farrell. He continued to exhibit swelling of the right knee and pain with range of motion. Dr. Farrell noted Dr. Lieber's opinion that the petitioner had attained MMI and that the ongoing symptoms were no longer related to the work accident, but Dr. Farrell indicated that he "respectfully disagree(d)."

The petitioner's most recent visit to Dr. Farrell was on April 9, 2013, at which time the right knee was noted to be unchanged, exhibiting persistent clicking, locking, and feelings of giving way. Dr. Farrell reiterated his recommendation for arthroscopic surgery.

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 petitioner testified that he slipped off a wet running board while washing a company vehicle, landing on his right leg and feeling a "pop" in his right knee. The histories reflected in the records of Northwest Community Hospital, Lincolnway Medical Associates, and Dr. William Farrell, are consistent in all significant respects with the petitioner's testimony. There is no evidence to the contrary.

Based on the foregoing, and the credible testimony of the Petitioner, the Arbitrator concludes that the petitioner sustained an accident which arose out of and in the course of his employment on May 30, 2012.

In Support of the Arbitrator's Decision relating to (F.), Is Petitioner's current condition of ill-being causally related to the injury, and (K.), Is Petitioner entitled to any prospective medical care, the Arbitrator finds and concludes as follows:

The petitioner testified that he had no problems or treatment relating to his right knee prior to his accident of May 30, 2012. This testimony is corroborated by the voluminous records of Lincolnway Medical Associates, the petitioner's primary care physicians, going back as far as 2000. These records reflect treatment for such things as hypertension, chronic sinusitis, urinary tract infections, sleep apnea and other such ailments. Conspicuously missing from these records is any mention of the petitioner's right knee.

The petitioner testified that his persistent right knee symptoms of pain and swelling began with the accident of May 30, 2012 and have persisted without interruption since that time. This testimony is essentially corroborated by the treating records of Dr. Farrell and Newsome Physical Therapy. The petitioner testified that he has not sustained any intervening injuries to the right knee. The only reference to an intervening accident is found in the physical therapy note of August 6, 2012 in which the petitioner reported having fallen onto his right knee while on steps on August 4. The therapist noted that the petitioner's right knee was scraped. It is apparent, however, that the general condition of the petitioner's right knee both before and after this incident is identical. There is certainly no indication that this petitioner's fall on the stairs was sufficiently traumatic as to remove the work accident as a contributing factor in the ongoing treatment.

The basis of the respondent's causation defense appears to be the examining report of Dr. Lawrence Lieber. Dr. Lieber opined that the petitioner's accident at work resulted in a minor sprain which did not serve to aggravate the pre-existing degenerative joint disease, except perhaps temporarily. It is difficult to reconcile Dr. Lieber's opinion with the fact that a) the petitioner had no pre-existing right knee symptoms or medical treatment; b) the petitioner's pain and swelling began with the traumatic accident at work on May 30, 2012; c) the petitioner's pain, limited range of motion and swelling have persisted since that time (and, indeed, were found by Dr. Lieber himself at the time of his examination); and d) there is no other traumatic event which would explain the timing and the persistence of the petitioner's symptoms. Moreover, it is significant that Dr. Farrell, the orthopedic surgeon most familiar with the petitioner's right knee problems, feels that the petitioner's right knee problems are related to the accident at work and in need of further surgery.

Given the persistence of the petitioner's subjective complaints, supported by the objective evidence of an MRI and persistent right knee swelling over an extended period of time; and given the failure of conservative treatment such as physical therapy, steroid injections and prescription medication to ameliorate those complaints; and given the recommendations of Dr. Farrell, the petitioner's treating orthopedic surgeon; the Arbitrator finds that the petitioner's current condition of ill-being relative to his right knee is causally connected to the work accident of May 30, 2012, and that the petitioner is entitled to undergo a repeat arthroscopy of his right knee as prescribed by Dr. Farrell.

In Support of the Arbitrator's Decision relating to (L.), What temporary benefits are due, the Arbitrator finds and concludes as follows:

The petitioner claimed to be entitled to Temporary Total Disability benefits from May 31, 2012 through September 3, 2012, a period of 13 5/7 weeks. The Respondent did not dispute the period of disability but merely its liability for payment of Temporary Total Disability benefits based upon the dispute as to whether a compensable accident occurred. Having found that the petitioner did sustain a compensable accident, the Arbitrator finds that the petitioner is entitled to Temporary Total Disability benefits from May 31, 2012 through September 3, 2012. The petitioner was, however, paid his full salary during the period of his Temporary Total Disability so no specific award of Temporary Total Disability benefits is made herein.

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

Colleen M. Oberlander,
Petitioner,
vs.

University of Chicago,
Respondent.

14IWCC1026

NO: 03 WC 61334

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of medical expenses, temporary total disability, permanent partial disability, penalties and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed 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 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: NOV 25 2014
KWL/vf
O-11/1/14
42

Kevin W. Lamborn

Thomas J. Tyrrell

Michael J. Brennan

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

14IWCC1026

OBERLANDER, COLLEEN M
Employee/Petitioner

Case# 03WC061334

UNIVERSITY OF CHICAGO
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:

1987 RUBIN & CLARK LAW OFFICES LTD
ARNOLD G RUBIN
20 S CLARK ST SUITE 1810
CHICAGO, IL 60603

2461 NYHAN BAMBRICK KINZIE & LOWRY PC
L ELIZABETH COPPOLETTI
20 N CLARK ST SUITE 1000
CHICAGO, IL 60602

STATE OF ILLINOIS)
)SS.
COUNTY OF COOK)

☐ Injured Workers' Benefit Fund (§4(d))
☒ Rate Adjustment Fund (§8(g))
☐ Second Injury Fund (§8(e)18)
☐ None of the above

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION 14IWCC1026

Colleen M. Oberlander
Employee/Petitioner

v.

University of Chicago
Employer/Respondent

Case # **03 WC 61334**

Consolidated cases: **N/A**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Molly Mason**, Arbitrator of the Commission, in the city of **Chicago**, on **June 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 present condition of ill-being causally related to the injury?
G. ☐ What were Petitioner's earnings?
H. ☐ What was Petitioner's age at the time of the accident?
I. ☐ What was Petitioner's marital status at the time of the accident?
J. ☒ Were the 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 9/8/2003, Respondent *was* operating under and subject to the provisions of the Act.

On this date, an employee-employer relationship *did* exist between Petitioner and Respondent.

On this date, Petitioner *did* sustain an accident that arose out of and in the course of employment.

Timely notice of this accident *was* given to Respondent.

Petitioner's current left upper extremity neuropathic pain condition, cervical spine condition, chronic depression and opioid dependency condition of ill-being *are* causally related to the accident.

In the year preceding the injury, Petitioner earned **$51,480.00** ; the average weekly wage was **$990.00**.

On the date of accident, Petitioner was **39** years of age, ***married*** with **1** dependent child.

Petitioner ***has in part*** received related, 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 **$13,105.51** for TTD, **$-0-** for TPD, **$-0-** for maintenance, and **$-0-** for other benefits, for a total credit of **$13,105.51**.

Respondent is entitled to a credit of **$-0-** under Section 8(j) of the Act.

ORDER (Applies only to benefits awarded after March 17, 2005, the date of the 19(b) hearing)

- Respondent shall pay Petitioner temporary total disability benefits in the amount of **$659.99**/week for **191 5/7** weeks, for the periods of **3/18/2005 through 9/18/2006 (78 5/7 weeks)** and **7/14/2010 through 9/11/12 (113 weeks)**, which is the period of temporary total disability for which compensation is due.

- See pages 28-29 of the attached conclusions of law for the Arbitrator's medical award.

- Respondent shall pay Petitioner the sum of **$659.99**/week effective **9/12/12**, and for the duration of Petitioner's life because the injuries sustained resulted in medical permanent total disability as provided in Section 8(f) of the Act. The Arbitrator targets September 12, 2012 as the start date of the 8(f) award because September 11, 2012 is when Dr. Candido, Respondent's Section 12 examiner, testified under oath it is speculative whether Petitioner would derive any benefit from a structured de-escalation of narcotic pain medication. RX 6 at 58.

- Respondent shall pay **$10,000.00** in Section 19(l) penalties. The Arbitrator declines to award Section 19(k) penalties and Section 16 attorney fees, as requested by Petitioner.

RULES REGARDING APPEALS Unless a party files a *Petition for Review* within 30 days after receipt of this decision, and perfects a review in accordance with the Act and Rules, then this decision shall be entered as the decision of the Commission.

STATEMENT OF INTEREST RATE If the Commission reviews this award, interest at the rate set forth on the *Notice of Decision of Arbitrator* shall accrue from the date listed below to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

Molly C Mason
Signature of Arbitrator

8/28/13
Date

AUG 29 2013

14IWCC1026

Colleen Oberlander v. University of Chicago
03 WC 61334

Procedural History

Former Arbitrator, now Commissioner, DeVriendt conducted a Section 19(b) hearing in this case on March 17, 2005. On May 23, 2005, the Arbitrator issued a decision finding that Petitioner, a right-handed union electrician, sustained a compensable work accident on September 8, 2003 and established a causal connection between that accident and a CRPS [Chronic Regional Pain Syndrome] condition of ill-being involving her neck and left upper extremity. In finding in Petitioner's favor on the issue of causation, the Arbitrator elected to rely on Petitioner's treating physicians, Drs. Sonnenberg and Jain, rather than Respondent's Section 12 examiner, Dr. Wiedrich. The Arbitrator also noted that the "chain of events" supported a finding of causation. The Arbitrator found that Petitioner had not yet reached maximum medical improvement. The Arbitrator awarded medical expenses totaling $19,933.58 and two intervals of temporary total disability benefits totaling 76 1/7 weeks. The Arbitrator did not award temporary total disability benefits during a three-week period following December 22, 2004, the date on which Petitioner underwent low back surgery by Dr. Miz. The Arbitrator noted that Petitioner did not claim any relationship between the September 8, 2003 work accident and her low back condition of ill-being. Arb Exh 2.

Neither party filed a review.

Hearing of June 24, 2013 – Nature of Dispute

This case came before the current Arbitrator in an unusual posture, with Petitioner claiming, among other things, permanent total disability benefits from March 29, 2011 forward, along with penalties and fees based on Respondent's failure to pay those benefits, and Respondent claiming that permanency cannot be addressed based on Petitioner's refusal to submit to the opioid medication de-escalation regimen recommended by its pain management Section 12 examiner, Dr. Candido. Respondent maintains that this regimen is "reasonably essential to promote [Petitioner's] recovery" under Section 19(d) of the Act. Petitioner maintains that Section 19(d) has no application to this case and that there is no clear evidence indicating de-escalation would benefit Petitioner. T. 12-13.

Arbitrator's Findings of Fact

Petitioner's Testimony – 6/24/13

Petitioner testified she has not worked in any capacity since the Section 19(b) hearing of March 17, 2005. T. 16. As of her work accident, she was a journeyman electrician and member of Local 130. She held a "B" card, which qualified her to perform certain types of electrical work. T. 17.

Petitioner testified she graduated from Maria High School in 1983. She attended Fox College thereafter and then worked as a secretary for about fifteen years. In 1988, she began working as a journeyman electrician. T. 18. Her injury of September 8, 2003 occurred while she was pulling cable through conduit. T. 18. She has undergone a long course of treatment since that injury. T. 18. Since the hearing of March 17, 2005, she has continued seeing Dr. Jain, a pain medicine specialist. At Dr. Jain's recommendation, she has undergone MRI scans, EMG studies and numerous injections and nerve blocks since March 17, 2005. T. 23-24.

Petitioner testified she currently takes numerous medications at Dr. Jain's direction. She takes Neurontin (3,000 milligrams daily), Gabitril (three 4 milligram tablets each evening), Morphine (80 milligrams twice daily), Valium (80 milligrams once to three times daily), Cymbalta (30 milligrams daily), Naprelan (500 milligrams once to three times daily, as needed) and Oxycodone (325 milligrams, three times daily). Per Dr. Jain, she periodically undergoes blood and urine toxicology testing in connection with her medication intake. T. 26. She underwent physical therapy at the Achieve Orthopedic Institute from June 2005 to June 2010. The therapy consisted of core strengthening, walking while holding weights, using a stationary bicycle, carrying a weighted ball and squeezing balls. T. 27-28. On September 16, 2006, she underwent a functional capacity evaluation. T. 27.

Petitioner testified that the injections, blocks and therapy were intended to address her neck, left shoulder blade and left arm/hand complaints.

Petitioner testified she continued seeing Dr. Miz for her low back after the March 17, 2005 hearing. Dr. Miz performed a fusion at L3-L4 on November 21, 2007. She is not claiming any benefits from Respondent relative to her low back condition. T. 29.

Petitioner testified that, at Dr. Jain's direction, she saw Dr. Rosenow, an anesthesiologist specializing in pain management, in 2008 and 2010. Dr. Rosenow suggested she be evaluated to see if she could benefit from an intra-thecal pain pump. Following a trial of this device in 2008, Dr. Rosenow recommended she not have the device permanently installed. T. 30. In 2010, she underwent a similar evaluation to determine whether she could benefit from a spinal cord stimulator. Ultimately, Dr. Rosenow told her she was not a candidate for this stimulator. T. 30-31. Currently, no physician is recommending implantation of an intra-thecal pain pump or a spinal cord stimulator. T. 31.

Petitioner testified she saw Dr. Sonnenberg in June 2010, at Dr. Jain's referral. Dr. Sonnenberg is one of the physicians who originally diagnosed her condition prior to the 19(b) hearing. T. 31. When she returned to Dr. Sonnenberg in 2010, the doctor essentially recommended she return to Dr. Jain for additional pain management care. T. 32. She returned to Dr. Sonnenberg in 2013 due to a left shoulder problem. She is not currently scheduled to undergo left shoulder surgery. T. 33.

Petitioner testified there are days when her pain is "unbelievable." On some days, she experiences an immediate onset of head pain, emanating from the left side of her neck, and

then vomits. The pain starts in her neck and travels to her left shoulder blade and under her left arm to her left elbow and hand. T. 34. She has difficulty using her left hand to hold an object. She can see that an object is in her left hand but her left thumb "just lets go." T. 33-35. She avoids washing dishes because she drops things. When she "breaks stuff," it "causes a lot of arguments." T. 37. If she attempts to sweep, she has to apply ice to her left arm and shoulder six hours later. T. 34.

Petitioner testified there are many activities she can no longer perform due to her pain. Her life has "changed immensely." The longest she can sleep at any given time is four hours. She has to place pillows under her body and neck in order to try to get comfortable and has to frequently change positions. No position is comfortable for her. If she wakes up after an hour or two, and gets up to walk around, she sometimes finds it impossible to get back to sleep. T. 35. When it rains, she experiences an "unbelievable amount of pain." T. 35.

Petitioner described her specific symptoms as follows:

> "[The pain] starts from the neck down. . . . Nothing can touch my arm, nobody can touch my arm, nothing can touch my arm. It's unbelievable. It's a stabbing pain, sometimes it feels like nails. Right now it feels like someone is trying to pull my arm off. There's a huge amount of pressure on my arm, sometimes it feels like someone is grabbing my neck and is holding on. Very difficult not just for me but for my family as well.
>
> [M]y left hand and my left forearm get swollen like a balloon and then I can't do anything. It swells up so much that I feel like my hand is going to burst in my wrist, my forearm . . . Right now my left side of my hand is red. My hand is on fire right now and right in here [indicating the left elbow] it's all swollen." The left elbow looks like the veins are going to pop out, but it comes from underneath . . . my left armpit. It feels like it goes straight through and up into my neck. That's what it feels like and under my left shoulder blade as well."

T. 37. Petitioner testified her left arm turns "really red" at times and "black and blue" at other times. She indicated "it looks like I have a growth from where my wrist is and the top of my hand, my veins pop out." The outer part of the left wrist is "always swollen." T. 38.

Petitioner testified her condition has worsened since she last testified. T. 39.

Petitioner testified that her reaction to the various injections varies, depending on the type of injection Dr. Jain administers. Sometimes the doctor "knows exactly what to give" her but "there is [sic] other times when he doesn't." Sometimes an injection soothes her pain for a month to four months. T. 39.

Petitioner testified she is able to discern a distinct difference between her longtime left shoulder blade complaints and the left shoulder problem that was recently diagnosed. The two types of pain are "completely different." T. 40.

Petitioner testified she gets very tired and sleepy at times secondary to her medication intake. The extent of her fatigue varies, depending on what is going on around her when she takes the medication.

Petitioner denied having any new accidents since the 19(b) hearing. T. 41.

Petitioner acknowledged being examined by Dr. Candido at Respondent's request. She did not recall Dr. Candido suggesting that she decrease her medication. T. 42. Dr. Jain is not recommending a decrease. Dr. Jain told her she would have "serious problems" if she followed Dr. Candido's recommendation to decrease the medication. T. 42.

Petitioner recalled undergoing two functional capacity evaluations, with the first taking place in 2005 and the second in 2006. T. 43.

Petitioner testified that her husband's group carrier, United Health Care, paid $76,285.57 toward her complex regional pain syndrome treatment. T. 43. Some other bills relating to this treatment remain unpaid. She has been paying for her medication. T. 44.

Under cross-examination, Petitioner testified she has not looked for work since the 19(b) hearing of March 17, 2005. At some point, she began receiving disability benefits from an entity other than Respondent. She could not recall when she started receiving these benefits. T. 46. She saw Dr. Candido twice, in December of 2009 and August of 2011. T. 47. Dr. Miz operated on her lower back in 2005 and November of 2007. T. 47-48. Dr. Sonnenberg has not yet recommended any specific treatment for her left shoulder. She does not yet have an appointment to return to Dr. Sonnenberg. T. 49. Dr. Sonnenberg has indicated she injured her left shoulder but she has no recollection of such an injury. T. 50. She last saw Dr. Jain about three weeks ago. She is scheduled to undergo a ganglion nerve block on July 10, 2013. T. 51. It is her desire to continue seeing Dr. Jain and following his treatment protocol. T. 52.

On redirect, Petitioner testified she discussed the subject of de-escalating her narcotic medication with Dr. Jain. T. 53. Dr. Jain told her she could experience a "severe reaction," even "possibly a heart attack," if she came off her medications. Her heart rate could go up or down. It would be "very overwhelming" for her to try to reduce her medications, even if the de-escalation was gradual: "It couldn't be all at once, that's for sure, but I cannot miss any of the medications that I take because I do get a severe reaction from it." T. 54. Dr. Jain has changed some of her medications over the years but she has been on most of her current medications since 2005. T. 54-55.

Functional Capacity Evaluations

Petitioner underwent a functional capacity evaluation at Achieve Orthopedic Rehab Institute on November 17, 2005. The evaluator, Ashraf Abdelhamid, P.T., M.S., described Petitioner as "cooperat[ing] with all the test items in a pleasant, conversant manner and willing to work to a safe maximum performance." He noted that, during the evaluation, Petitioner complained of her left hand and arm more than her back. He further noted that Petitioner was unable to maintain appropriate body mechanics at all times secondary to increased left hand and forearm pain during the pushing, pulling, lifting and carrying tests. He concluded that, overall, Petitioner's performance did not match the medium physical demand/strength levels for the "electrician" DOT job title. RX 2.

Petitioner underwent a second functional capacity evaluation on September 18, 2006. The evaluator, David McCartney, P.T., indicated that the Dictionary of Occupational Titles places Petitioner's occupation as an electrician in the medium strength category. McCartney found that Petitioner "meets these strength requirements and may return to work as an electrician." Specifically, he found Petitioner capable of a maximum lift of 21 pounds and maximum carrying of 25 pounds. He went on to state, however, that Petitioner would have to avoid pushing/pulling more than 35 pounds in order to successfully return to work as an electrician. PX 19.

