STATE OF ILLINOIS	)		
	) SS.		
COUNTY OF PEORIA	)		

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Heath Schaffer,
Petitioner,

vs. NO: 13 WC 26238

Emerald Performance Materials,
Respondent.

19IWCC0272

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 disease, temporary disability, permanent 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 April 24, 2018, 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: JUN 3 - 2019
o040419
BNF/mw
045

Barbara Flores

Deborah Simpson

Marc Parker

ILLINOIS WORKERS' COMPENSATION COMMISSION

NOTICE OF ARBITRATOR DECISION

SCHAFFER, HEATH
Employee/Petitioner

Case# **13WC026238**

EMERALD PERFORMANCE MATERIALS
Employer/Respondent

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On 4/24/2018, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.98% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

2217 SHAY & ASSOCIATES
TIMOTHY M SHAY
1030 DURKIN DR
SPRINGFIELD, IL 62704

0000 RUSIN & MACIOROWSKI LTD
R MARK COSIMINI
2506 GALEN DR SUITE 108
CHAMPAIGN, IL 61821-7047

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

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

HEATH SCHAFFER
Employee/Petitioner

v.

EMERALD PERFORMANCE MATERIALS
Employer/Respondent

Case # **13** WC **26238**

Consolidated cases: **N/A**

19IWCC0272

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Gerald Granada**, Arbitrator of the Commission, in the city of **Peoria**, on **March 15, 2018**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **7/18/10**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$83,832.84**; the average weekly wage was **$1,612.17**.

On the date of accident, Petitioner was **32** 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 for any short-term or long-term disability benefits it has paid to Petitioner to be off-set against any award rendered by the Arbitrator or the Commission by agreement of the parties.

ORDER

Petitioner failed to prove he sustained accidental injuries, which arose out of and in the course of his employment for Respondent. Therefore all benefits are denied.

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

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

Signature of Arbitrator

4/23/18
Date

APR 24 2018

FINDINGS OF FACT

This case involves a Petitioner alleging injuries due to an occupational disease sustained while working for the Respondent on July 18, 2010. Respondent dispute Petitioner's claims and the issues in dispute are: 1) accident, 2) causation, 3) medical expenses, 4) TTD, and 5) permanency.

Petitioner began working for Respondent in 2007. Respondent is a chemical plant which produces tire accelerants. Petitioner testified he was exposed to hydrogen sulfide gas. He described the safety equipment he utilized while working for Respondent. Petitioner testified they wore special uniforms consisting of a shirt and pants which were fire retardant and were resistant to chemicals. He also testified to wearing hard hats and gloves. Furthermore, Petitioner testified he wore respirators sometimes with supplied air and a "rattler." The rattler is a monitor which alerts the worker when the level of hydrogen sulfide gas increases to a certain number of parts per million. If the rattler is activated, the worker utilizes a respirator or a respirator with supplied air. The next step would be to detect the source of the leak. Petitioner testified he always wore a rattler, and it went off almost daily. He further testified that when he was around a chemical called toluene, he turned off the rattler because it always went off. Petitioner further indicated he was advised to silence the hydrogen sulfide alarm on the rattler, because it was not working right. Engineers came in and along with the maintenance workers could not find anything wrong and could not detect elevated concentrations of the chemical. Petitioner indicated this happened almost daily when they started using a new scrubber in the time period immediately before July 2010.

Petitioner also testified overhead lines would drip hydrogen sulfide, but he would not notice it until he removed his work clothes after his shift was over. Sometimes, the hydrogen sulfide would go through his sleeve. Petitioner would scrub it off during a post-work shower. Petitioner testified if he did not see the hydrogen sulfide on him, he would not be able to tell it was there.

With respect to the respirators, Petitioner testified they were full face. The workers routinely had fit tests for the respirators at the safety office. Petitioner indicated he wore a respirator if he was going to be exposed to chemicals or if he would be breaking lines, or if there was a strong smell.

Petitioner testified he worked in two different buildings. One building is referred to as the crude building and is numbered 711 on page three of Petitioner's Exhibit 24. Petitioner described the building as a big tin shed. The building is enclosed, and it contains two reactors, which are utilized to mix chemicals. The crude building is at least 100 feet long.

When asked about ventilation within the building, Petitioner testified there were ventilation fans, but they did not work. There was one working fan at the end of the building, which would draw everything from the building out. Petitioner also testified that they would sometimes raise the roll-up doors or open walk-through doors for additional ventilation. Petitioner testified he normally would not have to wear a respirator when inside the building, but if a chemical smell got strong, the workers would know there was a leak, and they would put on respirators. Petitioner testified he would use supplied air if entering a tank or if "breaking lines." When wearing a respirator, Petitioner testified that if the chemical smell was strong enough, he would still be able to smell it. He also explained if the respirator was functioning properly, he should not be able to smell any chemicals.

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Petitioner indicated there was an issue with leaking pipes in the crude building. They used a cinder block retaining wall around the tanks to contain leaks. Petitioner indicated there was always at least one thing leaking. Petitioner testified he was exposed to aniline, sulfur, toluene, and carbon disulfide. Petitioner's job duties as an operator required him to clean up some of the leaks. Petitioner indicated he has smelled several chemicals including carbon disulfide, hydrogen sulfide, toluene, and aniline. He also indicated hydrogen sulfide, toluene, and aniline got on his skin.

The second building described by Petitioner is known as the Nash building. The blueprint is contained on page two of Petitioner's Exhibit 24. Petitioner testified the Nash building is outside and open and is essentially a steel structure frame. Consequently, any exposures to chemicals would be in the open air. Petitioner described the chemical process as the Nash building being supplied with materials from the crude building. Petitioner ran reactors in the crude building, and the product would be sent to the Nash building. Petitioner also ran an extracting process at the end of the crude building, which would pump tar into trailers that were outside.

With respect to the work performed outside, Petitioner testified that during the winter, some lines would freeze. He testified to having to break the lines to free hydrogen sulfide sludge. The sludge could be splashed on a worker, and it could also be smelled. Petitioner testified he wore a respirator because the smell was terrible. Petitioner indicated when he finished working, he smelled like the chemicals and smelled like the crude building. He could not detect the smell after taking a shower, but he also indicated his bedsheets were stained with chemicals coming out of his pores. He did not know how frequently that occurred, but he testified it happened quite a bit.

When asked about his alleged accident on July 18, 2010, Petitioner testified he does not remember everything. He further acknowledged having a lot of memory loss. Petitioner recalled his rattler and hydrogen sulfide monitor went off on July 18, 2010. Petitioner remembered cutting a small branch off a tree and it striking him on the head. He testified there were no effects from that incident. Petitioner further testified he was not abusing alcohol at that time, but he had been a binge drinker. When asked about the episodes that led Petitioner to reporting to the emergency room on July 18, 2010, Petitioner testified that after having an incident at Emerald, he had to learn to walk and talk again. He also testified he would go 3-7 days where he did not remember anything. He was still functioning, but not in a proper way. At the time of trial, Petitioner was receiving treatment for depression and anxiety. He was no longer having any issues with walking.

Petitioner's medical treatment began July 21, 2010 when he reported to the St. Francis Medical Center emergency room. (Px.25) The history indicates Petitioner hit his head on a shed. He was described as having the appearance as though he was intoxicated. He was noted to have a bump on his head, and he demonstrated slurred speech. The emergency room diagnosis was a post-traumatic headache. The doctor thought the symptoms were likely secondary to a combination of sleep deprivation and the recent head trauma. A neurological exam performed at St. Francis Medical Center revealed a past medical history of alcoholism and a concussion when in high school. The history also indicates Petitioner hit his head on a shed, and he fell and hit his head 10-15 times both on ground level and when falling off a 7-foot ladder. Petitioner's wife advised that Petitioner drank close to a case of beer and took some of her pills. She indicated a whole bottle of Klonopin was missing. Petitioner was discharged from the hospital July 23, 2010. (Px.25)

On July 26, 2010, Petitioner reported to the Methodist Medical Center emergency room. (Px.33) The history indicates Petitioner experienced multiple falls as well as hallucinations. He reportedly fell two days earlier and

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hit his head and suffered a loss of consciousness. Petitioner's wife described Petitioner's behavior as consisting of almost manic episodes. Petitioner and his family indicated Petitioner developed his symptoms 2-4 days after his head injury. The doctor concluded the symptoms could potentially be explained by a concussive head injury.

Petitioner returned to the St. Francis Medical Center emergency room July 29, 2010. His wife was concerned about possible mania. She reported Petitioner was not sleeping. Petitioner also fell 6 or 7 times since being discharged from the hospital several days earlier.

On August 3, 2010, Petitioner's wife called their family physician, Dr. Riech, requesting a note to keep their electricity on because Petitioner could not be hot. Additionally, she told Dr. Riech they needed the lights on so Petitioner did not fall. On August 4, 2010, Dr. Riech noted Petitioner was confused because of sleep deprivation. He did not think there was any type of thought disorder. Dr. Riech also noted that he did not see where toluene causes manic behavior, but it could explain confusion and balance problems.

On August 6, 2010, Dr. Riech noted Petitioner was improving. However, there was a concern with a history of depression which could be from bipolar disorder as well as Petitioner being in the midst of mania. Both Petitioner and his wife expressed a concern about chemical exposure. Dr. Riech commented Petitioner's onset of symptoms was abrupt rather than gradual. Petitioner told Dr. Riech that his psychiatrist, Dr. Heritch, thought his altered mental status was more likely due to the effects of toxic chemical exposure. The records of the psychiatrist, Dr. Heritch, were not offered in evidence.

Dr. Riech referred Petitioner for an occupational consult to assess whether the chemical exposure was a causing event. Dr. Riech further commented the chemical of concern was toluene and Petitioner was also exposed to aniline. He also advised Petitioner to continue following up with psychiatry. (Px.30)

On August 20, 2010, Dr. Edward Moody, an expert in occupational medicine, evaluated Petitioner. Petitioner indicated he had no memory of the onset of his symptoms or of any events around that time. Petitioner denied the excessive use of alcohol. He told Dr. Moody he drank one or two times per month and had 8-10 drinks per time. Petitioner told Dr. Moody he did not recall any instances of a known chemical exposure or of any equipment malfunctions. On exam, Dr. Moody noted Petitioner's gait was essentially normal. He commented there was an unknown etiology of Petitioner's mental status impairment, ataxia, memory deficits, and behavior issues. He also noted a potential cause was exposure to carbon disulfide, but there was no documented history of an exposure to carbon disulfide. Dr. Moody recommended a neuropsychological evaluation to assess whether Petitioner was suffering from toxic encephalopathy.

On September 10, 2010, Dr. Nersesyan evaluated Petitioner at the Illinois Neurological Institute. (Rx.2) Dr. Nersesyan opined that Petitioner had no neurological deficits. He also noted the lab studies did not reveal any toxic exposure.

An EMG study performed on November 2, 2010 did not reveal any abnormalities. Dr. Riech noted Petitioner's condition was worsening the farther out they got from exposure to carbon disulfide. He expressed a concern that the exposure was not the cause of Petitioner's problems especially because Petitioner was suffering from depression and stress prior to the onset of symptoms in July 2010.

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A number of physicians at the University of Iowa evaluated Petitioner on November 23, 2010 and December 1, 2010. (Px.34) The records from the University of Iowa indicate that Petitioner advised Dr. Robert Jones, a neuropsychologist, that he had no recollection of the events from July 18, 2010 through early September 2010. Following his evaluation, Dr. Jones concluded there was little to no evidence of residual neuropsychological deficits from a possible chemical exposure. He diagnosed Petitioner with a reactive mood disturbance. Dr. Jones concluded there were no neuropsychological reasons to prevent Petitioner from returning to work.

Similarly, on December 1, 2010, Dr. Fuortes cleared Petitioner to return to work in January 2011. (Px.34) Dr. Sarvenaz Jabbari rendered an opinion Petitioner was suffering from a depressive psychosis that was exacerbated by factors such as financial stress, long work hours, sleep deprivation, and possible chemical exposure at work. It was recommended that Petitioner treat with a psychologist and undergo therapy focused on cognitive behavioral therapy.

On January 10, 2011, Petitioner returned to see Dr. Moody. (Rx.3) Dr. Moody described Petitioner's amnesiac episodes as bizarre. He indicated there was no objective evidence of an inability to return to work. However, Petitioner had not followed up with his psychiatric treatment, so Dr. Moody was not willing to say Petitioner was fit for work.

Petitioner was evaluated by Dr. Andrew Lancia, a psychiatrist, January 28, 2011. (Px.35) Dr. Lancia reviewed the notes from the University of Iowa and interpreted them to show they did not feel Petitioner's condition was due to a chemical exposure. Dr. Lancia noted the neuropsychological testing indicated Petitioner's symptoms and condition were secondary to a mood disorder with psychotic depression. Dr. Lancia diagnosed Petitioner with dissociative amnesia, probable bipolar disorder, and he could not rule out malingering.

On January 11, 2012, Petitioner was seen at the Methodist Medical Center emergency room for a psychological evaluation. He was diagnosed with bipolar disorder and dissociative amnesia.

On March 4, 2012, Petitioner was taken by ambulance to the St. Francis Medical Center emergency room after returning to his home from chopping wood. Petitioner was reportedly staggering, and he laid down on the floor, and his wife could not wake him. (Px.29) While at the hospital, a consult was performed by Dr. Theresa Regan, a neuropsychologist. Her note indicates Petitioner had past use of synthetic marijuana, which is known to be associated with the onset of psychotic disorders particularly in at-risk individuals. The history provided to Dr. Regan was that Petitioner "stopped" alcohol consumption five weeks earlier. Petitioner's wife indicated Petitioner would binge drink "like 30 plus beers once every couple months." He also experimented with drugs including marijuana and possibly cocaine. Dr. Regan indicated Petitioner was worked up for possible toxic exposure at Iowa, but the results were unremarkable. Dr. Regan concluded the cause of Petitioner's altered mental status was unclear, but the use of synthetic marijuana could be a causative factor for Petitioner's recurrent episodes.

Also while at the hospital, Dr. Bitar, a psychiatrist, performed a consultation. He diagnosed Petitioner with bipolar disorder, resolving altered mental status, and alcohol abuse. He recommended personality testing for Petitioner.

The consult by Dr. Wang in the St. Francis Medical Center neurology department resulted in a diagnosis of a likely psychiatric disorder. Another consult in the neurology department concluded Petitioner's altered mental

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status was not neurological but was more likely either psychological or malingering. It was noted Petitioner had a normal EEG study and a normal CT-scan. While being evaluated by a nurse practitioner in the neurology department, Petitioner's wife was insistent that Petitioner was having an episode, but the nurse indicated Petitioner was alert and appropriate.

On September 27, 2012, Petitioner told Dr. Riech that he would not go back to see Dr. Bitar. Dr. Riech refused to refill Petitioner's prescription for Clonazepam because he was concerned Petitioner was misusing the medication. On October 8, 2012, Dr. Riech noted that Dr. Bitar told Petitioner he thought Petitioner was lying. When Petitioner was evaluated by Dr. Riech November 16, 2012, Petitioner indicated he stopped all medications. He was still suffering from anxiety and depression.