Dr. Jain's Deposition Testimony

Dr. Jain's deposition extended over a period of four years. PX 21a-e. At the initial post-19(b) session, on September 24, 2007, the doctor acknowledged having previously been deposed in this case in October of 2004. PX 21a at 5.

Dr. Jain testified he specializes in anesthesia and pain management. He has continued to treat Petitioner since the 19(b) hearing of March 17, 2005. PX 21a at 8. He saw Petitioner about twenty times between that date and September 4, 2007. PX 21a at 8-9. During this period, he administered a number of blocks and injections. All of these procedures related to Petitioner's cervical spine or left upper extremity condition. PX 21a at 10-11. He also performed a rhizotomy on June 12, 2006. The purpose of this procedure was to provide "long term relief" of Petitioner's neck pain. PX 21a at 11-12. Petitioner experienced "some improvement in pain and function" secondary to the blocks, injections and rhizotomy. PX 21a at 12. Petitioner experienced less spontaneous burning and was better able to use her left arm. PX 21a at 12.

Dr. Jain testified that, as of September 24, 2007, Petitioner was taking Duragesic, Remeron (an antidepressant), Skelaxin, Gabitril and Neurontin. PX 21a at 13.

Dr. Jain testified he prescribed a functional capacity evaluation on November 1, 2005. Following this evaluation, he found Petitioner capable of sedentary, light duty work with no lifting over 25 pounds. At that time, he viewed Petitioner as incapable of resuming her former

trade as an electrician. PX 21a at 16. Petitioner would not be able to performed sustained or repetitive work and would not be able to work overhead. PX 21a at 16-17.

Dr. Jain testified he prescribed a second functional capacity evaluation because the first was performed before Petitioner reached maximum medical improvement. He also wanted to see whether there was any improvement. PX 21a at 18. The second functional capacity evaluation was valid. It showed that Petitioner could resume working in the medium strength category, which was consistent with her electrician occupation. After the second evaluation, he prescribed a cervical MRI, a cervical epidural injection and work conditioning. He believes the work conditioning was not approved. PX 21a at 21-22. In March of 2007, he issued a letter releasing Petitioner to full-time light duty work with no lifting over 10 pounds and no prolonged overhead activity. These restrictions stemmed from the work accident of 2003. They were based solely on the left upper extremity condition. PX 21a at 22-24. The restrictions were permanent. PX 21a at 23. The restrictions are based in part on Petitioner's recurrent pain and the "very tenuous balance" between that pain and her medications. PX 21a at 24.

Dr. Jain testified he viewed the second functional capacity evaluation as "overly aggressive" based on his examination findings. He did not agree with the evaluator's conclusion that Petitioner could push and pull up to 35 pounds. PX 21a at 25-26. He did not want to get into a situation in which Petitioner returned to work and immediately experienced a recurrence. PX 21a at 26. Based on the description of an electrician's duties set forth in the 19(b) decision, Petitioner would not be capable of resuming work as an electrician. PX 21a at 31.

Dr. Jain testified that Petitioner "probably" reached maximum medical improvement around the time of the second functional capacity evaluation. Petitioner continued to require care after that evaluation but the care was primarily to treat acute flare-ups from Petitioner's baseline pain. PX 21a at 33.

Dr. Jain opined that Petitioner's prognosis is fair, meaning that she will continue to need medical interventional, behavioral and rehabilitative care. PX 21a at 34. Petitioner's current condition, complex regional pain syndrome, involves her neck as well as her left upper extremity. PX 21a at 34. That condition is causally related to the September 18, 2003 work accident. PX 21a at 36.

Dr. Jain testified he reviewed reports prepared by an examiner, Dr. Lazar. He disagreed with Dr. Lazar's causation-related opinions and comments concerning complex regional pain syndrome. It did not appear that Dr. Lazar performed an extensive examination. PX 21a at 38.

Dr. Jain testified that Petitioner was temporarily totally disabled during the interval between the two functional capacity evaluations. PX 21a at 40. That disability stemmed only from Petitioner's neck and left upper extremity conditions of ill-being. PX 21a at 40.

Dr. Jain testified he referred Petitioner to Dr. Brown, a psychologist, for "behavioral, non-invasive management of her pain condition." PX 21a at 41-42. He made this referral based on Petitioner's diagnosis but also because he takes a multi-disciplinary approach with any patient whose pain-related care extends beyond three to six months. PX 21a at 42. He is recommending that Petitioner continue to see Dr. Brown in order to address the "catastrophic nature of her pain" in terms of how that pain has affected her work, her relationships with others, her sleep and her mental state. PX 21a at 43-44.

Dr. Jain testified he is also treating Petitioner for low back and sciatic pain. PX 21a at 46.

Dr. Jain testified that his office used the medical fee schedule to generate charges after February 1, 2006. Some of Petitioner's bills have been paid. Respondent did not make any payments after August of 2005. Someone in his office would have to go through his bill in order to determine which charges relate to complex regional pain syndrome and which relate to lumbar spine care. PX 21a at 50.

At the next session, on April 28, 2008, Dr. Jain testified that Petitioner reported 50% relief after the rhizotomy but "continued to have left-sided neck discomfort with palpation." PX 21b at 65. Because of the chronic nature of Petitioner's pain, Petitioner may require additional rhizotomies in the future. PX 21b at 66.

Under cross-examination, Dr. Jain testified that Petitioner's neck problems are due to her complex regional pain syndrome. Petitioner "probably would not have the neck problems independently of developing the injury to her hand and arm." PX 21b at 71. In late 2005, both he and Dr. Miz treated Petitioner for her lumbar spine condition. His notes indicate he prescribed the first functional capacity evaluation for Petitioner's lumbar spine. PX 21b at 78, 84. As of the second functional capacity evaluation, there was some possibility of Petitioner returning to work as an electrician. PX 21b at 87. He is not aware whether Petitioner ever completed the work hardening he prescribed. PX 21b at 88. The work hardening was intended to address both the lower and upper extremity conditions. PX 21b at 90. As of the second evaluation, he felt Petitioner was possibly able to lift up to 21 pounds and carry up to 25 pounds but he had concerns about the evaluator's push/pull findings. PX 21b at 104. Even though it is "possible" for Petitioner to lift and carry the weight stated, such activity could increase the risk of recurrence. PX 21b at 105. Petitioner has lumbar radicular symptoms. Such symptoms are due to the autonomic nervous system. Petitioner also has cervical radicular symptoms. Petitioner has degenerative disc disease but it is very difficult to distinguish that condition from complex regional pain syndrome. Individuals who have cervical radiculopathy can develop sympathetically mediated, or CRPS type, symptoms. PX 21b at 111. He prescribed a cervical spine MRI in 2006 because of Petitioner's "persistent neck and upper extremity pain." PX 21b at 113. Epidural injections can be used to treat complex regional pain syndrome even though that syndrome affects the sympathetic nerve system. PX 21b at 114. Notes authored by Dr. Dave, his associate, reflect that Petitioner was continuing to smoke. "Nicotine can aggravate symptoms of chronic regional pain syndrome." PX 21b at 118. Petitioner was "relatively compliant" with Dr. Brown's recommendations. On March 28, 2007, Dr. Dave noted

he was "mandatorily" referring Petitioner to Dr. Brown for a non-invasive cognitive behavioral evaluation." Dr. Dave noted that Petitioner had been "non-compliant" with this referral to date. Dr. Jain testified that Dr. Dave may have been referring to the kind of cognitive evaluation that is done on patients who are taking narcotic pain medication. PX 21b at 121. Dr. Jain testified that Petitioner recently underwent lumbar spine surgery by Dr. Miz. He is continuing to treat the lumbar spine condition. PX 21b at 122.

On redirect, Dr. Jain testified he is unable to say whether the work conditioning was approved or not. PX 21b at 127. He never released Petitioner to full duty as an electrician. PX 21b at 128. He continues to believe Petitioner reached maximum medical improvement on September 18, 2006. PX 21b at 128. The permanent restrictions he imposed are independent of the 19(b) decision insofar as that decision contains a description of an electrician's duties. He is unable to state that Petitioner could perform duties involving lifting of 21 or 25 pounds. PX 21b at 129. In the past, he has treated Petitioner's accident-related condition as well as her lumbar spine condition at every visit. Going forward in time, he has created two charts so as to be able to address these conditions separately. PX 21b at 132. Dr. Jain reiterated that the neck-related care he has provided in this case stems from the work accident and from the complex regional pain syndrome diagnosis. Petitioner had no neck or upper extremity symptoms prior to the work accident. PX 21b at 133. The symptoms of complex regional pain syndrome could have aggravated a previously asymptomatic cervical spine condition. PX 21b at 133. Overall, Petitioner has been compliant with his recommendation that she treat with Dr. Brown. PX 21b at 134. It would be speculative to say that Petitioner's smoking has affected her recovery from complex regional pain syndrome. PX 21b at 135. He continues to agree with the work restrictions he previously imposed. Those restrictions relate only to the pain condition involving the neck and left upper extremity. PX 21b at 135.

On further redirect, conducted on September 9, 2008, Dr. Jain testified the first functional capacity evaluation reflected that Petitioner complained of pain in her upper cervical area, radiating into her left forearm. PX 21b at 146. The functional capacity evaluation was intended to address the lumbar spine but the disability was to the neck and upper extremity. PX 21c at 146. The functional capacity evaluation did not change his opinion that Petitioner's neck and upper extremity condition prevented her from working. PX 21c at 147. The various cervical, brachial plexus and stellate ganglion blocks he performed were intended to address the neck and upper extremity. PX 21c at 147.

Under re-cross, Dr. Jain looked back at testimony he gave in 2004 and agreed with his previous statement that CRPS is to be treated with a series of selective sympathetic blocks and medication, followed by therapy if improvement is noted. PX 21c at 150-151. When he first saw Petitioner, in 2004, he did not believe she had cervical radiculopathy. Petitioner was not diagnosed with cervical radiculopathy until September of 2005. The epidural steroid injections he administered were for both the cervical and lumbar spine. PX 21c at 153. Cervical degenerative disc disease is disc pathology. Such pathology is not caused by CRPS. PX 21c at 156. On November 29, 2005, Dr. Dave noted that Petitioner had still not seen Dr. Miz per Dr. Jain's recommendations. PX 21c at 157. Dr. Miz did see Petitioner in December of 2005. Dr.

Miz released Petitioner from his care on December 13, 2005, following the first functional capacity evaluation. PX 21c at 159. Dr. Jain testified he deferred to Dr. Miz when it came to Petitioner's lower back condition. PX 21c at 160.

On further redirect, Dr. Jain reiterated that complex regional pain syndrome could have aggravated Petitioner's cervical degenerative disc disease. PX 21c at 162. He did not release Petitioner to work on December 13, 2005. He again opined that Petitioner was temporarily totally disabled as a result of her complex regional pain syndrome from March 17, 2005 through September 18, 2006. PX 21c at 164.

At this point, the parties essentially agreed to begin Dr. Jain's deposition anew, based on the production of several recent medical records. PX 21c at 166. Respondent preserved its right to have Petitioner re-examined. PX 21c at 167.

Dr. Jain testified that Petitioner shaded in pain diagrams when she saw him on various dates in May, July and August of 2008. On those diagrams, Petitioner indicated she is experiencing pain in the left suboccipital, the left neck, shoulder and hand, the left lower back and buttock and the left calf. PX 21c at 169. The low back and leg pain is unrelated to Petitioner's complex regional pain syndrome. PX 21c at 169. He treated Petitioner for the CRPS as well as the lumbar condition in 2008. PX 21c at 170. He has performed injections since May 21, 2008, but not for the CRPS. PX 21c at 170. He has not divided up his charges so as to show which charges relate to the CRPS. PX 21c at 170-171. He has referred Petitioner to Dr. Rosenow, a neurosurgeon at Northwestern Memorial Hospital, for a second opinion. PX 21c at 171. He wants to solicit Dr. Rosenow's opinion concerning possible advanced modalities, such as neurostimulation or an intrathecal pump, that might relieve Petitioner's pain. PX 21c at 172-173. These modalities are primarily intended to address the CRPS but the referral was "in the context of [Petitioner] having recalcitrant low back and left lower extremity pain." PX 21c at 173. Dr. Jain identified Dep Exh 19 as a report performed by Dr. Brown, a psychologist, clearing Petitioner for implantation of an intrathecal pump. PX 21c at 174. [In Dep Exh 19, Dr. Brown indicated his evaluation revealed a "medium-high level of psychosocial risk for reduced outcome" based on Petitioner's pain behavior, depressed mood, high level of stressors, etc. Dr. Brown recommended a trial despite these factors, indicating that "any effort to move [Petitioner] away from oral pain medications is preferable."] Dr. Jain testified he views the pump as a "better option" for Petitioner. He does not know if Petitioner would be able to tolerate a stimulator. He would recommend that Petitioner proceed with a trial implantation if she receives clearance from the psychologist that Dr. Rosenow intends to use. PX 21c at 176. Given Petitioner's "extended history," he and Dr. Rosenow discussed performing a "very advanced trial," meaning that they would introduce different medications that have different durations. PX 21c at 176. The trial has to be done on an inpatient basis. PX 21c at 177. The hospital charges associated with the trial would run about $10,000 to $20,000. A permanent pump would be more expensive. PX 21c at 177-178. Dr. Rosenow would implant the permanent pump. PX 21c at 178. The pump would allow Petitioner to reduce her oral medications and thus reduce the side effects of those medications. PX 21c at 179.

Under cross-examination, Dr. Jain testified that he would recommend ongoing medication management and possibly injections in the event that the psychologist selected by Dr. Rosenow does not clear Petitioner for the pump. PX 21c at 182.

On July 20, 2010, the parties reconvened to "start a new evidence deposition" of Dr. Jain. Dr. Jain testified he has continued to treat Petitioner since he last testified in September of 2008. PX 21d at 7. Between January 14, 2009 and July 14, 2010, he saw Petitioner on a number of occasions for treatment of lumbosacral radiculopathy, lumbar post-laminectomy syndrome, complex regional pain syndrome of the left upper extremity, opioid dependence, fibromyalgia and depression. PX 21d at 8. Of these conditions, he would relate the complex regional pain syndrome, opioid dependence and depression to the work accident. It would be "hard to say one way or the other" whether the fibromyalgia stems from the work accident. PX 21d at 10. Fibromyalgia is a "diffuse, non-anatomical pain that could be related to an auto-immune phenomenon and is usually compounded by depression or behavioral changes." PX 21d at 10.

Dr. Jain testified he administered a number of blocks and injections to Petitioner between January 14, 2009 and July 14, 2010. None of these blocks and injections related to the complex regional pain syndrome. PX 21d at 11. The treatment he provided for that syndrome consisted of medication management. PX 21d at 12. Petitioner currently takes Percocet, Gabitril, Cymbalta, Neurontin, Valium and Embeda for the complex regional pain syndrome. Embeda is sustained-release morphine. He started Petitioner on Embeda after taking Petitioner off of Duragesic patches. Petitioner was reacting to the adhesive in the patches and the patches were not providing relief for the necessary duration. PX 21d at 12. The Embeda lasts for 12 hours. PX 21d at 12.

Dr. Jain testified that the rhizotomy he performed in April of 2009 related to the lumbar spine, not the left upper extremity. PX 21d at 12-13.

Dr. Jain testified that Petitioner did not have a permanent intrathecal pump implanted because the trial showed that she was not deriving benefit. The trial took place at Northwestern Memorial Hospital. Petitioner's reporting of relief was inconsistent with the drugs she was given. It was not that Petitioner was reporting inappropriately. Rather, it was that the drug was not effective in modulating the pain. Therefore, the trial was categorized as a failure. PX 21d at 14. In his opinion, Petitioner is not a candidate for an intrathecal pump. PX 21d at 14. Once the trial proved to have failed, he recommended a spinal cord stimulator. PX 21d at 14.

Dr. Jain testified that Petitioner is "dependent on opioids," meaning that there were be repercussions if the opioids were suddenly stopped. PX 21d at 15.

Dr. Jain testified he reviewed Dr. Candido's report. He agrees with Dr. Candido that Petitioner suffers from chronic neuropathic pain of the left upper extremity. PX 21d at 16. "Neuropathic pain" is an umbrella-type term. PX 21d at 15-16. Dr. Jain disagrees with Dr.

Candido's opinion that Petitioner had complex regional pain syndrome but, as of December 22, 2009, no longer has manifestations of this condition. Dr. Jain opined that symptoms of complex regional pain syndrome can change from time to time. PX 21d at 18.

Dr. Jain testified that Petitioner "may" currently be a candidate for a cervical spinal cord stimulator. Such a stimulator is an "accepted modality" for complex regional pain syndrome. It may afford relief of pain in the areas Petitioner describes, i.e., the left upper extremity, neck and suboccipital area. PX 21d at 18. In Petitioner's case, the neck and suboccipital area are all part of the complex regional pain syndrome. PX 21d at 18-19. Petitioner previously cleared the behavioral evaluation required for an intrathecal pump. The evaluation would be the same for a spinal cord stimulator. PX 21d at 19. He would recommend that Petitioner undergo a repeat evaluation by Dr. Brown specific to a spinal cord stimulator. If she "passes" that evaluation and is adequately educated about the purpose of the stimulator, he would proceed with a percutaneous trial. If the trial proved to be successful, he would refer Petitioner back to Dr. Rosenow for implantation of a permanent paddle and generator. PX 21d at 21. As of July 14, 2010, Petitioner was "more debilitated" and was experiencing "bouts of moderate to severe pain that really hasn't been well-controlled by the medication." PX 21d at 21. He is prescribing the stimulator trial for the neck, left upper extremity and suboccipital area, not the lumbar spine condition. PX 21d at 21-22.

Dr. Jain opined that Petitioner does not have secondary gain issues. Petitioner "seems to have physical findings that are consistent with her subjective complaints." PX 21d at 22. He is currently recommending a ganglion block. This would be for the cervical, not the lumbar, spine. PX 21d at 22.

Dr. Jain opined that the CRPS-related treatment he has provided to Petitioner from January 2009 to the present has been reasonable and necessary. PX 21d at 23.

Dr. Jain testified that, as of his last visit with Petitioner on July 14, 2010, Petitioner was not capable of working in any capacity. PX 21d at 24. He is now of the opinion that Petitioner needs care and is not at maximum medical improvement. PX 21d at 25.

Under cross-examination, Dr. Jain testified that he discussed Petitioner with Dr. Rosenow but did not create any notes concerning that conversation. PX 21d at 30. He acknowledged previously testifying that he was unsure whether Petitioner would be able to tolerate a stimulator. His opinion on that point has changed. PX 21d at 30. Petitioner's pain syndrome remains unchanged and her neck pain may in fact have worsened. PX 21d at 31.

Dr. Jain acknowledged that, as of August 26, 2008, Dr. Rosenow was not convinced that a stimulator would effectively treat Petitioner's pain. Dr. Jain indicated he would not undertake a stimulator trial until after Petitioner had seen Dr. Rosenow again. PX 21d at 34.

Dr. Jain acknowledged that Dr. Brown recommended Petitioner see a psychiatrist. Dr. Jain testified he has not received any records from a psychiatrist and does not know whether

Petitioner actually followed Dr. Brown's recommendation. PX 21d at 35. Dr. Brown recommended a psychiatric evaluation because Petitioner was exhibiting a high level of distress and her thinking had become "skewed." PX 21d at 35. Petitioner is currently taking Cymbalta, which is "both for pain and depression." PX 21d at 36. Petitioner's current medicines do not include any MAOI inhibitors. PX 21d at 37.