On November 18, 2013, Dr. David Fletcher, an occupational medicine physician examined Petitioner at the request of his attorney. In contrast to the histories provided to all of the other doctors, Petitioner told Dr. Fletcher hydrogen disulfide alarms were going off all day July 18, 2010. However, Petitioner did not remember that day or anything from the next two months after that time. Dr. Fletcher opined that Petitioner's condition was causally related to carbon disulfide exposure. Dr. Fletcher testified via evidence deposition on September 2, 2016. (Px.1) Dr. Fletcher testified that in addition to this case, he has also reviewed a series of potential cases for other employees of the Respondent. Dr. Fletcher testified he did not believe several of the Respondent's workers had an occupational-related disease. (Px.1, p.5) When he first examined Petitioner, Dr. Fletcher remembered Petitioner had a very profound ataxia in that he had a very wide stance gait - as though Petitioner was intoxicated and had a lack of coordination. (Px.1, p.7)

Dr. Fletcher attributed some of Petitioner's complaints to his exposures in the workplace. He noted Petitioner had "foggy days" such that Petitioner could not remember an entire day. Dr. Fletcher noted that happened to Petitioner one to two times every two weeks. Dr. Fletcher believed Petitioner could be suffering from chronic encephalopathy with subtle long-term chronic brain damage.

Dr. Fletcher acknowledged Petitioner's comorbidities including the use of alcohol, synthetic marijuana use, and bipolar disorder. However, he also believed Petitioner's exposure to carbon disulfide and toluene were contributing to his conditions.

Dr. Fletcher acknowledged Petitioner's presentation at the emergency room July 21, 2010 was consistent with a recent head trauma. He also acknowledged Petitioner's presentation July 21, 2010 could also be consistent with chronic alcohol abuse. Finally, Dr. Fletcher acknowledged a combination of head traumas and alcohol abuse would make it more likely for Petitioner's presentation to be consistent with those causes. (Px.1, pp.38-39)

Dr. Fletcher also acknowledged that the history provided to him of hydrogen sulfide alarms going off July 18, 2010 was not contained in any of the other medical records. (Px.1, pp.39-40)

When asked about Petitioner's treatment in March 2012 at St. Francis Hospital, Dr. Fletcher indicated Petitioner's symptoms could be consistent with post-concussion issues following repeated falls and head traumas. He also indicated Petitioner acknowledged using synthetic marijuana and cocaine. Dr. Fletcher agreed cocaine and synthetic marijuana use can cause chronic neurotoxicity-type problems similar to those exhibited by Petitioner. (Px.1, pp.53-54)

Dr. John Koehler testified via evidence deposition September 13, 2016. (Rx.4) Dr. Koehler evaluated Petitioner in August 2015. (Rx.4, p.7) Petitioner provided a history of being off work and boating on July 13, July 14, and July 15, 2010. Petitioner indicated he had an accident where he was on a ladder helping to cut a tree branch when he was struck in the head by a branch. Petitioner also told Dr. Koehler that while working July 17, 2010, he smelled an unusual smell, but it was transient, and no one else was affected by it. (Rx.4, p.9) Petitioner's history also included that on July 20, 2010, he fell again, and on July 21, 2010, he called his wife indicating he was sick and was crying on the phone. That was when he went to the hospital. He reportedly vomited along the way. (Rx.4, p.10) Dr. Koehler pointed out that Petitioner told him he did not remember anything around the time period in question, but then he told Dr. Koehler that he did remember those things. (Rx.4, pp.10-11)

On exam, Dr. Koehler noted Petitioner did not have any symptoms, and he felt normal and was doing well. (Rx.4, p.20) Dr. Koehler also noted the neurologic exam was completely normal as was the physical exam. (Rx.4, p.21) Dr. Koehler diagnosed Petitioner with a history of psychiatric and neurologic complaints extending from 2010 through 2012. He thought the etiology was unclear, and he further explained the condition was due to a multiplicity of features including head trauma compounded by a history of alcoholism and psychiatric illness. (Rx.4, p.21) Dr. Koehler explained that his opinion was based upon the chronological history and also from a proximate cause standpoint. He noted Petitioner was struck in the head and was knocked unconscious and then fell repeatedly after that, and his presentation after that time was consistent with that history. (Rx.4, p.22)

In addition to Petitioner's testimony and the testimony of the two examining doctors, Petitioner presented the deposition testimony of David Smid. Mr. Smid testified by way of evidence deposition July 28, 2017. (Px.23) Mr. Smid testified to numerous leaks and generally poor conditions in Respondent's facilities. He testified to routine exposures to numerous chemicals.

Petitioner also submitted several exhibits consisting of Material Safety Data Sheets. Petitioner's Exhibit 4 is the MSDS sheet for hydrogen sulfide. The short-term potential health effects include among other things headaches, disorientation, hallucinations, and brain damage. The potential long-term health effects include among other things effects on the brain.

Petitioner's Exhibit 8 is the MSDS sheet for toluene. The chronic health effects identified include chronic lung dysfunction. Repeated and prolonged over-exposure can cause irreversible brain and nervous system damage.

Petitioner's Exhibit 9 is the MSDS sheet for carbon disulfide. The noted effects on humans can include organic brain damage, neurobehavioral dysfunction, and other possible effects. It is also noted to be a severe irritant of the eyes, skin, and mucus membranes. Chronic exposure to carbon disulfide can cause visual changes, gastrointestinal disturbances, and kidney and liver damage.

Petitioner's Exhibits 11 and 12 are EPA Quarterly Non-Compliance reports dated January 1, 2007 through June 30, 2007. The exhibits have a long list of incomplete/deficient report notifications. However, there is no indication the information contained in those exhibits have any direct relevance to Petitioner or Petitioner's conditions.

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Petitioner's Exhibit 13 is an EPA finding of violation based upon Respondent's failure to perform monthly monitoring of valves, failing to cap open-ended lines, and failing to identify leaks July 23, 2009.

Petitioner's Exhibit 15 is a Compliance Certificate report from Respondent to the Illinois EPA. No evidence was presented suggesting that exhibit has any relevance to this case.

Petitioner's Exhibit 16 is a Consent and Agreement Order from the EPA. Respondent agreed to pay a fine in the amount of $158,000.00. The fine was for failing to immediately report releases of carbon disulfide and hydrogen sulfide into the atmosphere. The discharge of the chemicals occurred July 25, 2009, and Respondent did not report the discharge until July 27, 2009 for carbon disulfide and July 28, 2009 for hydrogen sulfide. No evidence was presented suggesting Respondent's delays in reporting the releases of chemicals contributed to Petitioner's conditions.

Petitioner's Exhibit 20 is a letter from the National Institute for Occupational Safety and Health to Respondent and is dated March 19, 2013. The letter documents an on-site evaluation of Respondent's facilities in conjunction with an open meeting with managers and union representatives to discuss the requests for the health hazard evaluation. The letter indicates current workers were interviewed about their work history, medical history, and work-related symptoms. Industrial hygiene sampling was performed and medical records were reviewed. Additionally, Respondent's written respiratory protection and hazard communication programs as well as accident reporting procedures were all reviewed. The on-site evaluation also included air sampling. The conclusions from the on-site evaluation were that the concentrations of several chemicals including toluene were low or non-detectable.