Dr. Jain testified that, on May 19, 2010, his assistant noted that Petitioner was exhibiting "significant cognitive distortion" and was reporting the presence of several demons in her house. PX 21d at 37. If Petitioner has a psychiatric illness that is not being treated, that would "absolutely" preclude her from undergoing a stimulator trial. PX 21d at 37-38, 40.

Dr. Jain testified he last saw Petitioner a week before the deposition. At that time, Petitioner did not seem cognitively impaired. She "seemed to have a pretty good handle on reality." PX 21d at 39. It is "very hard to functionally assess [Petitioner] at every visit." Petitioner had gotten more frustrated, possibly more depressed and less functional over time. PX 21d at 39-40.

Dr. Jain testified he does not necessarily have an opinion as to whether Petitioner's ganglion cyst is related to her complex regional pain syndrome. Dr. Sonnenberg would have to address this. PX 21d at 44.

The deposition that began on July 20, 2010 was concluded on March 29, 2011. On March 29, 2011, Dr. Jain testified he has been providing medication management to Petitioner since July 20, 2010. He has also administered stellate ganglion blocks and thoracic paravertebral blocks. PX 21e at 53.

Dr. Jain testified that Dr. Rosenow determined a spinal cord stimulator would not be beneficial to Petitioner. PX 21e at 54-55. Dr. Jain testified that, while he continues to believe in the percutaneous trial phase, he has opted to agree with Dr. Rosenow. PX 21e at 55.

Dr. Jain testified he performs urine drug screenings to ensure his patients are taking their prescribed medications and are not taking illicit medications. PX 21e at 55. Petitioner's screening of January 17, 2011 was "consistent with the medications that she was on." PX 21e at 56.

Dr. Jain testified he causally links the following conditions to the work accident: CRPS of the left upper extremity, neuropathic pain of the left upper extremity and opioid dependence. With respect to these conditions, Petitioner cannot work. Petitioner is "permanently and fully disabled." PX 21e at 58. Petitioner has reached maximum medical improvement. PX 21e at 58. Petitioner will require fairly complex ongoing care to maintain her current condition. PX 21e at 58. Specifically, Petitioner will require medication management, ongoing injection therapy, behavioral and psychiatric management and intermittent physical therapy. PX 21e at 59.

Under cross-examination, Dr. Jain testified he now agrees with Dr. Candido that a spinal cord stimulator is not needed. PX 21e at 61. He now agrees with the diagnosis of "neuropathic" pain. Dr. Sonnenberg used this term. Such pain is an "umbrella" term under which CRPS would fall. PX 21e at 62. According to his notes, Petitioner last saw Dr. Brown in December of 2010. Petitioner is "probably due for a follow-up with him." PX 21e at 62. Petitioner's primary care physician started her on Lexapro in December of 2010, a fact Dr. Brown noted the same month. Dr. Brown did not recommend a psychiatric consultation in December 2010. PX 21e at 66. Dr. Jain indicated he has no records showing that Petitioner ever saw a psychiatrist. PX 21e at 66. In January, Petitioner reported having lost her prescriptions. That would have been an automatic opioid violation but for the fact that Petitioner reported finding the prescriptions two days later. PX 21e at 67. In his practice, if a patient reports losing prescriptions twice, the patient is discharged from the program. PX 21e at 69. On August 8, 2010, Petitioner rated her pain at 8/10. Petitioner had an injection on October 4, 2010. On December 8, 2010, Petitioner rated her pain at 7-8/10. On January 12, 2011, Petitioner rated her pain at 8/10. Petitioner underwent a block on February 8, 2011 and again rated her pain at 8/10 on February 16, 2011. Petitioner underwent another block on February 28, 2011 and again rated her pain at 8/10 on March 9, 2011. Dr. Jain testified that pain scores are "fairly subjective." On February 8, 2011, Petitioner rated her pain at 2/10 after the block. The third day, Petitioner was 80% better and a week later she was 40% better. Petitioner is "not asking for a block every week but she goes into cycles where the pain increases and that's when she seeks out the blocks." PX 21e at 74. Petitioner has been in pain so long that "she lives in the 7s and 8s," in terms of the pain scale. PX 21e at 74. The blocks provide temporary relief lasting a couple of weeks. PX 21e at 75. None of Petitioner's previous electrician tasks are realistic for her given the amount of pain she is in and the medications she is on. The medications that Petitioner takes can "cause a significant [cognitive] impairment if she's trying to operate any machinery or do anything that requires higher cognitive function." Petitioner's pain has "become more recalcitrant" and less responsive to medication and injections. There is no long-term curative modality now. PX 21e at 80. Petitioner is "out of options." PX 21e at 80.

On redirect, Dr. Jain testified he views the injections as reasonable and necessary medical care for Petitioner. PX 21e at 83. There is no set "maximum" number of injections for a patient like Petitioner. If he had to speculate, he would estimate Petitioner will need four to five injections per year. PX 21e at 84.

Dr. Coe's Examination Findings and Deposition Testimony

Dr. Coe examined Petitioner and gave an evidence deposition on Petitioner's behalf. The deposition began on September 19, 2011 (PX 23a) and concluded on April 23, 2012 (PX 23b).

Dr. Coe obtained board certification in occupational medicine in 1991. PX 23a at 6. He is not board certified in pain management. PX 23a at 17. He divides his time between teaching

occupational medicine courses at the University of Illinois and operating a private practice called Occupational Medicine Associates of Chicago. PX 23a at 17-18.

Dr. Coe testified he refers patients to several different pain management specialists, including Dr. Jain. He is familiar with Dr. Candido only because he has reviewed the reports Dr. Candido generated in this case. PX 23a at 17.

Dr. Coe testified he examined Petitioner twice. In connection with those examinations, he generated reports dated August 25, 2009 and May 24, 2011 and a letter dated September 14, 2011. PX 23a at 20-21. He reviewed a large volume of records concerning Petitioner. PX 23a at 23. He also reviewed at least two depositions given by Dr. Jain. PX 23a at 32.

Dr. Coe testified that Dr. Jain performed multiple blocks and injections in the course of treating Petitioner. Dr. Coe described Petitioner as experiencing "limited" and "generally temporary" responses to these blocks. PX 23a at 33, 39.

Dr. Coe testified that Dr. Jain also treated Petitioner via "relatively high levels of pain control medications" such as Neurontin, also known as Gabapentin, Lyrica and Cymbalta. PX 23a at 29-30.

Dr. Coe testified that Petitioner's current regimen consists of ongoing, essentially permanent pain management via medication prescribed by Dr. Jain. PX 23a at 34. For the most part, that medication consists of "relatively high-dose, long-acting" narcotic analgesics. Petitioner is also undergoing treatment for depression and anxiety, with a psychiatrist prescribing medication for those conditions. PX 23a at 34-35.

Dr. Coe testified that Petitioner denied having any problems with her left arm, shoulder, hand, neck or head before the work accident of September 8, 2003. That denial is consistent with the records he reviewed. PX 23a at 36. As of his examinations, Petitioner complained of ongoing pain in her left arm going up to her shoulder and neck and down into her left hand. Petitioner indicated this pain increased with use of the left upper extremity. PX 23a at 37. Dr. Coe described Petitioner as having allodynia, hyperalgesia and dyesthesias, all of which are elements of chronic, nerve-related pain. PX 23a at 38-39. Petitioner also complained of tremors in her left hand. Dr. Coe testified he observed these tremors in 2011. The tremors were mild. Such tremors can be due to muscle weakness or nerve irritation. They can also be a side effect of the multiple medications Petitioner takes. PX 23a at 40.

Dr. Coe testified he identified a number of trigger points when he examined Petitioner. Trigger points "are not a fully subjective phenomenon" because they are "localized and specific." PX 23a at 44.

Dr. Coe testified he found "symmetrical warmth, coloration and hair distribution" when he examined Petitioner's left arm on August 25, 2009. He noted neck stiffness but a negative

Spurling's sign. The fact that some examination findings were negative indicates Petitioner was cooperating. He found no evidence of symptom magnification. PX 23a at 47-48.

Dr. Coe testified his examination findings in 2009 and 2011 were very similar. The only difference he noted in 2011 was an area of tenderness over Petitioner's left clavicle. PX 23a at 53.

Dr. Coe opined that Petitioner has a chronic pain syndrome which includes some elements of reflex sympathetic dystrophy, nondystrophic neuropathic pain and myofascial pain. The syndrome affects Petitioner's neck, left shoulder and left arm. PX 23a at 54-55, 62. The myofascial pain, which comes from soft tissues, muscles, tendons and ligaments is "likely a secondary pain syndrome" stemming from disuse of the left upper extremity. PX 23a at 59.

Dr. Coe testified that Dr. Candido's conclusions concerning the nature of Petitioner's pain are no different than his. Dr. Candido espouses the theory that Petitioner's spinal cord and brain have changed over the years due to her many years of chronic pain. PX 23a at 66.

Dr. Coe opined that there is a causal relationship between Petitioner's work accident and her current chronic pain condition involving her neck, upper chest and left arm. He further opined that this condition is permanent. PX 23a at 69. He has no causation-related opinions concerning Petitioner's lower back and leg conditions. PX 23a at 71. He found Dr. Jain's past and ongoing treatment to be reasonable and necessary. PX 23a at 70. When he examined Petitioner in 2009, he recommended (with respect to Petitioner's neck and left arm condition) that Petitioner try to work with occasional lifting of 5 pounds or less, limited forceful pushing/pulling/gripping with the left arm and no repetitive bending/twisting of the neck. PX 23a at 72. Such restrictions would clearly preclude Petitioner from resuming her former trade. PX 23a at 73. When he re-examined Petitioner in 2011, he found her to have reached maximum medical improvement. By that, he does not imply that Petitioner no longer needs care. He recommends that Petitioner continue seeing Dr. Jain and the "pain psychologist." He also recommends that Petitioner continue with her various medications. PX 23a at 75-76.

Dr. Coe testified he disagrees with Dr. Candido's August 9, 2011 opinion that Petitioner has not yet reached maximum medical improvement. He was surprised to see Dr. Candido say this. PX 23a at 79. In his earlier report, Dr. Candido had characterized Petitioner's pain as permanent. PX 23a at 80-81.

Dr. Coe testified he is familiar with the kind of opioid detoxification Dr. Candido discussed. There are programs to help patients wean themselves off of opioids. The process of weaning is "slow and difficult because there will be withdrawal." Withdrawal "can be blocked by a number of medications but it's still an extremely unpleasant process, no matter what you do." Dr. Candido is not suggesting that Petitioner abruptly stop her medications. Rather, he is suggesting de-escalation. Dr. Coe testified that, in Petitioner's case, such de-escalation would be an "experiment" that could cause Petitioner to become "much, much worse." Petitioner's pain could become intolerable. Petitioner already characterizes her pain as "intolerable" and is

"fairly dramatic" about this but de-escalation could create "truly intolerable" symptoms. PX 23a at 85. Dr. Coe opined that de-escalation is "not a reasonable treatment course" for Petitioner. PX 23a at 85.

At his continued deposition, on April 23, 2012, Dr. Coe testified he had reviewed some additional documents, including Dr. Jain's report of November 1, 2011, since September 19, 2011. PX 23b at 92. The additional materials he reviewed did not prompt him to change any of the opinions he expressed on September 19, 2011. PX 23b at 93-94. He continues to believe that Petitioner is "permanently and totally disabled, from a medical perspective, for gainful employment." PX 23b at 94. The treatment Petitioner underwent between September 19, 2011 and April 19, 2012 was reasonable and necessary. Dr. Jain's November 1, 2011 report confirms his opinion that ongoing pain management is necessary and that Petitioner's medications should not be discontinued on any kind of trial basis. PX 23b at 96.

Under cross-examination, Dr. Coe testified he is not board certified in either pain management or anesthesiology. PX 23b at 98. About 10% of his current practice involves direct medical treatment. PX 23b at 98. He undertakes "some types of pain management" in the course of that treatment. PX 23b at 98-99. For example, he prescribes and monitors pain medication. PX 23b at 99. If, however, one of his patients requires interventional pain management, he refers that patient to a pain management specialist such as Dr. Jain. PX 23b at 99. He would not undertake to treat Petitioner, based on Petitioner's presentation at the time of his examinations. PX 23b at 99. He does not know Dr. Candido. He has never seen the term "structured de-escalation" used. What Dr. Candido is proposing is actually withdrawal from medication. PX 23b at 100-101. He has witnessed such withdrawal in patients who are recovering from a specific procedure but he has not witnessed it in someone like Petitioner. PX 23b at 101. Narcotic analgesic medication "has a number of potential side effects." These side effects "generally lessen the longer a person takes the medication." PX 23b at 108. The principal side effects are sleepiness, lightheadedness, difficulty with balance and gait and difficulty with perception of distances. PX 23b at 108. The left arm tremor that Petitioner complains of could arise from chronic pain. It could also be a side effect of the medication that Petitioner takes. PX 23b at 109. Petitioner takes this medication "for a serious problem of pain." The prescription of this medication is "reasonable and appropriate." PX 23b at 110. When Petitioner saw Dr. Jain on February 16, 2012, she rated her pain at 9/10. He has seen references to urine drug testing in Dr. Jain's records but he has not seen the results of such testing. PX 23b at 112-113. He agrees with Dr. Candido that it is possible Petitioner has opioid-induced hyperalgesia. PX 23b at 113-115. He also agrees with Dr. Candido that the only way to really know whether Petitioner has this condition is to eliminate her narcotic medication. PX 23b at 116. Based on Petitioner's pain rating, her pain could only increase one point to 10/10 but, for someone like Petitioner, that slight increase could be the difference between tolerable and intolerable pain. PX 23b at 117. De-escalation of Petitioner's medication would not constitute a deviation from the standard of care but would be "something of an experiment on [a] living human being." He questions why this should be done. PX 23b at 118, 120. De-escalation would create a risk of physical changes such as convulsions. PX 23B at 119. Petitioner has a chronic pain problem. It is not as if her entire condition is opioid-induced

hyperalgesia. PX 23b at 121. Petitioner is "currently in known territory," in terms of side effects and risks. De-escalation of her medication would put her in "unknown territory." PX 23b at 122. In his report of September 19, 2011, Dr. Jain indicated that a brain MRI showed a change in the area of Petitioner's left cerebellum. This change was consistent with "some type of scar." Such scarring is "often seen either with some kind of vascular change in the brain" or with a small area of stroke. In Petitioner's case, this would have occurred in the past. There is no evidence of any recent infarct. PX 23b at 124-125. The finding is incidental. It does not require follow-up. PX 23b at 125.

On redirect, Dr. Coe testified that, in his note of September 19, 2011, Dr. Jain indicated Petitioner reported improvement of her headaches and vomiting following occipital nerve blocks. PX 23b at 127. Dr. Coe found this reporting significant because it means that Petitioner 'Is able to experience improvement," albeit temporary. PX 23b at 127. Opiod-induced hyperalgesia could explain why Petitioner complains of 9/10 pain despite ongoing care. Dr. Coe indicated he does not use a pain scale with his patients because he finds such scales to be "completely inaccurate." Many of his patients report 9/10 pain. Anyone who has 10/10 pain could not be sitting in a chair. Such pain would be completely intolerable. PX 23b at 130. It is "very difficult to say" whether Petitioner's reporting results from her pain alone or also from her frustration with her pain. PX 23b at 130. He cannot say, based on a reasonable degree of certainty, that Petitioner currently suffers from opioid-induced hyperalgesia. PX 23b at 131, 134. He agrees with Dr. Candido that the only way to determine whether Petitioner suffers from this condition is to totally stop her opioid use. In his opinion, the risks of opioid withdrawal outweigh the potential benefits. PX 23b at 132. Dr. Jain talks about the withdrawal as "potentially catastrophic."

Dr. Coe testified he would not describe the various nerve blocks administered by Dr. Jain as an "abysmal failure." The blocks have "repeatedly led to some improvement." The problem is that the "improvement is only temporary." PX 23b at 135-136. A pain scale is "highly personal" because it refers not only to pain but how a person feels about pain. PX 23b at 136. It is very difficult to make a patient understand what an "8" or a "9" or a "10" on such a scale really represents. PX 23b at 137.

Under re-cross, Dr. Coe acknowledged that opioid cessation could possibly improve Petitioner's condition. Improvement is unlikely but possible. PX 23b at 138-139. Some of Petitioner's current symptoms are not unlike those associated with narcotic withdrawal. In Petitioner's case, opioid cessation would have to be accomplished in an inpatient setting. PX 23b at 141. He would leave it to a pain management specialist to quantify Petitioner's opioid intake. He has seen much higher doses than Petitioner's but Petitioner is taking a "fair amount" of narcotic analgesic medication to allow her to tolerate her symptoms. PX 23b at 142. If he had a patient who he suspected of having opioid-induced hyperalgesia, he would make sure that patient continued seeing a pain management specialist. PX 23b at 142. He finds Petitioner to be medically permanently totally disabled for several reasons, including her chronic pain and her chronic use of narcotic pain medication. PX 23b at 143.

On further redirect, Dr. Coe testified that Petitioner's pain is multi-factorial as well as chronic. It is has persisted for almost nine years. Dr. Jain's records are one source of the opinions he has formed. Dr. Jain has treated Petitioner for eight years and is the doctor who "best knows" Petitioner. There is no guarantee that opioid cessation would not worsen Petitioner's symptoms. PX 23b at 147.

Dr. Candido's Section 12 Examination Findings

Dr. Candido initially examined Petitioner on December 22, 2009, on behalf of Respondent. In connection with this examination, he reviewed the 19(b) decision and records from Dr. Rosenow, Dr. Miz, Dr. Brown and Dr. Jain.

In his report of December 28, 2009, Dr. Candido noted that Petitioner came to his office accompanied by her sister. He described Petitioner as providing a "rambling and unstructured . . . history of present illness, often lacking coherence." He noted that Petitioner reported undergoing multiple procedures, including injections, blocks and rhizotomies, with 58 of those having been administered by Dr. Jain. He indicated Petitioner reported deriving temporary relief from the injections and no relief from neurolytic blocks, radiofrequency ablation or rhizotomies. He further indicated that Petitioner reported deriving minimal relief from her medication.

Dr. Candido noted that Petitioner complained of allodynia to light touch in the left wrist and left forearm up to the elbow, as well as the left lower extremity. He also noted that Petitioner typically rated her left hand and arm pain at 7/10 at rest and 8-9/10 with movement.

Dr. Candido indicated that Petitioner's current medications included Hydroclorothiazide, Klor-Con M20, Gabapentin, Gabitril, Diazepam, Cymbalta, Fentanyl patches and Percocet. He further indicated that Petitioner denied drinking alcohol or using illicit drugs but reported having smoked cigarettes for over thirty years.

Dr. Candido described Petitioner as alert and oriented but "rambling" in terms of her history.

On examination, Dr. Candido noted a full range of head motion, a supple neck, no abnormal coloration, temperature or hair/nail growth of the arms or hands, allodynia to light touch in the left forearm and wrist but no persistent allodynia during distraction maneuvers. He measured the circumference of both upper extremities at the biceps, forearm and wrist. On the left, the measurements were 35, 23.5 and 17.5 centimeters. On the right, the measurements were 35, 24 and 18.5 centimeters.

Dr. Candido diagnosed Petitioner with the following:

a. "Chronic cervical spine degenerative disc and facet joint disease.
b. Chronic lumbar spine degenerative disc and facet joint disease.

c. Status post lumbar spinal fusion with hardware placement.
d. Post-laminectomy syndrome – in remission.
e. Chronic neuropathic pain, left upper extremity.
f. Previous history of complex regional pain syndrome – resolved.
g. Chronic depression.
h. Nicotine dependence.
i. Opioid dependence."

Dr. Candido found Petitioner's presentation consistent with chronic regional pain syndrome only to the extent that Petitioner exhibited allodynia. Dr. Candido described allodynia as a "purely subjective phenomenon" that is "also found in many other neuropathic pain conditions." He found it "likely," based on Dr. Jain's examination findings, that Petitioner "at one time did have CRPS of the left upper extremity." He also found it likely, despite Petitioner's reporting, that the interventions provided for Petitioner "reversed the CRPS and eliminated it totally."

Dr. Candido opined that Petitioner might benefit from a spinal cord stimulator with respect to her chronic low back and radicular pain but he did not believe a stimulator would help Petitioner's neck, shoulder, arm or hand symptoms. Based on Petitioner's past compliance with multiple interventions, he found it likely that Petitioner would "go along" with stimulator implantation but unlikely that a stimulator would help. He ultimately concluded, based on Petitioner's pain ratings, that a stimulator would be a "monumental waste of time and effort" for Petitioner.

Dr. Candido concurred with the functional capacity evaluations. He described both of these evaluations as showing that Petitioner could return to restricted duty. He indicated that severe pain was the primarily limiting factor to Petitioner's resuming gainful employment.

Dr. Candido found Petitioner to have reached maximum medical improvement:

> "Pain management to date, for more than six years, has not made much of a dent in [Petitioner's] **perception of pain** [emphasis in the original]. It is likely then that her pain is being centrally mediated and is permanent. That being stated, I find no reason to suspect that any additional modalities provided on behalf of [Petitioner] are likely to effectively change her status and she is therefore at MMI, in my opinion."

RX 4.

Dr. Candido re-examined Petitioner on August 9, 2011. In connection with this re-examination, Dr. Candido reviewed updated records from Drs. Brown and Jain. He also reviewed a May 24, 2011 note authored by Dr. Coe.

Dr. Candido indicated that Petitioner continued to complain of 9/10 pain, despite having undergone additional blocks and injections. He described Petitioner as experiencing "some two weeks of reduction in symptoms" following each intervention, with those symptoms then returning to baseline. He indicated that Petitioner "confines herself to her home except when she needs to go out to see the doctor."

Dr. Candido noted that Petitioner's medication regimen remained largely the same, except that she had been off of Fentanyl patches for eighteen months.

Dr. Candido indicated that Petitioner was alert, oriented and cooperative. He did not note evidence of any formal thought disorder. On examination, he found "no objective evidence for CRPS or RSD of the left or right arms."

To his previous list of diagnoses, Dr. Candido added myofascial pain syndrome, chronic tension headaches and obesity.

Dr. Candido addressed Petitioner's treatment needs as follows:

> "The problems are largely due to obesity, opioid and nicotine dependence, and psychological dysfunction, including depression. All future treatments should be geared towards resolving, to the extent possible, those issues. In that regard, interventional pain management has little to nothing to offer [Petitioner] and perpetuation of opioid dependence will only lead to further dysfunction and probably to the development of opioid-induced hyperalgesia, if this has not already developed."

Dr. Candido went on to say that the question of whether Petitioner had developed opioid-induced hyperalgesia, "can only be assessed by a total cessation of opioid use." He indicated there was "little downside to considering a structured de-escalation of all opioid use," given Petitioner's consistent reporting of severe pain.

Dr. Candido found Petitioner "unfit to work at the present time, under the circumstances of ongoing opioid use." He indicated "there stands a chance" Petitioner could fulfill the functional capacity findings if structured de-escalation of opioids could be accomplished "under direct and strict supervision." He also indicated Petitioner would "likely benefit from an evaluation by an independent psychologist not affiliated with any of her present care providers."

Dr. Candido found Petitioner to be "not at MMI" based on her ongoing use of large-dose potent opioids. He indicated she would "likely be at MMI" if she was able to undergo a structured and supervised opioid de-escalation. Assuming Petitioner is currently at maximum medical improvement, he recommended only monthly prescription refills and supervised urine

toxicology examinations. He noted that no such examinations were provided to him and that he would like to review same. RX 5.

Dr. Candido's Deposition Testimony

Dr. Candido testified he is board certified in anesthesiology and has added qualification in pain medicine. He obtained the added qualification in 1994 and was recertified in 2004. RX 6 at 5. He is chairman of the department of anesthesiology at Illinois Masonic Medical Center. He devotes about 10% of his time to medical evaluations, including Section 12 examinations. RX 6 at 7-8. Most of the examinations he performs are for defendants. RX 6 at 8.

Dr. Candido testified he has an independent recollection of Petitioner. RX 6 at 9. When he first examined Petitioner, she told him she had undergone multiple procedures, none of which had provided pain relief. RX 6 at 12. She complained of allodynia, or pain to light touch, in her left wrist but, when he touched her left wrist while she was distracted, she did not withdraw her arm as she had previously. RX 6 at 15. In comparing the circumference and temperature of Petitioner's upper extremities, he adhered to the 2003 "Budapest criteria" for the diagnosis of complex regional pain syndrome. Per this criteria, an individual must exhibit at least two out of four findings (including allodynia and various temperature/sensory/motor changes) to "qualify" for complex regional pain syndrome. RX 6 at 19-20. The only difference he noted was that Petitioner's right wrist is slightly larger than her left. This is to be expected, since Petitioner is right-handed. RX 6 at 16-17. Based on his examination, he disqualified Petitioner from consideration of complex regional pain syndrome. RX 6 at 20.

Dr. Candido testified that, based on his initial examination and record review, he reached several diagnoses. While he believed that the multiple procedures performed by Dr. Jain "may have helped [Petitioner] to reduce what Dr. Jain suggested was CRPS," no further interventions were needed. He found Petitioner to have reached maximum medical improvement and capable of resuming work within the restrictions of the functional capacity evaluations. RX 6 at 21-22.

At this point in the deposition, Respondent's counsel asked Dr. Candido if he had an opinion as to whether the work accident caused or aggravated two of the conditions he diagnosed, i.e., chronic cervical and lumbar spine degenerative disease and facet joint disease. [Petitioner's counsel raised a continuing Ghere-based objection to causation-related questions, arguing that the doctor did not address causation in either of his reports. RX 6 at 23-25. That objection is addressed later in this decision.] The doctor opined that these conditions are not related to the accident, based on the treatment records and Petitioner's history of a sharp onset of left wrist pain without reference to other body parts. The doctor found a causal relationship between the work accident and Petitioner's chronic neuropathic pain in the left upper extremity. Although he found no evidence of complex regional pain syndrome, he "took it on good faith" that Dr. Jain concluded she may have had this condition and "provided therapies which are known to be appropriate under those circumstances." RX 6 at 26-27. He did not find causation as to Petitioner's chronic depression or opioid dependency. RX 6 at 27.

Dr. Candido testified that, when he re-examined Petitioner on August 9, 2011, Petitioner again complained of severe, 9/10 pain, despite having undergone additional blocks. Petitioner told him that "every bone in her body hurts all the time." RX 6 at 29. Petitioner reported experiencing reduced symptoms for two weeks after each block, with those symptoms then returning to baseline. RX 6 at 30. Petitioner also voiced a new complaint of headaches in the left posterior occiput into the left side of her face and jaw. Petitioner indicated she left her home only to take her dog into her backyard and to attend medical appointments. RX 6 at 31. Petitioner related that she returned to Dr. Rosenow in 2010 and that he opined a spinal cord stimulator would not relieve her symptoms. Petitioner indicated she was able to drive but sparingly. RX 6 at 33-34. Petitioner told him she would "use the opportunity of fighting with her husband to escape the house and drive away in her car." RX 6 at 33-34. Petitioner reported seeing both a pain psychologist, Dr. Brown, and a priest for help in dealing with her condition. RX 6 at 34.

Dr. Candido testified that Petitioner currently takes Neurontin, an anti-epileptic drug that also works in certain neuropathic pain states. Petitioner's Neurontin dose is 3,000 milligrams daily. The doctor testified the largest daily dose he has ever encountered is 4,800 milligrams. RX 6 at 35. Petitioner is also on extended duration Kadian, or oral morphine, 180 milligrams per day. Petitioner's other medications include Gabitril (another neuropathic pain medication), Cymbalta (a serotonin reuptake inhibitor or antidepressant), Percocet (40 milligrams per day), Valium (taken at bedtime to assist with sleep), Lexapro (another antidepressant), Ondansetron, an anti-nausea medication, Lasix, a diuretic, and potassium, a supplement given to patients who take Lasix. RX 6 at 37-38.

Dr. Candido testified he again found no objective evidence of complex regional pain syndrome when he re-examined Petitioner. RX 6 at 39-41. He diagnosed myofascial pain syndrome, opioid dependence, chronic tension headache, obesity, chronic deconditioning, nicotine dependence, chronic depression, status post lumbar fusion, chronic degenerative disc and facet joint disease of the cervical and lumbar spine and neuropathic pain of the left arm. RX 6 at 40.

Dr. Candido recommended that "all future treatment be geared toward resolving the issues of obesity as well as opioid/nicotine dependence and psychological dysfunction, including depression." Based on Petitioner's continued reporting of severe, 9/10 pain, he felt there was "really little to no down side to considering a structured de-escalation of all opioid use." Such de-escalation "would be performed over a period of several weeks to several months."

Dr. Candido testified that even a very abrupt discontinuation of opioids does not cause heart failure or death. "Nobody dies from the abrupt cessation of narcotics." RX 6 at 42. He is not, however, recommending that Petitioner abruptly stop taking opioids. Instead, he is recommending a gradual de-escalation, incorporating the use of Clonidine, "so that [Petitioner]

could more appropriately deal with the symptoms of withdrawal, which could be somewhat unpleasant or uncomfortable." RX 6 at 43-44.

Dr. Candido further recommended that Petitioner be evaluated by an independent psychologist because it is apparent to him that the psychologist Dr. Jain is using cannot evaluate Petitioner without bias. Petitioner "could benefit substantially by being evaluated by somebody who [doesn't] stand to gain by having her remain in the practice." RX 6 at 43.

Dr. Candido testified that, while he found Petitioner to be at maximum medical improvement in his initial report, Petitioner is not currently at maximum medical improvement based on her large dose of narcotics and need for de-escalation. RX 6 at 44.

Dr. Candido found it "astounding" that Dr. Jain had performed 75 nerve blocks on Petitioner "without any palpable response." If one were to combine ten of his own most frequently seen patients, and added them together, they have not received 75 nerve blocks in aggregate. RX 6 at 46.

Dr. Candido opined that the procedures Dr. Jain were "absolutely not reasonable" and "absolutely not necessary." He further opined that Petitioner's current narcotic intake is neither reasonable nor necessary, based on Petitioner's own reporting. Petitioner "ought to choose or elect to be treated in a different pathway." RX 6 at 46. All of Petitioner's medications as of August 9, 2011 are "potentially associated with side effects," including "opioid-induced hyperalgesia," a well-known phenomenon "where individuals who are subjected to any stimulation feel worse pain . . . than if they were otherwise not consuming medications." Narcotics alter the receptor density in the central nervous system. Narcotics also reduce the levels of serum testosterone in men and women. Women need testosterone for well-being. The chronic intake of narcotics can also impair wound functioning and the ability to fight off infectious processes. Valium, or Diazepam, is a "very highly addictive substance" that can have a synergistic effect on the use of narcotics in terms of causing respiratory depression. RX 6 at 48.

After reading Dr. Jain's report of November 1, 2011 (Candido Dep Exh 4), Dr. Candido testified he and Dr. Jain agree on only one thing, i.e., that Petitioner is not at maximum medical improvement based on her current medications. RX 6 at 50-51. Dr. Candido testified there are some discrepancies between the doses Dr. Jain describes in his report and those Petitioner described at the re-examination but those discrepancies do not prompt him to change any of his opinions. RX 6 at 55. Dr. Candido testified he recommends de-escalation primarily to address Petitioner's apparent cognitive and emotional dysfunction. Petitioner comes off as "very scattered" and this would impair her ability to function at a workplace. RX 6 at 56-57.

Under cross-examination, Dr. Candido testified his file concerning Petitioner does not contain the cover letter he received from Respondent's counsel. He lacks the space to retain such documents. He types his own reports, so as to avoid any errors in transcription, and retains the reports on discs. RX 6 at 59-60.

Dr. Candido agreed with Dr. Wiedrich that the subjective symptoms of complex regional pain syndrome, such as perceived pain and swelling, can wax and wane. He does not, however, believe that the signs of the syndrome can wax and wane. RX 6 at 62-64.

Dr. Candido described Dr. Rosenow as a competent neurosurgeon. Dr. Rosenow diagnosed Petitioner with "complex neuropathic pain condition," not complex regional pain syndrome. RX 6 at 66-67. Neuropathic pain is defined as "disordered or abnormal functioning of the peripheral nervous system." RX 6 at 70. Neuropathic pain is an umbrella-type category that includes CRPS. Post-amputation "phantom limb" pain also falls under the heading of neuropathic pain. RX 6 at 71. Dr. Candido testified he is unable to be specific as to the type of neuropathic pain Petitioner has. It appears she has a "post-traumatic neuropathic pain syndrome with several of the common features of neuropathic pain and, besides allodynia, none of the features of complex regional pain syndrome." RX 6 at 72. Petitioner's neuropathic pain stems from her work accident. RX 6 at 72. Dr. Candido testified he fails to understand why Dr. Jain continues to refer to Petitioner as having complex regional pain syndrome since he has documented no evidence to support this diagnosis. RX 6 at 73. He acknowledged he has not read Dr. Jain's deposition testimony. RX 6 at 74. The type of injections Dr. Jain and his colleagues administered "could certainly be consistent with the treatment of neuropathic pain." RX 6 at 77.

[CONT'D]

Arbitrator's Credibility Assessment

Petitioner testified to constant, unrelenting pain that severely limits her daily activities. Petitioner also testified that she perceives her left wrist and inner arm as green and swollen. She stated she felt as if her veins were going to pop out. Petitioner became agitated and less coherent while describing these symptoms.

Dr. Candido, Respondent's most recent Section 12 examiner, noted some inconsistencies in Petitioner's presentation with distraction maneuvers. Dr. Coe, Petitioner's examiner, described Petitioner as "cooperative to the extent that she could cooperate." He did not note any evidence of symptom magnification. Dr. Brown, at one point, noted that Petitioner declined to see a psychiatrist at his recommendation. Dr. Brown's most recent notes do not reflect that he is continuing to recommend a psychiatric consultation. PX 3. Dr. Jain described Petitioner as "compliant overall." Dr. Jain also testified that Petitioner is not malingering. The urine drug test results in evidence cover a limited period but reflect compliance with the prescribed medication. No one who has treated or evaluated Petitioner has noted evidence of drug-seeking behavior.

While the Arbitrator did not observe anything unusual about the appearance of Petitioner's left hand or arm, she was only briefly in proximity to Petitioner. Overall, the Arbitrator has no basis for questioning Petitioner's veracity. Petitioner appears significantly debilitated. The Arbitrator is persuaded by Dr. Coe's opinion that Petitioner typically rates her pain at 9/10 because she incorporates her "frustration with her pain" into her rating.

Did Petitioner establish causal connection?

As a preliminary matter, the Arbitrator sustains Petitioner's Ghere-based objection to Dr. Candido's causation-related testimony. RX 6 at 23. Neither of Dr. Candido's reports contains any mention of the issue of causal connection. Candido Dep Exh 2-3. Having the doctor address causation for the first time at his deposition constituted unfair surprise, in the Arbitrator's view. The Arbitrator notes, however, that even if Ghere had no application to this case, much of Dr. Candido's causation-related testimony was ultimately helpful to Petitioner. On direct examination, Dr. Candido acknowledged there is a causal relationship between the work accident and Petitioner's chronic neuropathic left upper extremity pain. RX 6 at 26. He did not find causation as to Petitioner's depression and opioid dependency. Under cross-examination, however, he conceded that neuropathic pain can be a cause of chronic depression and that Dr. Jain's prescription of narcotic pain medication was a causative factor in the development of Petitioner's opioid dependency. RX 6 at 11-12, 15.

The Arbitrator finds that Petitioner established a causal connection between her work

accident and a chronic pain condition that involves her neck and left upper extremity. The Arbitrator further finds that Petitioner established causation as to her chronic depression and opioid dependency. In so finding, the Arbitrator relies not only on Dr. Candido's testimony but also on the "law of the case" doctrine. In the prior 19(b) decision, Arbitrator DeVriendt found causation as to a condition, then thought to be complex regional pain syndrome, or "CRPS," involving Petitioner's left upper extremity and neck. Respondent could have filed a review but opted not to do so. The 19(b) decision thus became the final decision of the Commission. Under the "law of the case" doctrine, an unreversed decision of a question of law or fact made during the course of litigation settles that question for all subsequent stages of the suit. Irizarry v. Industrial Commission, 337 Ill.App.3d 598, 606-7 (2nd Dist. 2003).

The Arbitrator recognizes that eight years have passed since the 19(b) hearing and that, during that time, thinking about Petitioner's condition has evolved. The Arbitrator subscribes to Dr. Candido's theory, expressed in his first report, that Petitioner initially exhibited features of CRPS, with those features subsiding over time based on Dr. Jain's various interventions. Candido Dep Exh 2 at 12. The Arbitrator also subscribes to Dr. Coe's opinion that Petitioner's current pain condition of ill-being is multi-factorial. Dr. Candido and Dr. Coe agree that CRPS falls under the "umbrella" of neuropathic pain syndrome.

The Arbitrator finds that Petitioner failed to establish causation as to her facial pain/headaches and severe sinusitis, conditions that required treatment in 2011. The Ingenix print-out of charges paid by Petitioner's husband's group carrier reflects that Dr. Alzein has treated Petitioner for headaches and sinusitis. Dr. Alzein's records are not in evidence and no physician has linked the headaches or sinusitis to the work accident. See further below.

Is the structured de-escalation proposed by Dr. Candido "reasonably essential to promote [Petitioner's] recovery? Is Petitioner's claim for weekly benefits barred by her continued use of narcotic pain medication as prescribed by Dr. Jain? Is Petitioner permanently and totally disabled?

At the hearing, Petitioner claimed two intervals of temporary total disability benefits, with the second interval ending on March 28, 2011, and permanent total disability benefits from March 29, 2011 forward. Respondent stipulated to temporary total disability benefits from March 18, 2005, the day after the 19(b) hearing, through August 4, 2005. The parties agreed that Respondent paid $13,105.51 in temporary total disability benefits covering the period March 18, 2005 through August 4, 2005. Arb Exh 1.

At the hearing, Respondent, citing Section 19(d) of the Act, contended that Petitioner is not entitled to temporary total disability benefits (beyond those already paid) as a consequence of declining to participate in a structured de-escalation of narcotic pain medication. Dr. Candido, Respondent's Section 12 examiner, first recommended such de-escalation in his second report, dated August 9, 2011. In the same report, he found that Petitioner had not yet reached maximum medical improvement and was "unfit to work" based on her current

medications. [In his initial report of December 28, 2009, Dr. Candido found Petitioner to be at maximum medical improvement but suggested implantation of a spinal cord stimulator for Petitioner's lower back condition, a condition Petitioner stipulates is unrelated to the work accident.] Respondent's counsel wrote to Petitioner's counsel on February 20, 2012, citing Dr. Candido's recommendation and directing Petitioner to contact Loretto Hospital to schedule an initial evaluation so that de-escalation could begin. RX 1. The letter provides no details as to the type of de-escalation program offered by Loretto Hospital. Nor does it indicate how long the program was expected to last. There is no evidence indicating Petitioner contacted Loretto Hospital. At the hearing, Petitioner expressed a preference for continuing the regimen prescribed by Dr. Jain.