Petitioner's Exhibit 22 is a comprehensive report from the U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, and the National Institute for Occupational Safety and Health. The report is dated June 2014. The report documents a health hazard evaluation that was requested by the Union. Additionally, Dr. Fletcher indicated in his deposition testimony that he recommended the health hazard evaluation. The evaluation included reviewing the crude production and potential exposures to aniline, carbon disulfide, and hydrogen sulfide. Additionally, toluene was utilized during the crude process. The evaluation included interviewing 10 of the employees working at the time, reviewing OSHA logs of work-related injuries and illnesses and workers' compensation claims for the years 2010, 2011, and 2012. Air sampling records and facility procedures were reviewed, as were medical surveillance records for the workers. The evaluators also performed an extensive literature search for information regarding the predominant chemicals to which the employees could be exposed. The evaluation also included air sampling and surface sampling. The evaluators concluded that all airborne exposure levels that were measured were well below occupational exposure limits except for OTOS exposure to employees involved in the bagging process. There is no evidence that Petitioner was involved in the OTOS bagging process.

CONCLUSIONS OF LAW

1. With regard to the issues of accident and causation, the Arbitrator finds that the Petitioner failed to meet his burden of proof. In support of this finding, the Arbitrator relies on the testimony and medical evidence presented. This case was filed under the Occupational Diseases Act. An occupational disease is a disease arising out of and in the course of employment. A disease shall be deemed to arise out of the employment if there is apparent to the rational mind, upon consideration of all of the circumstances, a causal connection

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between the conditions under which the work is performed and the occupational disease. It is the claimant's burden to prove that he suffers from such a disease, and that there is a causal connection between his disease and his employment. Omron Electronics v. Illinois Workers' Compensation Comm'n, 2014 IL App (1st) 130766WC. In this case, there is no apparent connection between the Petitioner's employment and any clear occupational disease. As a preliminary matter, it is very unclear as to what occupational disease Petitioner is claiming. He testified to having "episodes" which involved him having an altered mental status resulting in him having amnesia for blocks of time extending over several days or weeks. He has also been diagnosed with depression and anxiety which pre-existed the alleged accident date. The only evidence tying these various conditions to Petitioner's employment is the testimony of Petitioner's retained expert, Dr. Fletcher. Although Dr. Fletcher opined that Petitioner may be suffering from chronic encephalopathy secondary to Petitioner's work exposures, this diagnosis is not supported by any of the Petitioner's other medical providers. More notably, Dr. Fletcher acknowledged that Petitioner's presentation to the medical providers was consistent with previous head traumas, alcohol abuse, and bipolar disorder. He further testified Petitioner's symptoms were consistent with the use of cocaine and synthetic marijuana.

The Arbitrator gives great weight to the fact that Petitioner's family physician Dr. Riech, Petitioner's treating occupational medicine physician Dr. Moody, Respondent's examining occupational medicine physician Dr. Koehler, numerous doctors at the University of Iowa, and at least two psychiatrists, Dr. Lancia and Dr. Bitar - all have declined to attribute Petitioner's complaints and conditions to the chemical exposures in the workplace.

To further add to the challenges in this case are the questions of credibility raised by Petitioner's testimony. For example, Petitioner testified as to memory loss to explain his apparent inability to describe what may have happened on the alleged accident date. Yet he was able to recall many details about his job duties and the various details related to his employment with Respondent. Also, Petitioner denied having any idea of what was synthetic marijuana, yet he admitted to both Dr. Regan and Dr. Fletcher that he had used the substance. Each of those doctors rendered an opinion that Petitioner's presentation was consistent with the use of the drug. The Arbitrator also notes that a number of the Petitioner's medical providers indicated Petitioner's possible malingering.

In reviewing the medical evidence, the Arbitrator notes that the initial medical records document Petitioner having multiple head traumas and substance abuse. The medical evidence unequivocally establishes that Petitioner's presentation and symptoms are consistent with those histories. Based on these finding, the Arbitrator concludes that the Petitioner has failed to prove a causal connection between his employment and any occupational disease; and accordingly failed to prove that he sustained accidental injuries arising out of and in the course of his employment with Respondent on July 18, 2010.

2. Based on the Arbitrator's findings with regard to the issues of accident and causation, all other issues are rer red 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 MADISON	)	☐ Reverse	☐ Second Injury Fund (§8(e)18)
			☐ PTD/Fatal denied
		☐ Modify	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Justin Dugan,
Petitioner,

vs. No: 15 WC 11529

19IWCC0273

Trillium Environmental,
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 casual connection, medical expenses (including prospective medical treatment), and temporary total disability, and being advised of the facts and law, affirms and adopts -- with modification, as discussed below -- the Arbitrator's Decision. The Arbitrator's Decision is attached hereto and made a part hereof.

The underlying facts of this claim were well laid out in the Arbitrator's Decision and are incorporated herein. Petitioner, a 26-year-old laborer, alleged injury on March 7, 2015, when he stepped on a live electrical wire (voltage unknown), while working at an environmental remediation site in Columbus, Mississippi. He alleged that the electric shock caused him to fall, hit his head on the floor, and briefly lose consciousness. His subsequent treatment for symptoms including numbness and tingling in the extremities and back pain, among other symptoms, consisted of chiropractic manipulation, physical therapy, and trigger point injections in the back. The last date of treatment was September 9, 2015 (when he received his last trigger point injection). He has not looked for work since the date of accident, claiming that "sequalae of his electrocution," including ongoing pain and other symptoms affecting a variety of bodily parts or systems, has disabled him from all employment.

19IWCC0273

The Arbitrator, following §19(b) hearing held on May 23, 2017, determined that, while Petitioner did sustain a work-related injury on March 7, 2015, he reached maximum medical improvement for that injury by September 9, 2015; Petitioner's current condition of ill-being was found to be not related to the accident. The Arbitrator awarded reasonable and necessary medical expenses totaling $15,773.62. She further found that Respondent was not liable for any temporary total disability compensation or prospective medical care.

The Commission agrees with the Arbitrator's findings that Petitioner suffered a work-related accident on March 7, 2015 and reached maximum medical improvement for that injury by September 9, 2015. However, as discussed below, the Arbitrator erred in not awarding any temporary total disability compensation.

The Arbitrator, in reaching her determinations, cited the credible and persuasive medical opinions of Section 12 examiner Dr. Andrew Zelby. Dr. Zelby examined Petitioner on April 8, 2016 and testified via evidence deposition on January 23, 2017. Dr. Zelby opined that Petitioner sustained a mild electrical injury along with a soft tissue back strain, and concussion, in accordance with Petitioner's report of a fall and loss of consciousness. (RX 1 at 25-26).

Regarding the electrical injury, Dr. Zelby stated, "that type of incident can cause numbness and tingling because of the effects of the electricity on the neural elements, but this resulted in no permanent condition of infirmity," and Petitioner's symptoms certainly would have resolved within about 2 weeks. Regarding the concussion, it was minimal and would have resolved within 6 months. (RX 1 at 25-26). For treatment of Petitioner's March 7, 2015 accident, Dr. Zelby believed that 4 to 6 weeks of chiropractic care or physical therapy (but not the injections) were reasonable. Dr. Zelby further opined that Petitioner reached maximum medical improvement at "the beginning of September 2015," which the Arbitrator noted correlated with the last time Petitioner received treatment from any medical services provider. (RX 1 at 27). (As mentioned already, this last date of treatment was September 9, 2015 -- about 6 months post-accident, and 20 months prior to arbitration hearing -- when Petitioner received his last injection from Dr. Michael Ambrose.)

As for Petitioner's ability to work following the accident, Dr. Zelby testified that 4 to 6 weeks off-work to recover was reasonable, followed by light duty of lifting 10 pounds frequently and 20 pounds occasionally. Dr. Zelby would have restricted Petitioner to ground work only for about 3 months. By 3 months post-accident, Dr. Zelby would allow medium physical labor, and, by 6 months, he would allow heavy labor with no restrictions. (RX 1 at 27-30).