At the outset, the Arbitrator notes that Section 19(d), as written, does not permit an employer to discontinue the payment of benefits. Rather, it provides, in pertinent part, that "**the Commission may, in its discretion, reduce or suspend the compensation** of any injured employee" who "shall refuse to submit to such medical, surgical or hospital treatment as is reasonably essential to promote his recovery." [emphasis added].

Having considered Petitioner's testimony and overall presentation, along with the various physician opinions rendered in this case, the Arbitrator concludes that Petitioner did not violate Section 19(d) by adhering to the recommendations of her treating physician, Dr. Jain, rather than Dr. Candido, Respondent's examiner. [See Kawa v. Ford Motor Company, 2011 Ill.Wrk.Comp. LEXIS 590, a decision in which the Commission found there was no Section 19(d) violation even though the claimant declined to attend a multi-disciplinary pain program at RIC per his treating physician's recommendation. The employer did not appeal this aspect of the Commission's decision. The Appellate Court ultimately held that the Commission's resolution of this issue included an implicit finding that the employer failed to prove the pain program was reasonably essential to promote the claimant's recovery. 2012 IL App (1st) 120469WC.] The Arbitrator further finds that the structured de-escalation of narcotic pain medication, in this case, is neither reasonably essential, nor reasonably likely, to "promote [Petitioner's] recovery." Petitioner has been taking narcotic pain medication for a substantial period of time. It is part of her daily regimen. Her sphere of activity is admittedly very limited but she is not bedridden. She has a routine of sorts. The Arbitrator agrees with Dr. Coe that de-escalation, for Petitioner, would constitute an experiment, and a cruel one at that. The Arbitrator also notes Dr. Candido's concession, under cross-examination, that it is "speculative" whether de-escalation would provide Petitioner any benefit. In the Arbitrator's view, that concession completely undermined all of the opinions Dr. Candido had previously rendered concerning de-escalation. In Illinois, it has long been held that the opinion of an expert witness cannot be based on speculation or conjecture. Dyback v. Weber, 114 Ill.2d 232, 243 (1986).

Based on the foregoing analysis, along with Dr. Jain's testimony and the treatment records, the Arbitrator finds that Petitioner was temporarily totally disabled from March 18, 2005 (the day after the 19(b) hearing) through September 18, 2006 (the date of the second functional capacity evaluation), a period of 78 5/7 weeks, and from July 14, 2010 through

September 11, 2012 [the date on which Dr. Candido's deposition was concluded], a period of 113 weeks. Respondent is to receive credit for the $13,105.51 in benefits it paid prior to hearing. Arb Exh 1.

The Arbitrator views Petitioner as reaching maximum medical improvement as of September 11, 2012 based on the concessions Dr. Candido made under cross-examination on that date. [See further below]. The Arbitrator further finds that Petitioner is medically permanently totally disabled and entitled to permanent total disability benefits from September 12, 2012 forward and for the duration of her life pursuant to Section 8(f) of the Act.

Is Petitioner entitled to medical expenses?

Petitioner seeks an award of $105,206.17 in medical expenses, with $76,285.57 of that amount representing payments made by her husband's group carrier, United Health Care. [See Ingenix print-out].

The non-Ingenix claimed bills include the following:

Center for Minimally Invasive Surgery	$ 955.13
Dr. Jain	$ 2,890.80
RS Medical	$ 1,037.67
Professional Neurology (upper extremity EMG)	$ 5,342.00
Brownstone, LLC (Dr. Brown)	$ 1,600.00
Achieve (therapy/work conditioning – PX 10)	$17,095.00

Based on the treatment records and the testimony of both Petitioner and Dr. Jain concerning the benefit provided by the various blocks and injections [see further below], the Arbitrator awards all of the foregoing expenses, subject to payment pursuant to Section 8(a) and the medical fee schedule.

The $76,285.57 paid by United Health Care [see Ingenix print-out] includes charges for treatment predating the 19(b) hearing. The attorneys in this case have provided no assistance to the Arbitrator in determining whether these charges were already awarded and paid. The Arbitrator directs the attorneys to compare the print-out against the bills awarded by Arbitrator DeVriendt. The print-out also includes charges for conditions the Arbitrator has found to be not causally related to the work accident, i.e., sinusitis and headaches. Of those charges listed on the print-out, the Arbitrator declines to award the payments made to Dr. Alzein (totaling $243.93) and the payments made to Southwest Hospital ($2,422.59) for a brain MRI performed on August 3, 2011. Dr. Alzein's records are not in evidence and no physician testified to a causal relationship between the need for this MRI and the 2003 work accident. It appears to the Arbitrator that the brain MRI was ordered to evaluate a complaint of facial pain. In summary, the Arbitrator awards the amounts paid by United Health Care/Ingenix other than any amounts previously awarded by Arbitrator DeVriendt and the amounts associated with Dr.

Alzein's care and the August 3, 2011 brain MRI.

The Arbitrator turns to the issue of the reasonableness and necessity of the palliative care (other than medication management) provided by Dr. Jain. The Arbitrator has given careful consideration to Dr. Candido's testimony concerning the numerous injections and blocks performed by Dr. Jain over the years. Essentially, Dr. Candido charges Dr. Jain with medical negligence in connection with this care. That is a serious charge and one that is not frequently seen in workers' compensation claims. The Arbitrator notes, however, that Dr. Candido also opined it was Dr. Jain's interventions that likely caused the initial symptoms of complex regional pain syndrome to recede over time. Dr. Candido further acknowledged that Petitioner has a neuropathic pain condition and that it is appropriate to treat such a condition with the kind of injections and blocks Dr. Jain performed. Overall, the Arbitrator finds Dr. Candido's treatment-related opinions inconsistent.

There is no question that Dr. Jain has performed many blocks, injections and other procedures over time. There is also no question that these interventions have been costly. Petitioner credibly testified the various procedures "soothed" her neck and left arm pain, albeit temporarily. Section 8(a) of the Act clearly allows for both curative and palliative treatment. In Second Judicial District v. Industrial Commission, 323 Ill.App.3d 758 (2nd Dist. 2001), the Appellate Court cited Efengee Electrical Supply Co. v. Industrial Commission, 36 Ill.2d 450, 453 (1967) for the proposition that "an employer's liability under [Section 8(a)] of the Act is continuous so long as the medical services are required to relieve the injured employee from the effects of the injury." The Court upheld the Commission's award of expenses stemming from multiple injections performed over a three-year period, with the evidence indicating that each of these injections only briefly relieved the claimant's recurrent neuropathic right arm pain. The Arbitrator relies on the plain language of Section 8(a) as well as Second Judicial District in awarding the expenses associated with the various cervical and left upper extremity injections and blocks.

Is Respondent liable for penalties and fees?

Petitioner seeks an award of penalties and fees only on the weekly benefits it maintains are due and owing from March 29, 2011 forward. Petitioner filed a petition for penalties and fees on March 29, 2013, about three months before the hearing. PX 25.

For the reasons stated earlier, the Arbitrator targets September 12, 2012 as the start date for the permanency award in this case.

On this record, the Arbitrator finds Respondent had a reasonable basis for relying on Dr. Candido's August 9, 2011 recommendation of structured de-escalation up until September 11, 2012, the day on which the doctor admitted, under oath, that: 1) it is speculative whether Petitioner would benefit from such a regimen; and 2) Petitioner is "unfit for work." At a minimum, those concessions should have triggered the payment of temporary total disability

benefits from August 9, 2011 through September 11, 2012, a period of 400 days or 57 1/7 weeks. Based on the passage of almost two years between August 9, 2011 and the hearing of June 24, 2013, the Arbitrator awards Section 19(l) penalties at the rate of $30.00 per day and in the maximum amount of $10,000.00. The Arbitrator declines to award Section 19(k) penalties and fees, as requested by Petitioner. Such an award is discretionary. The 19(l) award is not insignificant.

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

JUAN CARLOS ALVIA,
Petitioner,

14IWCC1027

vs.

NO: 11 WC 29092

COUNTRY CLUB HILLS POLICE,
Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by Petitioner herein and notice given to all parties, the Commission, after considering the issue of permanent disability and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed February 4, 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: NOV 25 2014
KWL/mav
O: 09/30/14
42

Kevin W. Lamborn

Thomas J. Tyrrell

Michael J. Brennan

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

14IWCC1027

AVILA, JUAN CARLOS
Employee/Petitioner

Case# **11WC029092**

12WC040945

COUNTRY CLUB HILLS POLICE DEPT
Employer/Respondent

On 2/4/2014, 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:

1836 RAYMOND M SIMARD PC
221 N LASALLE ST
SUITE 1410
CHICAGO, IL 60601

2965 KEEFE CAMPBELL BIERY & ASSOC LLC
DANIEL J BODDICKER
118 N CLINTON ST SUITE 300
CHICAGO, IL 60661

STATE OF ILLINOIS)
)SS.
COUNTY OF COOK)

☐ Injured Workers' Benefit Fund (§4(d))
☐ Rate Adjustment Fund (§8(g))
☐ Second Injury Fund (§8(e)18)
☒ None of the above

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
NATURE AND EXTENT ONLY

14IWCC1027

JUAN CARLOS AVILA
Employee/Petitioner

v.

COUNTRY CLUB HILLS POLICE DEPARTMENT
Employer/Respondent

Case # **11** WC **29092**

Consolidated cases: **12 WC 40945**

The only disputed issue is the nature and extent of the injury. An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **David Kane**, Arbitrator of the Commission, in the city of **Chicago**, on **January 7, 2014**. By stipulation, the parties agree:

On the date of accident, **April 21, 2011**, Respondent was operating under and subject to the provisions of the Act.

On this date, the relationship of employee and employer did exist between Petitioner and Respondent.

On this date, Petitioner sustained an accident that arose out of and in the course of employment.

Timely notice of this accident was given to Respondent.

Petitioner's current condition of ill-being is causally related to the accident.

In the year preceding the injury, Petitioner earned **$82,992.00**, and the average weekly wage was **$1,596.00**.

At the time of injury, Petitioner was **32** years of age, ***married*** with **2** dependent children.

Necessary medical services and temporary compensation benefits have 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**.
The parties stipulated that Respondent paid Petitioner his full salary during the period of temporary total disability.

After reviewing all of the evidence presented, the Arbitrator hereby makes findings regarding the nature and extent of the injury, and attaches the findings to this document.

ORDER

Respondent shall pay Petitioner the sum of **$669.64**/week for a further period of **5.01** weeks, as provided in Section **8(e)** of the Act, because the injuries sustained caused **the permanent partial loss of use of the right foot of Petitioner to the extent of 3%.**

Respondent shall pay Petitioner compensation that has accrued from **08/08/11** through **01/7/14**, and shall pay the remainder of the award, if any, in weekly payments.

RULES REGARDING APPEALS Unless a Petition for Review is filed within 30 days after receipt of this decision, and a review is perfected in accordance with the Act and Rules, then this decision shall be entered as the decision of the Commission.

STATEMENT OF INTEREST RATE If the Commission reviews this award, interest at the rate set forth on the *Notice of Decision of Arbitrator* shall accrue from the date listed below to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

David A. Kane
Signature of Arbitrator

February 4, 2014
Date

FEB 4 - 2014

14IWCC1027

STATEMENT OF FACTS

JUAN CARLOS AVILA V. COUNTRY CLUB HILLS POLICE DEPARTMENT

11WC 29092

This case comes before the Arbitrator on undisputed facts with regard to the incident in question. Petitioner testified to his employment with Respondent, the City of Country Club Hills Police Department, as a patrol officer on and around the date of loss of April 21, 2011 Petitioner was 32 year old.

Petitioner testified that on April 21, 2011 he rolled his right ankle while he was responding to a burglary call when he slipped on a wet concrete stoop. Country Club Hills Fire Department paramedics took Petitioner to St. James Olympia Fields Hospital on April 22, 2011. (Res. Ex.1). X-rays taken at the Hospital showed no evidence of any fracture. (Res. Ex. 2).

Petitioner followed up with David Mehl, M.D. on May 2, 2011 who diagnosed a grade 2 right ankle sprain (Res. Ex. 3). Dr. Mehl placed Petitioner into a lace up ankle brace, took him off work for two weeks and referred him to physical therapy 3 times a week for four weeks. (Res. Ex. 3). An MRI of the right ankle was taken on July 15, 2011. The impression was of a small to moderate ankle joint effusion, a chronic sprain of the lateral ligamentous complex without definite disruption, and posterior tibial tenosynovitis. (Res. Ex. 5).

On August 3, 2011, Petitioner saw Dr. Mehl. (Res. Ex. 6). Dr. Mehl's note indicates he reviewed the MRI which showed a chronic sprain of the ATFL (anterior talofibular ligament) without tear. Dr. Mehl examined Petitioner and noted no gross instability is present, range of motion has returned to nearly normal and strength had improved as well. Dr. Mehl

indicated Petitioner still had some medial tenderness. Dr. Mehl's impression included (1) nearly healed right ankle sprain and (2) Medial arch pain. Dr. Mehl opined Petitioner to have reached maximum medical improvement with therapy. Dr. Mehl's plan was that Petitioner would benefit from a medial arch support which Dr. Mehl noted was administered that day. Dr. Mehl's note does not indicate an opinion that the Medial arch pain was related to Petitioner's work injury. Dr. Mehl returned Petitioner to regular work as a police officer effective August 8, 2011, with the arch support as tolerated, and noted that Petitioner has a lace up ankle brace he can use for work as well.

Petitioner testified he wears the lace up brace at work at all times. Petitioner testified that he noticed, after he returned to regular work after the August 8, 2011 visit and before he had a second injury to his ankle on March 31, 2012, that he had a lot more instability in his ankle, swelling, stiffness and pain.

On September 27, 2011, Petitioner saw Johnny L. Lin, M.D., for an Independent Medical Examination. (Res. Ex 8). Dr. Lin noted Petitioner complained of variable amounts of pain. Dr. Lin opined Petitioner was able to work a full duty job without any restrictions, but with use of an ankle brace if Petitioner has pain. Although Dr. Lin noted Petitioner may benefit from a cortisone injection into the tibiotalar joint there is no evidence that Petitioner ever sought or received an injection.

Findings of Fact & Conclusions of Law

Nature and Extent of the Injury:

The Arbitrator finds that the Petitioner has sustained a 3% loss of use of the right foot as a result of the April 21, 2011 injury.

This finding is based upon the Petitioner's testimony and the treating

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medical records. Petitioner had x-rays at the Hospital on April 21, 2011 which showed no fracture. Petitioner had an MRI on July 15, 2011 which showed a sprain with no tear. Dr. Mehl noted no gross instability on August 8, 2011 when he opined Petitioner reached maximum medical improvement. Petitioner was returned to full duty work effective August 8, 2011.

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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 up	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

JUAN CARLOS ALVIA,

Petitioner,

14IWCC1028

vs.

NO: 12 WC 040945

COUNTRY CLUB HILLS POLICE DEPARTMENT,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by Petitioner herein and notice given to all parties, the Commission, after considering the issue of permanent disability and being advised of the facts and law, modifies the Decision of the Arbitrator as stated below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

Petitioner, a police officer, injured his right ankle on March 31, 2012, after jumping to avoid an on-coming vehicle. There was no dispute that this incident is compensable under the Act, and there is no dispute that Respondent properly compensated Petitioner during his period of temporary total disability and paid all related medical bills. The only contested issue was as to the nature and extent of Petitioner's permanent total disability, and the arbitration hearing on this issue was heard on January 7, 2014, by Arbitrator David Kane.

Arbitrator Kane, after taking into consideration the enumerated factors as listed in Section 8.1(b) of the Act, found Petitioner sustained a 7.5% loss of use of the right foot as a result of the March 31, 2012, accident. Petitioner appealed Arbitrator Kane's arbitration decision, arguing his injury merited a larger permanency award. The Commission agrees.

After reviewing the arbitration decision against the evidence, the Commission finds Arbitrator Kane erred when he found Petitioner had no complaints after returning to work concerning his right foot. Petitioner credibly testified he now wears boots to maintain stability in

14IWCC1028

his right ankle as well as experiencing swelling in his ankle on more strenuous days, stiffness in his ankle when it is kept in the same position for a prolonged period of time, such as when he drive a patrol car. Also credibly testified to was Petitioner's need to medicate with Ibuprofen several times a week as well as his having to change certain aspects as to how he performs his duties as a police officer due to the residual effects of the March 31, 2012, accident. In recognition of Petitioner's lingering pain and functional deficits, the Commission finds Petitioner has experienced a 12½% loss of the use of his right foot.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $695.78 per week for a period of 15.865 weeks, as provided in §8(e) of the Act, for the reason that the injuries sustained caused the 12½% loss of the use of the right foot; Respondent is credited for the permanent partial disability benefits of 3% loss of use of the right foot was awarded pursuant to the February 4, 2014, arbitration decision (11 WC 29092).

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: NOV 25 2014
KWL/mav
O: 09/30/14
42

Kevin W. Lamborn

Thomas J. Tyrrell

Michael J. Brennan

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

14IWCC1028

AVILA, JUAN CARLOS
Employee/Petitioner

Case# 12WC040945
11WC029092

COUNTRY CLUB HILLS POLICE DEPT
Employer/Respondent

On 2/4/2014, 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:

1836 RAYMOND M SIMARD PC
221 N LASALLE ST
SUITE 1410
CHICAGO, IL 60601

2965 KEEFE CAMPBELL BIERY & ASSOC LLC
DANIEL J BODDICKER
118 N CLINTON ST SUITE 300
CHICAGO, IL 60661

STATE OF ILLINOIS)
)SS.
COUNTY OF COOK)

☐ Injured Workers' Benefit Fund (§4(d))
☐ Rate Adjustment Fund (§8(g))
☐ Second Injury Fund (§8(e)18)
☒ None of the above

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
NATURE AND EXTENT ONLY

14IWCC1028

JUAN CARLOS AVILA
Employee/Petitioner

v.

Case # 12 WC 40945

Consolidated cases: **11 WC 29092**

COUNTRY CLUB HILLS POLICE DEPARTMENT
Employer/Respondent

The only disputed issue is the nature and extent of the injury. An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **David Kane**, Arbitrator of the Commission, in the city of **Chicago**, on **January 7, 2014**. By stipulation, the parties agree:

On the date of accident, **March 31, 2012**, Respondent was operating under and subject to the provisions of the Act.

On this date, the relationship of employee and employer did exist between Petitioner and Respondent.

On this date, Petitioner sustained an accident that arose out of and in the course of employment.

Timely notice of this accident was given to Respondent.

Petitioner's current condition of ill-being is causally related to the accident.

In the year preceding the injury, Petitioner earned $**82,990.00**, and the average weekly wage was $**1,596.00**.

At the time of injury, Petitioner was **33** years of age, ***married*** with **2** dependent children.

Necessary medical services and temporary compensation benefits have 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**.
The parties stipulated that Respondent paid Petitioner his full salary during the period of temporary total disability.

After reviewing all of the evidence presented, the Arbitrator hereby makes findings regarding the nature and extent of the injury, and attaches the findings to this document.

ORDER

Respondent shall pay Petitioner the sum of **$695.78**/week for a further period of **12.525** weeks, as provided in Section **8(e)** of the Act, because the injuries sustained caused **the permanent partial loss of use of the right foot of Petitioner to the extent of 7.5%.**

Respondent shall pay Petitioner compensation that has accrued from **07/30/12** through **01/7/14**, and shall pay the remainder of the award, if any, in weekly payments.

RULES REGARDING APPEALS Unless a Petition for Review is filed within 30 days after receipt of this decision, and a review is perfected in accordance with the Act and Rules, then this decision shall be entered as the decision of the Commission.