Given that Dr. Zelby opined that it would not have been unreasonable to have the Petitioner off work for a short period of time immediately following his accident, the Arbitrator erred in her finding that Petitioner "is not entitled to receive temporary total disability benefits for any period of time." (Arbitrator's decision at 21). Based upon the opinion of Dr. Zelby, the Commission modifies the Arbitrator's Decision by awarding temporary total disability from March 8, 2015 through April 29, 2015.

Lastly, the Commission addresses the admissibility of video surveillance evidence submitted at trial by Respondent. Petitioner objected to the admission of this evidence on grounds including lack of foundation and improper authentication. A video recording may be admitted in evidence if it is properly authenticated and relevant to the issues in controversy. *People ex rel. Sherman v. Cryns*, 203 Ill.2d 264, 283 (2003). First, a foundation for a video recording must be laid by someone having personal knowledge of the filmed object and is capable of testifying that the video is an accurate portrayal of what it purports to show. *Cisarik v. Palos Community Hospital*, 144 Ill.2d 339, 342 579 N.E.2d 873 (1991).

In the case at bar, Respondent presented the testimony of Zarko Gligoravic, a supervisor at PhotoFax, Inc., the surveillance company retained by Respondent. Mr. Gligoravic testified that he oversaw the investigators who performed the surveillance and recorded the video, collected on several days between April 2015 and March 2017. The video footage was selected, compiled and submitted at hearing on DVD, along with corresponding surveillance reports, as Respondent's Exhibit 8. Mr. Gligoravic testified regarding the way his company identifies the subjects to be surveilled, assigns tasks to investigators, and finally provides finished work product (including video discs and written reports) to the company's clients. Mr. Gligoravic did not do any of the actual surveillance himself and had no prior familiarity with Petitioner. Mr. Gligoravic testified that, in his observation, the subject of surveillance as captured on video looked to be the same individual as Petitioner, who was sitting in the courtroom. However, Petitioner contended that the individual purported to be him in the video was actually his look-alike younger brother.

Inasmuch as Mr. Gligoravic did not have "personal knowledge of the filmed object," having done none of the surveillance himself, the Commission sustains Petitioner's objection and thus strikes those findings of the Arbitrator based upon the video recording. Even so, the Commission finds that, considering the totality of the admissible evidence, Petitioner has failed to prove entitlement to any benefits save for those described in this instant Decision and Opinion on Review.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed November 6, 2017, is hereby modified as stated herein and otherwise affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay to Petitioner the sum of $ 368.00 per week for for the period **commencing March 8, 2015 through April 29, 2015,** under § 8(b) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay to Petitioner the reasonable and necessary medical expenses as described in the Arbitrator's Decision, pursuant to §8(a) of the Act and subject to the medical fee schedule.

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 the accidental injury.

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

IT IS FURTHER ORDERED BY THE COMMISSION that this case is remanded to the Arbitrator for further proceedings for a determination of a further amount of temporary total compensation or of compensation for permanent disability, if any, pursuant to *Thomas v. Industrial Commission*, 78 Ill.2d 327 (1980).

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $ 17,000.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: JUN 5 - 2019

o-04/08/19
sm/ac
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Stephen J. Mathis

D. Douglas McCarthy

L. Elizabeth Coppoletti

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

DUGAN, JUSTIN
Employee/Petitioner

Case# **15WC011529**

TRILLIUM ENVIRONMENTAL
Employer/Respondent

19IWCC0273

On 11/6/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.26% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0781 KEEFE & GRIFFITHS PC
DANIEL KEEFE
10 S BROADWAY SUITE 500
ST LOUIS, MO 63102

1872 SPIEGEL & CAHILL PC
PHILLIP JOHNSON
15 SPINNING WHEEL RD SUITE 107
HINSDALE, IL 60521

19IWCC0273

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

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

JUSTIN DUGAN
Employee/Petitioner

v.

TRILLIUM ENVIRONMENTAL
Employer/Respondent

Case # **15** WC **11529**

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 **Christina Hemenway**, Arbitrator of the Commission, in the city of **Collinsville**, on **May 23, 2017**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. [ ] Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?

B. [ ] Was there an employee-employer relationship?

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

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

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

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

G. [ ] What were Petitioner's earnings?

H. [ ] What was Petitioner's age at the time of the accident?

I. [ ] What was Petitioner's marital status at the time of the accident?

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

K. [x] Is Petitioner entitled to any prospective medical care?

L. [x] What temporary benefits are in dispute?
[ ] TPD [ ] Maintenance [x] TTD

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

N. [ ] Is Respondent due any credit?

O. [ ] Other ______

FINDINGS

On the date of accident, **March 7, 2015**, Respondent *was* operating under and subject to the provisions of the Act.

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

On this date, 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 $**28,704.00**; the average weekly wage was $**552.00**.

On the date of accident, Petitioner was **26** 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** for TTD, $**0** for TPD, $**0** for maintenance, and $**0** for other benefits, for a total credit of $**0**.

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

ORDER

As explained in the Arbitration Decision, Petitioner sustained an accident which arose out of and in the course o his employment with Respondent on March 7, 2015. He provided timely notice of the accident. Petitioner's current condition of ill-being is not causally related to his accident. Petitioner reached maximum medical improvement on September 9, 2015. All benefit after that date are denied.

Respondent shall pay reasonable and necessary medical services totaling $15,773.62, as reflected in Petitioner's Exhibit 6 that remain unpaid. Specifically, Respondent shall pay the following bills, subject to the medial fee schedule as provided in Sections 8(a) and 8.2 of the Act, and subject to presentation on the appropriate HCFA forms with the appropriate codes included. Respondent shall receive credit for prior payments. Center for Advanced Medicine/Dr. Ambrose $3,533.00; Illinois Medicaid for Anderson Hospital $288.45; Gateway Regional Medical $3,632.21; Gateway Regional Medical $1,158.84; and Talley Chiropractic $7,161.12.

Respondent is not liable for any prospective medical care or any temporary total disability benefits.

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

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

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

Signature of Arbitrator

November 3, 2017
Date

NOV 6 - 2017

STATE OF ILLINOIS)
) SS **19IWCC0273**
COUNTY OF MADISON)

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

JUSTIN DUGAN
Employee/Petitioner

v. Case #: **15 WC 11529**

TRILLIUM ENVIRONMENTAL
Employer/Respondent

MEMORANDUM OF DECISION OF ARBITRATOR

FINDINGS OF FACT

Testimony

On March 7, 2015, Petitioner was 26 years old, single, and had one natural child and one child to whom he stood *in loco parentis*. He testified he was not currently employed and that his last employer was Respondent, Trillium Environmental. Petitioner testified that on the date of the accident he was working with wires in a lime solo in Mississippi and that his foot came into contact with a live wire, which gave him an electrical shock. He had been under the impression that the power had been cut off, when in fact it had not. The electrical shock caused him to fall, hit his head on the floor, and twist his low back. He testified he lost consciousness and has no memory of what happened after he was shocked. A co-worker witnessed the incident, picked him up off the ground, and told him what had happened. Petitioner testified he had no memory of what happened after he was shocked.

Petitioner testified that he reported the incident to his supervisor Andy and asked for medical treatment. He was informed that that day was going to be the last day on that particular job and that if he went for medical treatment in Mississippi he would lose his ride home and be left behind. As a result, he was unable to seek medical treatment for his injury until he got back to Illinois, following an eight to ten hour drive back from Mississippi, at which time he went to Anderson Hospital. Petitioner testified he also treated with Dr. Talley, a chiropractor, and with Dr. Ambrose. He had a lumbar MRI and a head CT. He last saw Dr. Talley about one week prior to the MRI, and was told by Dr. Talley that he could do no more chiropractic adjustments, as they could hurt Petitioner even worse and he did not want to paralyze Petitioner. He did not recall the date of his last visit with Dr. Talley. Petitioner testified that Dr. Talley and Dr. Ambrose kept him off work, as did the doctor who administered trigger point injections into his back, and whose name he could not remember.