STATEMENT OF INTEREST RATE If the Commission reviews this award, interest at the rate set forth on the *Notice of Decision of Arbitrator* shall accrue from the date listed below to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

David A. Kane
Signature of Arbitrator

February 4, 2014
Date

FEB 4 - 2014

STATEMENT OF FACTS

JUAN CARLOS AVILA V. COUNTRY CLUB HILLS POLICE DEPARTMENT

12WC 40945

This case comes before the Arbitrator on undisputed facts with regard to the incident in question. Petitioner testified to his employment with Respondent, the City of Country Club Hills Police Department, as a patrol officer on and around the date of loss of March 31, 2012. Petitioner was 33 year old on the date of loss.

Petitioner testified that on March 31, 2012 he injured his right ankle when he jumped out of the way of a vehicle to avoid getting hit. Petitioner testified he was taken to emergency room at St. James Hospital.

Petitioner followed up at St. James Occupational Health Center where x-rays of Petitioner's right ankle were taken on April 2, 2012. (Res. Ex. 11). The x-rays were compared to x-rays of Petitioner's right ankle taken on April 22, 2011. The findings were no fracture, the ankle mortise and talar dome are intact, the osseous structures appear intact and unremarkable. There was no bony destruction to suggest osteomyelitis. The impression was negative right ankle radiographs. Petitioner testified he was advised to continue wearing his brace and to elevate his leg when sitting.

Petitioner testified he started physical therapy on April 11, 2012. Petitioner testified Dr. Clifton Ward prescribed an MRI of the right ankle. On April 25, 2012, Dr. Clifton Ward discharged Petitioner to see Dr. David Mehl. (Res. Ex. 12). Dr. Clifton Ward's work status report dated April 30 noted Petitioner indicated he was walking a little better but it still hurt around his heel and when he turned it inwards. (Res. Ex. 13).

On July 27, 2012 Petitioner had an FCE performed at METT Physical Therapy. (Res. Ex. 15). It demonstrated that Petitioner could perform 97.5% of the physical demands of his job as a Police Officer. The FCE report stated that Petitioner's deficiencies occurred during squat and power lifts with goal weights of 100 lbs. each. Further, that Petitioner stated it would be an infrequent occurrence that he would actually be expected to left loads of that weight at his job. The report stated Petitioner had made excellent progress and that although he experience very mild ankle pain, 1 on a scale of 10, and very mild swelling he feels he is ready to resume his usual job duties as a police officer and discharge from the program was recommended.

On July 30, 2012, Dr. David Mehl found Petitioner to be at maximum medical improvement and capable of full duty. Dr. David Mehl released Petitioner to work full duty on July 30, 2012.

Petitioner testified he was off work on duty disability from April 11, 2012 until August 2, 2012.

Petitioner saw Simon Lee, M.D. on September 19, 2013 for an independent medical examination, (Res. Ex. 16) and for an impairment rating. (Res. Ex. 17). In his independent medical examination report Dr. Lee notes Petitioner denied any instability episodes or repeat injuries since it originally occurred. Dr. Lee noted that on examination Petitioner had some mild increased laxity of his right ankle and no mechanical symptoms. Dr. Lee diagnosed status post right ankle chronic sprain with mild laxity. Dr. Lee noted Petitioner only requires over the counter ibuprofen. Dr. Lee noted he believed there to be a mild amount of symptom magnification. Dr. Lee opined no work restrictions are necessary. Dr. Lin opined no further treatment is necessary other than what Petitioner is currently using, i.e.

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occasional bracing or use of high-top shoes or boots as required. Dr. Lee opined Petitioner reached MMI in 2012 and should be able to continue full work duty and employment.

Dr. Lee gave his opinions on impairment in his report dated September 19, 2013. (Res. Ex. 17) Dr. Lee opined that Petitioner has a 5% lower extremity impairment under the AMA guides.

Petitioner testified he still works as a patrol officer. Petitioner testified he still chases suspects when necessary and his ankle does not prevent him from chasing suspects. Petitioner testified since he returned to full duty work after the March 31, 2012 injury he has not reported to any of his supervisors that he has problems with his ankle to the extent he cannot perform his duties. Petitioner testified he can physically perform his job as a police officer.

Respondent's witness Lieutenant William Garrison testified he is patrol lieutenant with the Country Club Hills Police Department. He is responsible for supervision of the operations of the Patrol Division, scheduling and training. Lt. Garrison testified that Petitioner came back to full duty work after each of his ankle injuries. Lt. Garrison testified that since Petitioner came back to full duty work he has not complained that the condition of his ankle prevented him from doing his job as a patrol officer. Lt. Garrison testified he is not aware of any incident where Petitioner could not perform some duties of his as patrol officer because of his ankle when he was working full duty.

CONCLUSIONS OF LAW

Nature & Extent of the Injury

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The Arbitrator finds that Petitioner sustained a 7.5% loss of use of the right foot as the result of the accident of March 31, 2012. The Arbitrator notes that Respondent shall receive credit for the award of the right foot awarded for the April 21, 2011 date of loss (11WC 29092).

1. The reported level of impairment pursuant to the Section 8.1(b),
2. The occupation of the employee,
3. The age of the employee at the time of injury,
4. The employee's future earning capacity,
5. Evidence of disability corroborated by the treating medical records.

Of note, no single enumerating factor shall be the sole determining factor for disability.

Per Section 8.1(b) of the Act, the Arbitrator has considered the following:

(i) the reported level of impairment per the AMA Guide is 5% of the right foot;

(ii) The occupation of Petitioner is police officer. Petitioner continues to work full duty as a Patrol Officer and makes no complaints;

(iii) Petitioner was 33 years old at the time of the accident. Petitioner continues to work full duty as a Patrol Officer and makes no complaints;

(iv) Dr. Mehl released Petitioner to full duty work and Dr. Lee stated that Petitioner should be able to continue full work duty and employment;

(v) The medical records are consistent with the past subjective complaints of Petitioner. The Arbitrator notes Petitioner testified he can do his job as a Police Officer and has made no complaints since returning to full duty work.

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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 Maintenance	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☐ Modify	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

BRIAN KIRBY,

Petitioner,

14IWCC1029

vs.

NO: 11 WC 22769

UPS,

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 maintenance, re-instatement of vocational rehabilitation, and penalties, and being advised of the facts and applicable law, reverses the Decision of the Arbitrator and finds that Brian Kirby is entitled to maintenance benefits from April 25, 2013 through January 16, 2014 and re-instatement of vocational rehabilitation services. The Commission declines to award penalties in this matter. 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 has considered all the testimony, exhibits, pleadings and arguments submitted by the Petitioner and the Respondent. Based on the evidence, the Commission finds the alleged job offer from Progressive Truck Driving School was not a bona fide offer of employment.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

14IWCC1029

The Commission makes the following findings:

1. An Application for Adjustment of Claim was filed on June 15, 2011. The Petitioner was a 51 year old, married male with no dependants under the age of 18. Petitioner alleged a herniated disc as the result of pulling a pin on a truck on January 27, 2011. He had worked for UPS for 23 years.

2. Brian Kirby sustained an undisputed work-related injury to his back on January 27, 2011.

3. On August 31, 2011, Dr. Avi Bernstein performed revision of the lumbar laminectomy with bilateral L4-L5 neural foraminotomies; revision posterior spinal fusion at L4-L5, segmental instrumental using ExPedium Titanium System; left iliac crest bone graft and local bone graft, dural repair; and, running and triggered EMGs.

4. On February 23, 2012, Dr. Bernstein did not think Petitioner would be able to return to work performing heavy repetitive bending, lifting or twisting. PX.1.

5. Mr. Kirby underwent an FCE on March 16, 2012. He failed to demonstrate the ability to return to work as a Feeder Driver for UPS. He demonstrated the ability to function in the medium physical demand level. He demonstrated deficits with two handed lifting, two handed pulling to simulate a dolly job, job related sitting, and climbing in and out of truck. The FCE revealed that Petitioner did not meet the sitting tolerance or ability to climb in and out of a truck. The FCE was an accurate representation of his true work demands. PX.1.

6. Dr. Bernstein found Petitioner to be at MMI as of April 5, 2012. Petitioner was provided with permanent 50 pound lifting restrictions. PX.1.

7. Petitioner underwent vocational rehabilitation with Triune Health Group beginning on June 12, 2012. Caroline Ward-Kniaz testified that she was the vocational rehabilitation consultant for this case. She completed a transferable skills analysis and an initial vocational report. She noted that Petitioner was computer literate as he could operate a computer, the internet and e-mail. T.94. She did not, however, perform any vocational testing. T.95. She was of the opinion that jobs were available that Petitioner could perform without any formal training. He could perform jobs consistent with dispatchers, customer service, a truck parts customer service representative, and a commercial CDL instructor. T.104. She stated that her report does not include the deficits listed in the FCE. T.106.

8. Petitioner's benefits were terminated on November 27, 2012. Triune noted that Petitioner did not apply for driving positions presented to him. He did not call two employers and did not apply for jobs in person. He did not record any in person applications or phone

call follow-ups. He was also 10 minutes late for a meeting. PX.12. Petitioner testified that he did not apply for truck driving positions as they were outside of his restriction.

9. Mr. Thomas Szarek is a Claims Adjustor with Liberty Mutual. He testified that he sent Petitioner's attorney an e-mail on October 17, 2012 stating that Petitioner needed to be compliant with all requirements. Petitioner's attorney responded that his client could not drive and was not following up with those jobs. T.201. Benefits were terminated as Petitioner was not turning in job sheets, not following up with employers, and not applying for driving positions. T.207.

10. Ms. Kniaz testified that it was her opinion that Mr. Kirby was not following up with all the job leads in a timely manner. He was not turning in his job contacts as instructed. He was only completing online applications and not making in person visits to employers. He did not turn in any job logs or job contact sheets during the first two meetings on September 13, 2012 and October 9, 2012. She wanted Petitioner to perform cold calls and in person visits; however, she never physically went with him to do a cold call. T.118.

11. Ms. Kniaz testified that Petitioner continued to look for work despite his benefits having been terminated.

12. Ms. Kniaz sent Dr. Bernstein a letter on January 2, 2013 seeking clarification of Petitioner's work restrictions. T.128.

13. On January 10, 2013, Dr. Bernstein authored a letter to Ms. Kniaz stating that Petitioner had permanent 50 pound lifting restrictions. His restriction also included no repetitive bending, lifting or twisting and the ability to change position as required. He was doubtful that Petitioner could participate in any prolonged driving activity. Driving up to an hour was certainly reasonable. PX. 9.

14. Petitioner's benefits were re-instated on January 21, 2013. T.25. They discussed vocational training and that he needed computer skills. T.26. Petitioner noted that Triune would contact Liberty Mutual to get the funds for the computer classes. T.30.

15. Ms. Kniaz testified that she did not have any issues with Petitioner's job sheets after the re-instatement. They discussed computer classes offered at Wright College. T.123. She was going to provide the information regarding the computer training to Liberty Mutual for approval. She asked the Petitioner to go to Wright College to learn more about the computer classes. T.176. Petitioner testified that he never went to Wright College.

16. Petitioner testified that Triune never developed a plan as to how he was going to progress through vocational rehabilitation. T.16. He stated that he looked for jobs on Career Builder and Monster. He made a couple phone calls and did stop in at places. T.17.

Triune never performed vocational testing and never tried to determine his employment abilities. T.18.

17. Ms. Kniaz testified that she found a lead with Progressive Truck Driving School. She set up an interview between Petitioner and Pete Catizone for a Commercial Driving Instructor for February 7, 2013. Mr. Catizone wanted someone with computer skills and that person should be up to speed with Power Point. T.135. The position also had a $10,000.00 penalty if he left within two years. T.137. She never obtained approval from Liberty Mutual regarding the $10,000 fee.

18. Mr. Catizone testified that the interview with Petitioner went well. He offered him the position. T.247. He needed to pass a test, be fingerprinted and produce his transcripts. T.247. Ms. Kniaz stated the starting salary was $16.50 per hour. T.139. Mr. Catizone testified that the process usually takes two weeks to complete, but it took the Petitioner much longer. T.248.

19. Petitioner testified that he requested his high school transcripts and received an envelope 3 weeks later. He did not open the envelope as he assumed they were his transcripts. When he did open the envelope, it was another application for transcripts. He finally received his transcripts 2 weeks thereafter. T.36. He then obtained his fingerprints and passed the exam in April 2013. *Id.*

20. After Mr. Kirby obtained all the necessary paperwork, he contacted Mr. Catizone who had him report to the Belmont Center for training. Petitioner testified that he was never provided with Power Point training and never heard whether UPS would pay the $10,000 penalty. T.42.

21. Ms. Kniaz learned on April 22, 2013 that Progressive was not going to hire Petitioner. She noted that Petitioner was actually hired, but terminated when he did not complete the training in a timely fashion. T.142. He took too long to obtain his transcripts, was late to training on one occasion, left early once, and did not show up one day. T.143. They gave the position to someone who completed the job training in a timely fashion. T.150. Mr. Catizone testified that Petitioner would have been hired had he completed the training. T.251.

22. Petitioner stated that he got a call from Progressive on a Saturday morning to go to the Lansing Center. He was 15 to 20 minutes late as he had never been to that location. T.44. He was watching the instructor and when he returned from lunch the instructor left. He and 3 other students remained in the classroom until 2 p.m. He then went to the front desk and asked them to call the owner. There was no answer, so he left. T.47.

23. Petitioner testified that he missed three days of training due to an upper respiratory infection. He reported his illness to Mr. Catizone who told him not to worry about it and

come back when he felt better. T.49. No position was available when he completed the training. Petitioner's benefits were terminated on April 24, 2013. PX.13.

Awards for vocational rehabilitation are granted pursuant to Section 8(a) of the Act, which provides, in pertinent part, that an employer shall compensate an injured employee "for treatment, instruction and training necessary for the physical, mental and vocational rehabilitation of the employee..." 820 ILCS 305/8(a). The determination of whether a claimant is entitled to an award of vocational rehabilitation benefits is a question to be decided by the Commission, and its finding will not be reversed unless it is against the manifest weight of the evidence. *National Tea Co. v. Industrial Comm'n*, 97 Ill. 2d 424, 426, 454 N.E.2d 672, 73 Ill. Dec. 575 (1983); see also *Vestal v. Industrial Comm'n*, 84 Ill. 2d 469, 473-74, 419 N.E.2d 897, 50 Ill. Dec. 629 (1981). In resolving such a question, it is the function of the Commission to judge the credibility of the witnesses, resolve any conflicts in the testimony, and draw reasonable inferences from the evidence presented. *Sisbro, Inc. v. Industrial Comm'n*, 207 Ill. 2d 193, 207, 797 N.E.2d 665, 278 Ill. Dec. 70 (2003); *O'Dette v. Industrial Comm'n*, 79 Ill. 2d 249, 253, 403 N.E.2d 221, 38 Ill. Dec. 133 (1980). Section 8(a) of the Act permits an award of maintenance benefits while a claimant is engaged in a prescribed vocational rehabilitation program. *Greaney v. Industrial Comm'n*, 358 Ill. App. 3d 1002, 1019, 832 N.E.2d 331, 295 Ill. Dec. 180 (2005); *Connell*, 170 Ill. App. 3d at 55.

The Commission finds that the alleged job offer from Progressive Truck Driving School was not a bona fide offer of employment. Mr. Catizone testified that the position was contingent upon Petitioner obtaining his high school transcripts, obtaining his fingerprints, passing a written test, and completing the training course. Further, Ms. Kniaz testified that the employer wanted the prospective employee to be familiar with Power Point. It was Mr. Catizone's opinion that this process would take two weeks to complete.

Mr. Kirby testified that he encountered an issue obtaining his high school transcripts. Mr. Catizone confirmed that Petitioner mentioned to him that he had an issue obtaining his transcripts. The Petitioner ultimately obtained his transcripts, passed the written test, obtained his fingerprints and then presented for training. Despite the delay, Petitioner was allowed to begin his training.

Petitioner was informed at some point during the training that he would no longer be allowed to continue the training course. Mr. Catizone testified that it was the owner who terminated the Petitioner's training due to personnel issues. Mr. Catizone further testified that the other instructors informed him that Petitioner left early, arrived late, and did not show up to class. However, Mr. Catizone testified that he did not know why the Petitioner did not complete the training process as he was not there. The Commission does not find Mr. Catizone's testimony persuasive and finds that it is riddled with inadmissible hearsay.

The Commission finds no evidence to support that Petitioner was offered employment with Progressive Truck Driving School. First, Mr. Catizone could not recall how much the

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Petitioner was going to be paid. Second, Petitioner was not paid by Progressive for his time to attend the training. Third, the Commission is trouble by the fact that, if this was a legitimate job offer, why then was the same position offered to another person? Fourth, the Petitioner was required to agree to pay a $10,000.00 bond that would be forfeited should he leave Progressive's employ within two years of his hire. The Petitioner refused to agree to that condition and Respondent never indicated whether or not it would accept liability for the bond. Furthermore, the evidence establishes that Mr. Kirby was not familiar with Power Point and that Respondent did not provide computer training to Petitioner. Petitioner did not meet one of the basic skills necessary for the position.

As suggested above, Catizone's testimony was fraught with hearsay. He testified as to the thoughts of others. He testified as to comments of others and their personal assertions to him. He testified that others were familiar with Petitioner's problems and claimed no personal knowledge of the issues that arose during the Petitioner's attempt to complete the Progressive training regimen. Finally, the Commission notes that Catizone was paid in excess of $300.00 to appear and testify at the hearing on this claim. This is not the usual and customary fee for attendance.

It is this testimony that is most troubling to the Commission. Though the Petitioner was not always forthright in his answers on cross examination, his condition of ill-being is not in question. His physical limitations are well documented and preclude him from returning to the heavy work that he previously performed. He is not a star participant in the vocational rehabilitation process. Had he been the recipient of a bona fide job offer, the outcome of this litigation would have been far different.

Based on the totality of the evidence, the Commission finds that a bona fide job offer was not extended to the Petitioner. As such, the Commission finds that the Petitioner is entitled to re-instatement of vocational rehabilitation. Petitioner is also entitled to maintenance benefits from April 25, 2013 through January 16, 2014.

IT IS THEREFORE ORDERED BY THE COMMISSION, that the Decision of the Arbitrator filed on March 24, 2014, is hereby reversed.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay to the Petitioner the sum of $1,084.82 per week for a period of 49-5/7 weeks, from November 28, 2012 through January 20, 2013 and from April 25, 2013 through January 16, 2014, that being the period of maintenance under §8(a), and that as provided in §19(b)/8(a) 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 is hereby ordered to provide vocational rehabilitation services to the Petitioner via a certified rehabilitation counselor and Petitioner is hereby ordered to cooperate with the renewed vocational efforts.

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IT IS FURTHER ORDERED BY THE COMMISSION that Respondent be given a credit of $66,948.89 for TTD and $48,506.96 for maintenance benefits, for a total credit of $115,455.85.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner interest under §19(n) of the Act, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that this case be remanded to the Arbitrator for further proceedings consistent with this Decision, but only after the latter of expiration of the time for filing a written request for Summons to the Circuit Court has expired without the filing of such a written request, or after the time of completion of any judicial proceedings, if such a written request has been filed.