Petitioner testified that he was continuing to have complaints regarding his back, which he believed were related to his accident. He testified that his back was originally stiff mainly on the left side, but now it is more all over. He has trouble sleeping and his back has become stiffer since he stopped going to the chiropractor. He has tingling in his fingers, arms, and legs and a burning sensation. He testified he was also experiencing hearing problems, which he described as, "A delay in hearing, like my mind's not working as good as it was and I just am not registering things as quickly as I was."

Petitioner testified that his attorney sent him to Dr. Kennedy for an examination, and that his employer sent him to Dr. Zelby. He testified that he drove approximately seven hours to and from Dr. Zelby's appointment, and that at the end of his ride he felt terrible due to the pain in his back. He testified he had increased pain and stiffness after sitting for a long period of time.

Petitioner testified that he had not worked since his accident and since returning from his assignment in Mississippi, because he is "in complete pain". He testified that his pain is getting worse, that the treatment he received provided no relief, and that the injections did not provide the relief he was told they would provide. He testified that he had no problems prior to the work incident and that since then he has lost about 30 pounds of muscle. He testified that since the incident he has not lifted anything heavier than his son, who weighed about 20 pounds, but that he could probably push himself to lift up to 40 pounds.

On **cross-examination**, Petitioner testified he was unsure the last time he saw Dr. Talley, but agreed that if the doctor's records indicted it was July 6, 2015, then that should be correct. He testified Dr. Talley was a chiropractor and that the first time he saw him was March 9, 2015. He testified that he was told by Dr. Talley on his last date of treatment that he was unable to return to work. He denied asking Dr. Talley to prepare a statement regarding his inability to work. At each appointment, Dr. Talley conducted an examination and listened to his complaints.

Regarding the incident at work, Petitioner testified that he stepped on a wire on the floor but he did not know what it was plugged into. He was wearing shoes at the time. He did not know the amperage or voltage of the wire. He testified that after the incident occurred he laid down in a van for about an hour and half before the crew went back to the hotel. He went to Anderson Hospital when he returned home, and reported what had happened. He disputed that the hospital record was correct in stating that the incident occurred at approximately 6:00 a.m. He agreed that he reported a tingling sensation throughout his body and that he passed out, hitting his head, after the electrical shock. Petitioner could not recall if he was released from the hospital with any type of medication or with any type of restrictions.

Continuing on cross-examination, Petitioner testified that he next saw Dr. Talley, followed by Dr. Ambrose in the same office building. Dr. Talley referred him to Dr. Ambrose for complaints of testicular pain. He acknowledged that while treating with Dr. Talley he was also taking Zoloft and an anxiety medication, due to chronic anxiety from dealing with ongoing problems with his daughter.

Petitioner testified that he has not looked for any work since the date of his work accident on March 5, 2015. When asked if he was familiar with Dugan Construction Company, he acknowledged that it was his company, and that he advertised for them. He testified the company does roofing, but denied that it does any tree removal. He further testified that his "little brother" took over his company a little bit after he was hurt. He denied currently receiving a salary from the company.

Continuing on cross-examination, Petitioner was presented with Respondent's Exhibit 2 and identified it as a picture of himself, from his Facebook page dated April 14, 2016. The post referenced attending a St. Louis Cardinals game; however, Petitioner testified he did not recall being at the game, despite a response from him to a comment regarding the game. Petitioner was presented with Respondent's Exhibit 3 and identified it as a picture of himself holding his son, from his Facebook page also dated April 14, 2016. The post referenced taking his son to his first Cardinals ball game.

Petitioner was presented with a picture dated March 4, 2016, (marked as Respondent's Exhibit 5, but not tendered into the record), which he identified as a picture of himself holding a chainsaw. He testified that, although he was the person holding the chainsaw, the picture was not actually taken on March 4, 2016, but rather in 2012.

When asked about his daily activities since his accident on March 7, 2015, Petitioner testified he really does nothing, only what he can. On any particular day he will get up, have breakfast, watch his son, each lunch and dinner, and go to bed "like every other normal person". He will sometimes go to a birthday party or family event. He testified he has not looked for work since March 2015 because he was hurt. He denied that Dr. Kennedy told him he was able to work with restrictions. He testified that he has not seen any doctors for any treatment since he saw Dr. Kennedy on November 24, 2016, at the request of his attorney, as Respondent would not pay for any treatment. He acknowledged, however, that some of his bills had been paid for by the State of Illinois and stated, "That's the only way I could get an MRI was to go down and get Medicaid because you guys was not going to pay it."

Petitioner testified that he did not sell his construction company to his brother, but that he gave it to him to keep the family name going until he was better. He did not notify anyone at the State of Missouri, where the company was registered, that the ownership had changed. He testified that he had not filed any income tax return since 2015.

Petitioner was presented with Respondent's Exhibit 6 and identified it as a picture of himself and his son, from his Facebook page dated July 8. The post referenced going to a barbecue and swimming, and his son stepping on a hot coal. He testified he did not recall it. He identified Brittany Hewitt, one of the persons who commented on the post, as his girlfriend.

When asked if he remembered telling his friends on a Facebook post in October that he had plenty of firewood for them to come and get, he responded, "I don't know all these dates." He did not confirm or deny offering firewood to his friends.

Petitioner testified that he was currently taking anxiety medication which was prescribed by the psychiatrist he has been seeing. He could not remember her name, but sees her every few months and has been treating with her for a year or two.

Petitioner acknowledged that in 2015, 2016, and 2017, he had received traffic violations on various occasions, contrary to his assertion on direct that he sits at home and does nothing. He further acknowledged that he previously plead guilty to a Class IV felony but did not serve any jail time for the conviction. He acknowledged that he currently has various cases pending in different courts for traffic violations, including driving without insurance and driving on a suspended license. Petitioner could not recall if he was driving the Dugan Construction Company truck when he received the ticket for driving on a suspended license. He denied doing any work for Dugan Construction in the area of tree and brush removal since his accident date of March 7, 2015.

Petitioner was presented with Respondent's Exhibit 8, and asked to identify the person in pictures in the surveillance report. He testified that it was one of his brothers, and not him.

On **re-direct**, Petitioner testified that the company truck he previously owned was no longer his as of December, as he could not afford to make the payments. He testified that the company truck was also used by his three brothers for their work, which included trees, roofing, concrete and the like. They also used his trailers and equipment. He testified that he had not used his equipment since his accident on March 7, 2015, and that 99% of it had been sold.

On **re-cross**, Petitioner testified that one of his brothers lived with him for a little bit, but he could not remember the dates or the year. He confirmed that the truck in the picture (RX8) was his company truck, but that the person in the back was his brother Garrett and not him.

Respondent called Mr. Zarko Gligorevic as a witness. Mr. Gligorevic testified he was employed as a supervisor by PhotoFax, Inc., a surveillance company. He and his company were employed by Respondent's insurance carrier to undertake surveillance of Petitioner. He testified he was not the investigator who actually conducted the surveillance, but rather was acting in a supervisory capacity when the information was accumulated by the several individual investigators involved in the case. He explained that when he receives an assignment, he gets necessary information such as the subject's Social Security number and address. When a picture is available, the picture is supplied to the individual investigators. He testified that once the information is available, assignments are made to individual investigators who work in the geographical area where the subject is located. He testified that any video recorded of an individual is never edited. The investigators give all of the surveillance accumulated to the company on SD cards, which are downloaded onto the servers for further use.

Mr. Gligorevic testified that he had been contacted by Respondent's attorney to download from the server copies of the surveillance which had been completed, and the copies of that surveillance were presented at the hearing. He testified that he did not know Petitioner until he saw him at the hearing, and that it was his belief that the individual observed during the course of surveillance was, in fact, Petitioner.

On motion of the court and by agreement of the parties, the Arbitrator requested that the witness present the surveillance videos for viewing at hearing. Petitioner and his attorney were allowed the opportunity to simultaneously observe the matters which had been recorded on the three DVD's. Given the total length of the videos, each DVD was viewed only partially, until such time as Petitioner's attorney advised he did not need to see any additional footage. Throughout the viewing, Petitioner's attorney asked questions of the witness. The Arbitrator advised the videos would be viewed in their entirety as part of the review of all of the evidence.

On **cross-examination**, Mr. Gligorevic testified that the woman shown in the videos was the woman referred to in the reports as Petitioner's girlfriend. The following exchange then occurred:

Q. And did you ever witness in the videos any kisses or public displays of affection between who was identified in the video as the claimant and who was identified in the video as claimant's girlfriend?

A. I don't recall.

Q. Assuming that there were no kisses or public displays of affection that were captured on video, how would you know that it was the claimant's girlfriend?

A: It was an assumption I believe made on the report that that was his girlfriend….

In addition, the following exchange also occurred:

Q: Did you ever observe the person identified as the claimant smoking a cigarette:

A: I don't recall.

Q. Do you know whether the claimant is a smoker?

A: I don't know.

Petitioner was recalled as a **rebuttal witness**, having had the opportunity to observe the video surveillance. He testified that at no point did he see himself in the surveillance video. Rather, it was his little brother that was seen in the video wearing white sunglasses. He testified he does not own white sunglasses such as those shown in the video. Petitioner was then shown what was marked as Petitioner's Exhibit 7, which he identified as a picture of himself, his mother, and his brother. He noted that his brother, pictured in the middle with his tongue out, was wearing sunglasses similar to the sunglasses observed in the video. He testified that the person he saw on the surveillance videos was this brother, who would also use his truck, and who lived in the house right behind his own. Petitioner testified that he does not smoke. He was shown what was marked as Petitioner's Exhibit 8, which he identified as a picture of his brother Gary Walliser. He noted his brother had a beard in the picture, similar in length and style to his own beard. He testified that his brother looks like him and used to us his I.D.

On **cross-examination**, Petitioner testified that the photographs described above were printed before the hearing began. He anticipated they would be needed to establish his identity and to rebut the testimony regarding the surveillance video.

Medical

Petitioner presented to Anderson Hospital at approximately 9:17 p.m. on March 7, 2015. The Arbitrator notes that the primary insurance company was listed as Illinois Medicaid. He

reported he had been electrocuted at about 6:00 that morning when he was working in a lime silo and stepped on a live wire. He was not sure of the voltage or amplitude he was shocked by. He was wearing shoes at the time. He reported he felt tingling throughout his body and then he passed out and hit his head. He noted he was unable to leave work, due to his boss. Since that time he had had tingling in his hands and feet, bilateral shin burning pain, heart palpitations, and back and neck pain. He also reported he had previously been electrocuted that Wednesday by a socket, but he did not pass out or have any significant symptoms afterward, except for daily diarrhea since then. He reported a history of anxiety. His physical examination was normal, except for appearing to be anxious. Lab results were normal, as were chest x-rays and an EKG. Petitioner was discharged with instructions to encourage fluids, take Tylenol or ibuprofen as needed, avoid caffeine, and to "follow-up with work comp provider in the morning". No work restrictions were documented on the discharge instructions. PX4.

Talley Chiropractic

On March 9, 2015, Petitioner presented to chiropractor Jason Talley. He reported pain in his back, neck, and knee from an incident at work. He stated he was using a vacuum cleaner, holding the wire with his foot and hand, and felt a jolt. He blacked out and ended up on his back in a twisted position. He stated there was a sore spot on the back of his head, and he knew he at least hit his head. He complained of pain starting in the lower back with aching and burning, extending to the back of the neck and mid-back. He also reported he had a "funny feeling" or tingling type feeling in his fingers and lower extremities. On examination, there was no motor weakness, but he did have significant rigidity throughout his lumbar, thoracic, and cervical spine. Dr. Talley noted he was visibly in pain and had significant myospasm. He also noted subluxation at L5, S1, C1, C6, and C7. He recommended therapy, including muscle stimulation, myofascial release, ice, and chiropractic manipulation. Assessment was cervical whiplash, lumbar strain/sprain, and some radiculitis. PX2.

Petitioner returned to Dr. Talley on March 10, 2015. His complaints and examination were unchanged. Dr. Talley recommended he follow up with his primary care physician and/or pain management physician Dr. Ambrose to make sure that the tingling was not from being electrocuted. He followed up on March 11 and reported he was doing better and felt looser. Examination showed minimal change. On March 13 he reported he was starting to loosen up but still had some tingling in his hands and legs. On exam he appeared to be less rigid. It was noted he was seeing his primary physician, Dr. Ambrose, that day. He returned on March 18 and reported he had been unable to make visits recently as had a baby the day before. He was very sore and sleeping uncomfortably. Exam was unchanged. PX2.

On March 20, 2015, Petitioner returned to Dr. Talley and reported he was "doing terrible". He stated he was having a lot of tingling and leg pain, that his back and neck were very stiff, and that he was having a lot of muscular spasm. Dr. Talley advised it would take some time before they got the problem under control. On exam, he had significant myospasm from his lower lumbar region through the thoracic and cervical regions. He had decreased flexion and rigid posture. He returned on March 23 and reported he was having a severe headache but that his back was feeling a little better. On exam, Dr. Talley noted he had"C1 capsular swelling on the right with subluxation and severe tenderness and mild spasm of the occipital and posterior

cervical region". Lumbar flexibility was slightly improved. On March 25 Petitioner reported his headache had gone away and the low back was very tight but improving. On exam, there was improved cervical function and less swelling at C1. He was still very rigid and tight in the hamstrings and lumbar area, but noted to be moving better. PX2.

On March 27, 2015, Petitioner returned to Dr. Talley and reported he was doing better overall but had a migraine that day, which he believed was due to stress. He also had some neck and mid-back pain, but was improving. There was no major change on exam. On April 1 he returned and reported his low back was better but he still had neck pain and headaches. He continued to get random tingling in his hands and feet. Exam was unchanged. On April 3 he was doing a little better but still had a headache. There was minimal change on exam. On April 6 he reported he was still having a lot of pain in his neck and lower back and was concerned that he was not getting better faster. Dr. Talley believed they needed to be more progressive with stretching and strengthening activities. On exam, there was less hypertonicity in the lower lumbar and mid-cervical regions. His trapezius muscles were tight bilaterally and he was still very rigid to palpation in the lower cervical and lower lumbar areas. Dr. Talley noted that upon performing a pelvic lift exercise, Petitioner reported testicular pain. He instructed him to be careful with that exercise and advised it was normal nerve pain. PX2.

On April 7, 2015, Petitioner returned to Dr. Talley and reported continued pain in his neck with minimal change. He continued to be concerned with his progress. Dr. Talley opined that Petitioner's intersegmental function of the cervical spine was improving, but noted it was still very rigid. On April 8 Petitioner reported his low back was better but he still had pain in his neck. Exam was unchanged. On April 10 he reported he was the same, that his low back continued to improve, and his neck seemed to have plateaued. It was noted that Dr. Taylor discussed getting a cervical MRI if insurance approved. On April 14 examination was unchanged. On April 20 he reported he was not improving and was very concerned that he was still getting tingling in his hands and feet. He also reported groin pain with the pelvic lift exercise and recently noticed a lump in his testicle. He was advised to see Dr. Ambrose for that condition. On April 22 he reported a lot of neck pain. Examination showed his overall neck range of motion was improving and his low back had improved significantly. Lumbar and pelvic function was improved, as was flexibility in the hips and hamstrings. PX2.