No bond is required for removal of this cause to the Circuit Court by Respondent. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: NOV 26 2014

MJB/tdm
O: 10/6/14
052

Michael J. Brennan

Thomas J. Tyrrell

Kevin W. Lamborn

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF 19(b) DECISION OF ARBITRATOR

KIRBY, BRIAN J
Employee/Petitioner

Case# **11WC022769**

14IWCC1029

UNITED PARCEL SERVICE
Employer/Respondent

On 3/24/2014, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.08% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

A copy of this decision is mailed to the following parties:

1911 EDWARD G SHENOO ATTORNEY AT LAW
4801 W PETERSON AVE
SUITE 305
CHICAGO, IL 60646

2461 NYHAN BAMBRICK KINZIE & LOWRY PC
MARTHA GELY-KRUTO
20 N CLARK ST SUITE 1000
CHICAGO, IL 60602

STATE OF ILLINOIS)
)SS.
COUNTY OF COOK)

☐ Injured Workers' Benefit Fund (§4(d))
☐ Rate Adjustment Fund (§8(g))
☐ Second Injury Fund (§8(e)18)
☒ None of the above

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

BRIAN J. KIRBY,
Employee/Petitioner

Case # **11 WC 22769**

v.

14IWCC1029

UNITED PARCEL SERVICE,
Employer/Respondent

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **LYNETTE THOMPSON-SMITH**, Arbitrator of the Commission, in the city of **CHICAGO**, on January 16, 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 Maintenace benefits and additional vocational rehabilitation.

FINDINGS

On the date of accident, 1/27/2011, Respondent *was* operating under and subject to the provisions of the Act.

On this date, an employee-employer relationship *did* exist between Petitioner and Respondent.

On this date, Petitioner *did* sustain an accident that arose out of and in the course of employment.

Timely notice of this accident *was* given to Respondent.

Petitioner's current condition of ill-being *is* causally related to the accident.

In the year preceding the injury, Petitioner earned $73,225.29; the average weekly wage was $1,627.23.

On the date of accident, Petitioner was **51** years of age, *married* with **0** dependent children.

Respondent *has* paid all reasonable and necessary charges for all reasonable and necessary medical services.

Respondent shall be given a credit of $66,948.89 for TTD, $48,506.96 for maintenance, and $0 for other benefits, for a total credit of $ 115, 455.85.

Respondent is entitled to a credit of $0 under Section 8(j) of the Act.

ORDER

Respondent shall pay Petitioner maintenance benefits of $1,084.82 per week for 11 4/7 weeks, from November 28, 2012 through January 20, 2013 however; Petitioner has failed to prove, by a preponderance of the evidence, that he is entitled to maintenance benefits from April 25, 2013 through January 16, 2014 and none are awarded, pursuant to the Act b . Respondent has no responsibility to provide Petitioner with future maintenance benefits and vocational rehabilitation services.

Respondent shall be given a credit of $66,948.89 for TTD and $48,506.96 for maintenance benefits, for a total credit of $115,455.85.

No penalties or attorney fees under Section 16, Section 19(k) and Section 19(l) 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.

14IWCC1029

FINDINGS OF FACT

The disputed issues in this matter are; 1) the maintenance period; 2) maintenance arrearage; 3) future maintenance; and 4) vocational rehabilitation. *See*, AX1.

The petitioner was 51 years old at the time of the work accident on January 27, 2011. He had been employed by the Respondent for 23 years. He testified that on the date of the accident he was in Black River Falls, Wisconsin dropping his trailer to make a switch with another driver coming from Minneapolis, Minnesota, when he felt a pop in his back while bending over to pull the hook to release the trailer. Upon his return to Chicago, he sought treatment at the company clinic and was released to return working his regular duties.

On February 10, 2011, he was seen at Advocate Lutheran General Hospital for further treatment. He was referred to an orthopedist and under the care of Dr. Avi Bernstein; the petitioner underwent a lumbar laminectomy with bilateral L4-5 neural foraminotomies; and a revision posterior spinal fusion, at L4-5, on August 31, 2011. At his follow-up appointment, on December 1, 2011, Dr. Bernstein referred him to physical therapy. The petitioner completed a physical therapy program, followed by work conditioning.

The petitioner completed a functional capacity evaluation ("FCE") on March 15, 2012, at the request of Dr. Bernstein. After examining the petitioner and reviewing the FCE, Dr. Bernstein placed the petitioner on a fifty (50) pound, permanent, lifting restriction and his driving was restricted, pursuant to his FCE. On April 5, 2012, he was released from care and advised to follow-up on an "as needed" basis. (PX1).

The petitioner could not return to work as a feeder driver for the Respondent, due to his permanent restrictions; therefore, Liberty Mutual hired Triune Health Group to offer vocational rehabilitation services to the petitioner. Triune Health Group assigned Caroline Ward-Kniaz, as the petitioner's vocational consultant. (RX1).

Ms. Ward-Kniaz testified that she has been a vocational rehabilitation consultant for sixteen (16) years and that she is certified. She also testified that prior to meeting with the petitioner, she reviewed the medical records of Dr. Avi Bernstein, the FCE, the job description for a feeder driver, and the operative report from August 31, 2011. On May 31, 2012, she scheduled a meeting with the petitioner to conduct a vocational assessment. At this meeting, she asked the petitioner questions about his education level, social background, medical treatment, work history, military experience and hobbies. After the meeting, she completed a transferable skills analysis and completed her initial vocational rehabilitation report and plan. (RX1).

The petitioner testified that he met with Ms. Ward-Kniaz to discuss how the vocational rehabilitation process would work, that she drafted his resume, taught him how to apply for

jobs online and provided him with job leads. He also testified that she did not offer any formal training or have a vocational plan for him.

Both the petitioner and Ms. Ward-Kniaz testified that they continued to meet on a bi-weekly basis. At each meeting, Ms. Ward-Kniaz would provide the petitioner with additional job leads or contacts for employment opportunities, within his restrictions. The petitioner testified that he was unable to follow up on some of the leads provided, as these positions required driving.

Ms. Ward-Kniaz testified that the leads offered were within Dr. Bernstein's restrictions of no lifting over fifty (50) pounds and that Dr. Bernstein's restrictions did not limit Petitioner' ability to drive. Ms. Ward-Kniaz testified that it is customary to follow the treating doctor's assessment and restrictions over what is reported on the FCE, as the treating doctor has a better understanding of what the petitioner can and cannot do. The Arbitrator notes that the FCE's restrictions did include driving restrictions of approximately eight (8) minutes.

Ms. Ward-Kniaz testified that the petitioner was often difficult to reach and she had to go through his attorney to have him contact her. She further testified that she advised the petitioner to follow up on his online applications with phone calls. She testified that she warned the petitioner, on several occasions, regarding his lack of efforts with the vocational rehabilitation process. (RX2)

She further testified that petitioner failed to turn in job contact sheets on September 13, 2012 and October 9, 2012; and that he did not follow up on the job leads given to him on September 26, 2012. She also stated that in general, the petitioner failed to follow-up on all of the job leads provided, in a timely manner. She also testified she did not provide the petitioner with formal training because of his lack of interest in being re-trained; and based on her analysis, there were jobs that he was capable of performing, without formal training. Finally, she testified that she documented everything in her reports, which were sent to Petitioner's counsel and to Liberty Mutual Insurance Company. (PX5 & RX1) (Tr. pgs.95 & 165).

The petitioner testified that except for driving positions, he followed all of Ms. Ward-Kniaz instructions, i.e., that he applied for job opportunities online and made "cold calls." He further testified that he was always responsive and would call or email Ms. Ward-Kniaz immediately. On cross-examination, the petitioner testified that his e-mail account was "locked up for a few weeks" and he was not able to use it, and that once he had submitted an application online he did not always call the employers to follow-up, as he was instructed to do. The petitioner testified that on November 28, 2012, his maintenance benefits were terminated because Ms. Ward-Kniaz was not happy with his efforts.

Mr. Thomas Szarek, the claims manager for Liberty Mutual Insurance Company, testified over Petitioner's objection, that the decision to terminate Petitioner's maintenance benefits was his,

with the advice of legal counsel; due to Petitioner's non-compliance and subpar effort in the vocational rehabilitation process.

Ms. Ward-Kniaz testified that in an effort to assist the petitioner, she took it upon herself to contact Dr. Bernstein, on January 2, 2013; asking him to clarify the petitioner's work restrictions. Dr. Bernstein sent Ms. Ward-Kniaz a letter on January 10, 2013, with amended restrictions, which changed his restriction of very little driving, per the FCE, to driving up to one hour. On cross-examination, she testified that in her sixteen (16) years as a vocational counselor, she has never had to approach a doctor to clarify work restrictions because the Petitioners' attorneys always clarified any discrepancies. Based on the amended work-restrictions, Ms. Ward-Kniaz was given permission to resume vocational rehabilitation services for the petitioner. (Tr. 162).

The petitioner testified that his benefits were reinstated on January 21, 2013. The petitioner further testified that in February 2013, through the efforts of Ms. Ward-Kniaz, he was asked to interview for an in-classroom, driving instructor's position, with Progressive Truck Driving School ("Progressive"). He testified that he interviewed with Mr. Peter Catizone, lead instructor for Progressive, on February 7, 2013. According to the petitioner and Mr. Catizone, the interview went well. Mr. Catizone testified that he liked Petitioner's background and thought he would make a good instructor. Mr. Catizone further testified that during the interview he offered the petitioner the instructor position contingent upon the petitioner passing his state examination and completing the training. (T. 246).

The petitioner testified that in order to become an instructor he needed to take a drug test, pass a physical examination, obtain a copy of his high school transcripts, be digitally fingerprinted and pass the state examination. He also testified that he was required to have knowledge of Power Point and that he told Ms. Ward-Kniaz that he needed computer training.

The petitioner further testified that he passed the physical examination and drug test and that he sent a request for his high school transcripts. He testified that it took him five weeks to obtain the transcripts because when he received the envelope from his high school, he did not open it right away and when he did open it, it did not contain all of his transcripts and he had to request them again. He further testified that he could not take the state examination because there was a stop in his license, which took time to take care of. He testified that he passed the test in April of 2013 and began his training with Progressive. Petitioner also testified that he was late one day for training in Lansing, because he got lost; and that he left early one day because he was left by himself in the classroom, with nothing to do. Finally, he testified that he did not get the job of in-classroom instructor because another trainee finished the training ahead to him.

Ms. Ward-Kniaz testified that she contacted Wright College and provided the petitioner with the information regarding the computer courses. She asked him to go to the school to register, but

the petitioner failed to follow up. She also testified that when she spoke with Peter Catizone from Progressive, Mr. Catizone advised her that Ms. Gina Buda, owner of Progressive Truck Driving School, did not hire the petitioner because he did not complete the training process within a proper period. (RX1 & Tr. pgs. 142 & 176).

Ms. Ward-Kniaz further testified that after she had spoken with Mr. Peter Catizone she contacted the petitioner and his attorney. She further testified that she reported to Liberty Mutual; and that she had no input as to whether to terminated Petitioner's benefits.

Mr. Thomas Szarek testified that based on the information received from Ms. Ward-Kniaz, he terminated the petitioner's maintenance benefits as well as vocational rehabilitation assistance. (Tr. pg. 234).

On direct examination, Mr. Peter Catizone testified that he was surprised to see the petitioner still with them because of the length of time that had passed between his initial interview and the beginning of his training. He also testified that he had other positions available for the petitioner had he completed the training. Finally, he testified that Ms. Buda, the owner of Progressive, terminated the petitioner's training process, because of his lack of punctuality and failure to show up. (Tr. pg. 271).

The petitioner testified that his maintenance benefits were again terminated on April 25, 2013, and that no one asked for his side of the story. He also testified that he continued to independently look for work after the termination and that he had out-of-pocket expenses of approximately $200.00, for which he had not been reimbursed. Upon cross-examination, the petitioner testified that he did not have any documentation with him regarding his search for employment and that he never submitted receipts for reimbursement of out-of-pocket expenses. (Tr. pg. 79).

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CONCLUSIONS OF LAW

L. What temporary benefits are in dispute?

The Arbitrator finds that Petitioner failed to prove entitlement to maintenance benefits from April 25, 2013 through January 16, 2014 however; Respondent shall pay Petitioner maintenance benefits from November 28, 2012 through January 20, 2013.

The Arbitrator finds that there was confusion, by Ms. Ward-Kniaz, regarding the petitioner's work restrictions, as she was looking at the doctor's restrictions and not considering the petitioner's FCE results. While this is understandable, it seems as though this confusion led to her some of her frustration with the petitioner's actions of not following up on all of the leads that she had provided.

Although Petitioner testified that he followed up on all job leads given to him by Ms. Ward-Kniaz, except for those requiring driving, the records show that Petitioner failed to turn in job contact sheets on September 13, 2012 and on October 9, 2012, which accounted for over fifty (50) job leads. He also failed to call the employers to follow-up on his online applications, as requested.

On October 18, 2012, the petitioner was provided with seven additional job leads and was asked to follow-up with different prospective employers. He failed to do so. On October 23, 2012, he was asked to contact U.S. Freight Ways for a dispatcher position and again failed to follow-up.

The petitioner's benefits were reinstated on January 21, 2013, in a good faith effort by Liberty Mutual to give the petitioner another opportunity to obtain employment. Again, Ms. Ward-Kniaz met with the petitioner and his attorney and explained what was expected of him. Ms. Ward-Kniaz sent a letter to Petitioner's counsel after the meeting documenting those expectations.

On February 7, 2013, the petitioner interviewed and was offered a job as an in-classroom CDL instructor for Progressive Truck Driving School. This job was for a permanent, full time position paying $16.50 an hour. The petitioner only needed to obtain the proper documentation and complete the in-house training at Progressive. He failed to do so.

Mr. Peter Catizone testified that it usually takes prospective instructors about two weeks to complete the process of obtaining all proper documentation, passing the examination and completing the training. Therefore, the petitioner should have completed his training by the end of February 2013. During this time, he was receiving weekly maintenance benefits of $1,084.82. Per Petitioner's testimony, it took him over five weeks to obtain his high school transcripts.

Once the petitioner finally had his documents ready and had passed the examination, he only needed to complete the in-house training at Progressive. He failed to do so. Within his training period, he arrived to class late, left early one day and missed several days of training, due to illness.

"Where rehabilitation of the injured employee is ordered, there are boundaries which reasonably confine the employer's responsibility including the requirement that the claimant makes a good faith effort to cooperate in the rehabilitation effort." *National Tea Company v. Industrial Commission*, 97 Ill.2d 424, 454 N.E. 2d 672, 73 Ill. Dec. 575 and *Archer Daniels Midland Company v. Industrial Commission*, 138 Ill.2d 107, 115-16, 149 Ill. Dec 253 (1990).

The Arbitrator finds that not only did the petitioner fail to show a sense of urgency, in obtaining the new position, he failed to make a good faith effort to cooperate in the rehabilitation process. Therefore, he is not entitled to maintenance benefits from April 25, 2013 through January 16, 2014, the date of hearing; however, because of the understandable confusion, regarding his work restrictions, the petitioner is awarded maintenance benefits from November 28, 2012 through January 20, 2013.

O. Is Petitioner entitled to additional vocational rehabilitation services?

The Arbitrator finds that Petitioner failed to prove, by a preponderance of the evidence, that he is entitled to future vocational rehabilitation services.

In this case, the petitioner was provided vocational rehabilitation services as soon as it became apparent he could not return to his job as a feeder driver for UPS. The petitioner testified that he met bi-weekly with Ms. Ward-Kniaz beginning on May 31, 2012 and that she provided him with substantial job leads at every meeting, drafted his resume, made contact with potential employers, trying to place him in a full time position within his restrictions; even though he was not totally compliant with the process.

Through Ms. Ward-Kniaz's efforts and assistance, Petitioner interviewed for the position of an in-classroom commercial truck driver instructor with Progressive Truck Driving School, which from testimony, was his for the taking.

On February 7, 2013, Petitioner interviewed with Mr. Peter Catizone and was offered the position of in-classroom instructor, contingent on him completing his training. Ms. Ward-Kniaz and Mr. Catizone testified that this position paid $16.50 an hour and was for a full-time, permanent position. All witnesses testified as to the requirements of the process, which included passing a physical examination, digital fingerprinting, obtaining a copy of his high school transcripts, passing the state examination and completing the in-house training at Progressive.

Mr. Catizone testified that it takes his prospective instructors approximately two weeks to complete the process of obtaining all proper documentation, passing the examination and completing the training. Per Petitioner's own testimony, it took him over five weeks to obtain his high school transcripts.

Although it took Petitioner, three times as long as other prospective instructors to complete the documentation process, Progressive gave him the opportunity to complete the training. Per Mr. Catizone's testimony, the petitioner was scheduled for a week of training, but only showed up twice that week. Petitioner testified that he became ill and could not attend all of the sessions. On another occasion, the petitioner was scheduled to report to the Lansing location at 8:00 a.m., but did not show up until 8:30 a.m. He testified that he did not know his way around Lansing and got lost. Petitioner was also requested to stay at class until 4:00 p.m., but left at 2:00 p.m. He testified that he left because he was in the training classroom by himself, with no instructor and nothing to do. There was also testimony that he did not attend another training session on a Saturday at the Belmont location. The petitioner testified that he was ill and could not attend.

The petitioner further claimed that he did not get the job because another trainee finished the training first. Mr. Peter Catizone testified that the job was the petitioner's to lose and that he had positions available "all day for many different things"; and that the owner did not want the petitioner to continue to train, as she did not like his performance during training.

The record shows that Petitioner was offered a full-time, permanent position paying $16.50 an hour which demonstrates Petitioner had sufficient skills to obtain employment, without further training or education. The evidence also shows that this position was lost due to the petitioner's lack of diligence in pursuing it. Therefore, the Arbitrator finds Petitioner has failed to prove, by a preponderance of the evidence, that he is entitled to additional vocational rehabilitation services.

O. Is the Testimony of Peter Catizone admissible?

The Arbitrator finds that there is no basis to sustain Petitioner's counsel's objection with regards to the testimony of Mr. Peter Catizone, because he did not receive notice of this witness by subpoena.

Neither Section 16 of the Workers' Compensation Act or Section 7030.50 of the Rules Governing Practice Before the Illinois Workers' Compensation Commission requires that notice be given to opposing counsel, when a party issues a subpoena for a witness.

Furthermore, as stated by the Arbitrator in the case of *Charles Szymczak v. Edmar Heating & Cooling*, 2010 Ill. Wrk. Comp. LEXIS 522 "professional courtesy suggests that notice of subpoena be given to the opposing party. For the reasons stated above the Arbitrator overrules

Petitioner's counsel objection to the testimony of Mr. Peter Catizone and the testimony is admitted into evidence.

M. Should penalties or fees be imposed upon Respondent?

Section 19(k) of the Illinois Workers' Compensation Act states that "[i]n cases where there has been any unreasonable or intentional underpayment of compensation, or proceedings have been instituted or carried on by the one liable to pay the compensation, which do not present a real controversy, but are merely frivolous or for delay, then the Commission may award compensation additional to that otherwise payable under this Act equal to 50% of the amount payable at the time of such award.

Section 19(l) of the Act states that "[i]f the employee has made written demand for payment of benefits under Section 8(a) or Section 8(b), the employer shall have 14 days after receipt of the demand to set forth in writing the reason for the delay. In case the employer or his or her insurance carrier shall without good and just cause fail, neglect, refuse or unreasonably delay the payment of benefits under Section 8(a) or Section 8(b), the Arbitrator or the Commission shall allow to the employee additional compensation in the sum of $30.00 per day for each day that the benefits under Section 8(a) or Section 8(b) have been so withheld or refused, not to exceed $10,000.00. A delay in payment of 14 days or more shall create a rebuttable presumption of unreasonable delay.

Section 16 of the Act states that "[w]henever the Commission shall find that the employer, his or her agent, service company or insurance carrier has been guilty of delay or unfairness towards an employee in the adjustment, settlement or payment of benefits due such employee within the purview of paragraph (c) of Section 4 of this Act; or has been guilty of unreasonable or vexatious delay, intentional under-payment of compensation benefits, or has engaged in frivolous defenses which do not present a real controversy, within the purview of the provisions of paragraph (k) of Section 19 of this Act, the Commission may assess all or any part of the attorney's fees and costs against such employer and his or her insurance carrier.

The Arbitrator finds the Respondent acted reasonably and in good faith during its handling of this claim, and finds further that the petitioner did not make penalties or attorney's fees disputed issues on the request for hearing form. The Arbitrator does not find Respondent's actions to be vexatious or unreasonable therefore, the petitioner's request for fees and penalties is denied.

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ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
11WC22769
SIGNATURE PAGE

Signature of Arbitrator

March 24, 2014
Date of Decision

MAR 24 2014

STATE OF ILLINOIS)
) SS.
COUNTY OF)
MADISON

☐ Affirm and adopt (no changes)	☐ Injured Workers' Benefit Fund (§4(d))
☐ Affirm with changes	☐ Rate Adjustment Fund (§8(g))
☒ Reverse	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☐ Modify ☐	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

KEVIN KLEIN,

Petitioner,

vs. NO: 12 WC 21780

DYNEGY MIDWEST GENERATION, **14IWCC1030**

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of accident, causal connection, medical expenses, temporary total disability and permanency, and being advised of the facts and law, reverses the Decision of the Arbitrator, for the reasons stated below.

On May 29, 2012, the Petitioner testified that he was working while on scaffolding. He stated: "It was a perforated scaffold surface, and I had to check the bolting on four control valves, and in order to do that, I had to get on my knees because the control valves come up and over". He had to be on his knees because there is no room to stand under the valves. He testified further: "I had to squat down and actually crawl behind the control valves to check the bolting to see if they were bolted up, if the bolts were tight." At that point he felt pain and said he knew he had injured his right knee.

Petitioner had pain and swelling, reported it and initially tried to work through it. Petitioner was able to work that week and went on vacation the following week. Petitioner had increased pain, informed Respondent and sought medical attention with Dr. Mark Eavenson, who was concerned about a meniscus tear and prescribed an MRI.

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Petitioner was referred to and saw Dr. George Paletta on June 25, 2012. Dr. Paletta stated in his medical records that the "[Petitioner] had climbed up to a fair height at that point to inspect some scaffolding, where there were some valves. He was trying to figure out what tools he might need to deal with that particular project. As he got up to this scaffolding, it was the type where there were some perforations with some prominent pieces of metal or nipples. As he went to kneel down to inspect this area of work, he went to kneel on the right knee and felt pain." An MRI showed a meniscus tear and he was referred for further orthopedic evaluation. Following exam and review of films, Dr. Paletta diagnosed a medial meniscus tear and mild MCL strain, and prescribed surgery. He noted that the MRI was "suggestive of a more acute tear. There does not appear to be a lot of intrameniscal signal abnormality suggestive of a degenerative component." He also noted a question of a small osteochondral defect at the posterior tibial plateau. Dr. Paletta performed arthroscopic right knee surgery on July 31, 2012 involving a partial medial meniscectomy. Dr. Paletta opined the tear was causally related to the described May 29, 2012 accident.

The Arbitrator found that the accident was not a compensable accident because the Petitioner failed to prove that Petitioner was at a greater risk than the general public and therefore the injury did not "arise out of employment". In the recent case *Don Young v. Industrial Comm'n*, IL App 4th 130392WC (2014), issued by the Illinois Appellate Court, three categories of risk to which an employee may be exposed were described (neutral, personal and employment-associated). The court stated that a neutral risk does not generally arise out of employment unless the employee is exposed to said risk to a greater degree than the general public.

While we agree with the Arbitrator that kneeling down would generally be considered a neutral risk, we find that the activity in which Petitioner was involved in on May 29, 2012 was an employment-associated risk. Petitioner was checking the bolts on four control valves on a metal scaffolding with a perforated metal surface. Petitioner had to kneel down and crawl under the valves in order to perform this duty. The confined space, corrugated floor, and unique activity that Petitioner was performing resulted in a level of risk to his knee greater than that to which the general public is typically exposed to. Therefore, the injury that occurred on May 29, 2012 did arise out of Petitioner's employment with Respondent. We also find the testimony of Dr. Paletta to be persuasive with regard to the acute nature of the tear in the right knee, and thus rely on his opinion that the Petitioner's right knee condition is related to the May 29, 2012 accident.

Finding both accident and causation for the May 29, 2012 accident, medical expenses should be awarded in this case. Petitioner is entitled to the medical expenses submitted into evidence within Petitioner's Exhibit 11 which are related to the right knee injury sustained on May 29, 2012. It should be noted that the hearing before the Arbitrator included an additional and separate accident date and injury, and any medical expenses within Petitioner's Exhibit 11 related to the consolidated claim are not awarded and are addressed in the decision issued in that case, 12 WC 19385.

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With regard to total temporary disability (TTD), Respondent indicated on the record that it was not disputing the period of TTD claimed by Petitioner, just its liability for same. Therefore, TTD should be awarded for the stipulated period following the May 29, 2012 injury, June 11, 2012 through September 4, 2012, a total of 14-6/7 weeks.

According to Section 8.1(b) of the Act, for injuries that occur after September 1, 2011, in determining the level of permanent partial disability, the Commission shall base its determination on the following factors:

1) The reported level of impairment pursuant to the AMA Guidelines;
2) The occupation of the injured employee;
3) The age of the employee at the time of the injury;
4) The employee's future earning capacity; and
5) Evidence of disability corroborated by the treating medical records.

1) The reported level of impairment pursuant to the AMA Guidelines.

The parties did not provide an impairment rating for the right knee. As such, this factor does not influence the permanent partial disability determination.

2) The occupation of the injured employee.

Petitioner worked as a welder/mechanic for Respondent. As part of his job duties, Petitioner must kneel down and squeeze into confined spaces in order to perform his responsibilities as a welder/mechanic. His position requires him to be on his feet often and use his knee throughout the day. Therefore, this injury has impacted his job in a more significant way than it would have impacted, for example, a worker who performed a seated job.

3) The age of the employee at the time of the injury.

Petitioner was 53 years old at the time of his injury and will likely be employed for quite a few more years with a surgically repaired right knee.

4) The employee's future earning capacity.

Petitioner did not submit evidence to demonstrate that his future earning capacity was affected in any way by the injury and so this factor also does not influence the disability determination.

5) Evidence of disability corroborated by the treating medical records.

All of the medical evidence supports that Petitioner suffered a compensable work injury on May 29, 2012. Petitioner sought medical treatment shortly after his accident. Petitioner was seen by Dr. Paletta on June 25, 2012 and was diagnosed with a posterior horn tear of the medial meniscus, which was repaired. Petitioner testified he was improved following surgery, but still had some weakness and pain depending on the weather. Dr. Paletta noted the part of the knee that was not operated looked good without significant degenerative changes. Petitioner returned

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to his regular work duties without restrictions. Post-operative examination after 8 weeks post-surgery was essentially normal.

Based on the five factors outlined in the Act, we find that Petitioner is entitled to 17.5% loss of the right leg. He sustained an acute partial medial meniscus tear, which was repaired, and following rehabilitation, Petitioner failed to report any major issues. While he still experiences weakness in his right knee, has trouble lifting himself up, and pain with certain weather, his final examination was normal and he has continued to work in the same job as he had before the accident with no evidence of a diminution of wages.

While the Petitioner's Petition for Review indicates "credit" as an issue on appeal, a review of the transcript (Tr. 4-5) and Request for Hearing (Arbitrator's Exhibit 1) indicates that the parties stipulated to Respondent's entitlement to credit under Section 8(j), as well as for prior TTD/TPD and salary continuation benefits. As such, we affirm the Arbitrator's findings regarding credit to Respondent. However, it should be noted that Respondent is only entitled to credit within case 12 WC 21780 for payments made prior to hearing that are related to case 12 WC 21780. Respondent is not entitled to credit within case 12 WC 21780 for benefit payments made prior to hearing with regard to the consolidated case of 12 WC 19385.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Arbitrator's decision is reversed as stated herein.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $1,009.12 per week for a period of 14-6/7 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 $695.78 per week for a period of 37.625 weeks, as provided in §8(e) of the Act, for the reason that the injuries sustained caused the 17.5% loss of the right leg.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner all reasonable and necessary medical expenses submitted as part of Petitioner's Exhibit 11 that are causally related to the May 29, 2012 right knee injury, per the Fee Schedule under §§8(a) and 8.2 of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner interest under §19(n) of the Act, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall have credit for all amounts paid, if any, to or on behalf of Petitioner on account of said accidental injury.

14IWCC1030

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $60,300.00. 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: NOV 26 2014
TJT: pvc
O: 09/29/14
51

Thomas J. Tyrrell

Michael J. Brennan

Kevin W. Lamborn

STATE OF ILLINOIS)
) SS.
COUNTY OF MADISON)

☒ Affirm and adopt (no changes)	☐ Injured Workers' Benefit Fund (§4(d))
☐ Affirm with changes	☐ Rate Adjustment Fund (§8(g))
☐ Reverse Choose reason	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☐ Modify Choose direction	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Kevin Klein,

Petitioner,

vs.

NO: 12 WC 19385

14IWCC1031

Dynegy Midwest Generation,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of accident, causal connection, medical expenses, temporary total disability, permanent partial disability, 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 February 2, 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.

14IWCC1031

The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: NOV 26 2014
TJT:yl
o 9/29/14
51

Thomas J. Tyrrell

Michael J. Brennan

Kevin W. Lamborn

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

KLEIN, KEVIN
Employee/Petitioner

Case# **12WC019385**
12WC021780

DYNEGY MIDWEST GENERATION
Employer/Respondent

14IWCC1031

On 2/3/2014, 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:

4463 GALANTI LAW OFFICES PC
DAVID GALANTI
PO BOX 99
EAST ALTON, IL 62024

0299 KEEFE & DePAULI PC
NEIL GIFFHORN
#2 EXECUTIVE DR
FAIRVIEW HTS, IL 62208

14IWCC1031

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

Kevin Klein
Employee/Petitioner

v.

Dynegy Midwest Generation
Employer/Respondent

Case # 12 WC 19385

Consolidated cases: 12 WC 21780

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Edward Lee**, Arbitrator of the Commission, in the city of **Collinsville**, on **December 27, 2013**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☒ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☐ What was the date of the accident?
E. ☐ Was timely notice of the accident given to Respondent?
F. ☒ Is Petitioner's current condition of ill-being causally related to the injury?
G. ☐ What were Petitioner's earnings?
H. ☐ What was Petitioner's age at the time of the accident?
I. ☐ What was Petitioner's marital status at the time of the accident?
J. ☒ Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. ☒ 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

14IWCC1031

On **9/6/11 & 5/29/12**, 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 **$78,711.36**; the average weekly wage was **$1,513.68**.

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 **$2,817.08** for TTD, $- for TPD, $- for maintenance, and **$11,472.47 as salary continuation** for other benefits, for a total credit of **$14,289.55**.

Respondent is entitled to a credit of **$20,115.71 in medical payments** under Section 8(j) of the Act.

ORDER

- Petitioner failed to prove a compensable accident as the bilateral knee injuries did not result from him being exposed to any risk greater than that to which the general public is exposed.
- As Petitioner failed to prove an accident that arose out of his employment with Respondent, medical, Temporary Total Disability, and Permanent Partial Disability are denied as moot.
- As the Parties stipulated, Respondent is entitled to a credit of $2,817.08 in Temporary Total Disability, $11,472.47 in salary continuation, and $20,115.71 in total payment of medical bills under both Group Health Insurance and Workers' Compensation.

RULES REGARDING APPEALS Unless a party files a *Petition for Review* within 30 days after receipt of this decision, and perfects a review in accordance with the Act and Rules, then this decision shall be entered as the decision of the Commission.

STATEMENT OF INTEREST RATE If the Commission reviews this award, interest at the rate set forth on the *Notice of Decision of Arbitrator* shall accrue from the date listed below to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

Signature of Arbitrator

1/31/14
Date

FEB 3- 2014

14IWCC1031

FINDINGS OF FACT

Petitioner was an employee of Respondent on September 6, 2011, and also on May 29, 2012. Two injuries were filed with the Illinois Workers' Compensation Commission and consolidated at trial.

Petitioner testified that on September 6, 2011, he was working as a welder/mechanic and knelt down on grating to screw it down and felt a pop in his left knee. (Tr 11-12) He testified that he went to Dr. Lyndon Gross on October 14, 2011, and gave a slightly different history to Dr. Gross that on September 6, 2011, "he squatted down and felt a pop in his left knee." (Px7 at 7) Dr. Gross testified that he was unaware of any history of twisting, being in a rush, carrying anything, being in an awkward position, or stressing. (Px9 at 13) There was no evidence presented at trial to the contrary. According to Dr. Gross, Petitioner was doing nothing different at the time of the accident than an individual getting a box of cereal off the bottom shelf at a grocery store. (Px9 at 13-14) Petitioner testified that he gave Dr. Gross an honest explanation of the injury and that he felt Dr. Gross understood what happened. (Tr 19) Petitioner underwent a left knee medial meniscus repair on October 26, 2011, with Dr. Gross. (Px8) He was ultimately released to full duty and placed at maximum medical improvement on December 8, 2011. (Px7 at 1) In his deposition, Dr. Gross admitted that other than knowing that Petitioner was a welder, he did not have any other information of his job activities. (Px9 at 16)

Petitioner went on to testify at trial that on May 29, 2012, he injured his right knee. (Tr 15) He stated that on this date he squatted on his knees to check bolting on control valves and felt the same sensation as when his left knee was injured. (Tr 15-16) Petitioner did not seek medical treatment and went on vacation. (Tr21) Petitioner came under the care of Dr. George Paletta on June 25, 2012. On this date he gave a history of being on scaffolding inspecting valves and trying to figure out what tools might be necessary for the job, when "he went to kneel down to inspect this area of work, he went to kneel on the right knee and felt pain." (Px8 at 6) Dr. Paletta testified that there was no history of a twist, fall, physical stress, being in a rush, or carrying tools at the time of the onset. (Px3 at 13-14) In his deposition, Dr. Paletta stated he imagined the onset to come about from being in the same body position as someone at the grocery store trying to get cereal off the bottom shelf. (Px3 at 14) Petitioner testified that he gave Dr. Paletta an honest explanation of the injury and that he felt Dr. Paletta understood what happened. (Tr 20) Petitioner underwent a right knee medial meniscectomy by Dr. Paletta on July 31, 2012, and was released from care at full duty and maximum medical improvement on October 1, 2012. (Px2, Px1 at 2) The only time Dr. Paletta references Petitioner's occupation is in a passing comment in his initial exam report mentioning that he is a welder. (Px1 at 6)

On September 4, 2012, Petitioner was examined by Dr. Richard Lehman. Dr. Lehman recorded Petitioner's history of squatting down and feeling a pop in his left knee on September 6, 2011. (Rx1 at B-1) He recorded a similar history for the right knee of squatting down, with no rotational stress. (Rx1 at B-1) Dr. Lehman testified that the left knee condition was not caused by his work anymore than the normal activities of the general public. (Rx1 at 11-12) Concerning the right knee, Dr. Lehman was of the same opinion that the Petitioner was at no greater risk than the general public doing the activity that

caused the right knee to become symptomatic. (Rx1 at 13-15) Petitioner testified at trial that he felt Dr. Lehman understood the onset of his knee symptoms. (Tr 19-20)

Petitioner testified at trial that he had some residual aches with his bilateral knees and some perceived weakness, but was released to full duty work and had not sought medical treatment for either knee since being released from care. (Tr 14-15, 17-18)

With regard to "C", did an accident occur that arose out of and the in course of Petitioner's employment by Respondent?

To obtain compensation under the Act, Petitioner bears the burden of proving by a preponderance of the evidence that he has suffered a disabling injury that arose out of and in the course of his employment. Baggett v. Industrial Commission, 201 Ill.2d 187, 775 N.E.2d 908 (2002). "In the course of employment" refers to the time, place, and circumstances surrounding the injury. Lee v. Industrial Commission, 161 Ill.2d 77, 81, 656 N.E.2d 1084 (1995). It is not enough to simply show that an injury occurred during work hours or at the place of employment, but the injury must also "arise out of the employment". Parro v. Industrial Commission,167 Ill.2d 385, 393, 657 N.E.2d 882 (1995). The State of Illinois does not recognize the positional risk doctrine. Brady v. Louis Ruffolo & Sons Construction, 143 Ill.2d 542, 578 N.E.2d 921 (1991). If Petitioner is exposed to a risk greater than the general public, the injury is considered to have arisen out of the employment, but on the other hand if the Petitioner's exposure to risk is equal to that of the general public, the injury is not compensable. O'Fallon School District v. Industrial Commission, 313 Ill.App.3d 413, 416, 729 N.E.2d 523 (2000). In order to find that Petitioner's employment exposes him to a risk greater than that to which the general public is exposed, the hazards, dangers, or risks must be distinctive to the employment. Illinois Institute of Technology Research Institute v. Industrial Commission, 314 Ill.App.3d 149, 153, 731 N.E.2d 795 (2000). The injury does not arise out of the employment if the injury results from a hazard to which the employee would have been equally exposed to separate from the employment. Caterpillar Tractor Co. v. Industrial Commission, 129 Ill2d 52, 57, 541 N.E.2d 665 (1989).

Petitioner claims to have suffered a separate injury to his left and right knees. The onset of both conditions is similar and the claims were consolidated.

The totality of the evidence shows the left knee became symptomatic while he was squatting. The treating surgeon, Dr. Gross, was of the opinion that the onset of the left knee condition put the body in no different position than an individual getting an item off the bottom shelf at a store. There is no evidence of Petitioner being in a rush or carrying tools or equipment. There is no evidence of Petitioner physically stressing, falling, or twisting when his knee became symptomatic.

With regard to the right knee, the evidence yields that Petitioner was kneeling. The treating surgeon for this knee, Dr. Paletta, was of the opinion that the onset of the condition had the body in no different position than an individual getting an item off the bottom shelf of a store. There is no evidence of Petitioner being in a rush or carrying tools or equipment. There is no indication in the record that he was physically stressing, fell, or was twisting when he first noticed the right knee pain.

The medical records contain no evidence that Petitioner's job as a welder put him at a greater risk than the general public to suffer injuries to his knees. Other than a casual notation of Petitioner's job as a welder, there is no further mention in the treatment records or depositions of Drs. Paletta or Gross. Petitioner only mentions that he squats at work in a follow-up question to address his perceived lack of strength to lift himself out of a squatting position. (Tr 14) He does not describe his job in any way other than a brief mention of his job title as a welder/mechanic. (Tr 11)

Based upon the foregoing and the record as a whole, Petitioner has failed to prove a compensable accident, as the bilateral knee injuries did not result from him being exposed to any risk greater than that to which the general public is exposed.

With regard to "J", whether the medical services that were provided to the Petitioner were reasonable and necessary; with regard to "K", whether the Petitioner is entitled to any Temporary Total Disability Benefits; the Arbitrator finds the following:

Due to Petitioner failing to prove that either the left or the right knee injury was compensable under the Act, Petitioner's claims for payment of medical, Temporary Total Disability, and Permanent Partial Disability are denied as moot.

With regard to "N" whether the Respondent is due credit the Arbitrator finds the following:

The parties stipulated that Petitioner had received and Respondent is due credit for payment of $2,817.08 in Temporary Total Disability, $11,472.47 in salary continuation, and $20,115.71 in total payment of medical bills under both Group Health Insurance and Workers' Compensation. The Act sets forth in §8(b)7 that "The payment of compensation by an employer or his insurance carrier to an injured employee shall not constitute an admission of the employer's liability to pay compensation." Blocker v. Ford Motor Company, 06 W.C. 28418, 08 I.W.C.C. 1045, 2008 WL 4635521 (2008).