On April 29, 2015, Petitioner returned to Dr. Talley and reported he was about the same. He voiced concern about the lack of improvement with his neck and wanted to go ahead with the MRI. Dr. Talley provided a prescription, but noted he may have trouble getting it scheduled. On May 1 Petitioner reported he believed they were making progress with his neck finally. He noted after being adjusted he felt good for about a day. Dr. Talley advised he needed to continue to get stronger and more flexible in the cervical spine, and then the pain would diminish. On May 8 Petitioner reported he was still really hurting in his neck. He reported he had "a minor fender bender yesterday". The other driver hit his tailgate but there was no damage to his truck. He was "guarded" but was sure the accident didn't help. Exam was unchanged. On May 18 he returned and reported he had been out of town. Complaints and exam were unchanged. PX2.

On June 5 he reported he was doing okay but still had some pretty significant stiffness and pain in the lower back. He stated he had stayed away from doing any major activity, as he

did not feel his body could handle picking up, bending, or twisting for any extended time. It was noted that the goal in treatment was to increase strength of the cervical and lumbar regions and overall flexibility. On June 9 he reported he was doing pretty good. Flexibility in the hamstrings continued to improve and his exam was otherwise unchanged. On June 12 he was doing okay and did not have as much tightness in his legs. He still had some pain in the posterior neck. On June 17 he reported his neck and back were doing okay but he had a lot of tightness in his hamstrings and some cramping into his legs. On exam, the function of the cervical and lumbar regions continued to improve. He was still somewhat rigid in the posterior cervical spine, with tenderness. Hamstrings were very tight bilaterally. On June 19 Petitioner reported he was 60-70% improved, but did still have some neck pain. On exam, there was improved function, but continued tightness in the hamstrings. PX2.

On June 26, 2015, Petitioner returned to Dr. Talley. He reported he was doing okay but tightened up in between his adjustments. He seemed to be 65-70% improved, but seemed to have plateaued. On exam, he tolerated most activities and had improved intersegmental function. There was some posterior cervical tightness but improved overall. On June 30 he reported that his back had really flared up again, and he had some leg pain and pain into the groin and testicular region. His neck was doing okay. He advised there was no new accident. On exam, he was hypertonic in the lumbar spine, there was right SI subluxation, and his hamstrings were tight. PX2.

On July 6, 2015, Petitioner reported he was doing about the same overall. He continued to have testicular pain. Dr. Talley noted he would refer Petitioner back to Dr. Ambrose for evaluation and possible referral for MRI. Dr. Talley further noted, "We will see the patient back after he sees Dr. Ambrose and the MRI results." PX2. The Arbitrator notes this is the final treatment record from Dr. Talley.

The Arbitrator further notes that Dr. Talley's records also included a statement of unknown origin or date, in the form of a narrative. It summarized Petitioner's work accident, his complaints, and his treatment by Dr. Talley since the accident. It also contained the following with regard to Petitoner's work status:

> *"The patient has been unable to work in any capacity since the March 7 incident. He should likely remain off work another 1-2 months as we work on therapeutic strengthening and work strengthening. The patient is currently being treated to 3 times per week and is improving. I do expect the patient to go back to a full duty status after he is released from care."*

It is unclear when this report was generated, the reason it was generated, or to whom it was directed. There is a handwritten notation at the bottom of the page of "Kennedy 11/16/15", which appears to be an indication that a copy of the records was sent to Dr. Kennedy. The Arbitrator presumes this refers to Dr. Kennedy but, again, the report is undated and there is no salutation to suggest that it is directed to anyone, including Dr. Kennedy. The Arbitrator further notes that Dr. Talley's daily treatment notes from March 10, 2015, through July 6, 2015, make no reference whatsoever to Petitioner's work status, his ability or inability to work, or even what his job duties consisted of. For these reasons, the Arbitrator gives no weight to this particular report from Dr. Talley.

Dr. Michael Ambrose/Center for Advanced Medicine

On March 13, 2015, Petitioner presented to Dr. Ambrose. He advised he had a primary care doctor, but had a recent injury and was looking for a new primary care doctor in the area. He reported he was recently in a work accident involving an electrocution and since then had been having tingling in his hands and feet. He was unsure of the voltage involved. He reported a history of chronic anxiety which increased after the accident. He advised he was also having issues with a daughter, apparently he was not the father, and it was in the court system. Physical examination was normal. Assessment was anxiety disorder and effects of electric current. Dr. Ambrose noted the tingling in Petitioner's hands and feet was normal after such an event and that he had no cardiac or pulmonary issues. He was to follow up in one month. PX5.

Petitioner did not return to Dr. Ambrose again until July 6, 2015, and it was noted that the office "had some trouble reaching him". He reported he had been seeing his chiropractor with intermittent relief but continued to have back pain with radicular pain into his left groin and back of both thighs which had been present since the accident. Dr. Ambrose noted, "He is requesting an MRI." He reported ongoing anxiety, which was being treated with Zoloft and benzodiazepine. On exam, straight leg raise on the left was positive and "Patrick's reverse" was positive for pain in the back but not over the SI joint. Assessment was lumbosacral neuritis, lumbago, and myalgia. Dr. Ambrose noted the electric shock was likely the cause of Petitioner's peripheral neuropathy, since it was in all four extremities. He recommended referral to a neurologist. Dr. Ambrose further noted that Petitioner did not bring up a lumbar injury when he was seen the first time, but understood he had been treating with a chiropractor for this issue since the accident. He ordered a lumbar MRI. He also recommended epidural or trigger point injections, given the significant trigger points throughout the lumbar spine. Petitioner refused and wanted to see what the MRI showed first. Finally, Dr. Ambrose noted Petitioner had complaints of dizziness and headaches, and he ordered a head CT scan and recommended referral to a neurologist. PX5.

On August 27, 2015, Petitioner underwent a lumbar MRI which revealed (1) L4-5 small right paracentral disc protrusion with borderline central spinal stenosis and no evidence of neural foraminal stenosis; (2) L5-S1 small to moderate left posterior lateral disc extrusion partly effacing the left S1 nerve root centrally and mild bilateral neural foraminal stenosis. PX5. On August 28, 2015, Petitioner underwent a CT scan of the head. There was no acute intracranial process identified. PX3.

On September 1, 2015, Petitioner followed up with Dr. Ambrose "for ongoing evaluation for his back leg pain and left-sided scrotal pain". He reported he had been seeing Dr. Talley, who "released him and says he can't help much anymore". Dr. Ambrose noted he had seen Petitioner for ongoing leg pain and back pain, with neuropathy-like symptoms, as well as for issues with anxiety and depression. He noted Petitoner's symptoms had become more focal over the past month or so and "he's been hard to follow up with". Petitioner reported most of his pain was now in his mid-back and lumbar spine, radiating to both legs, left worse than right. Dr. Ambrose noted a lumbar MRI had been done, which showed posterior disc protrusion at L4-5 and mild L5-S1 protrusion left with involvement of neuroforaminal space and encroachment. He indicated this could be contributing to Petitioner's symptoms. He noted Petitioner had refused

injections in the past, but now wanted to start them, as his pain was staying at 7-8/10. On examination, there was tenderness to palpation over the left and right erector spinae muscles, trigger points were noted, and there was some tenderness on the left side. Straight leg raise was positive bilaterally and Fabere's test was negative. Dr. Ambrose administered a trigger point injection and performed osteopathic manipulation and therapy. Petitioner advised he could not lift anything heavier than his child, who weighed less than 20 pounds, and Dr. Ambrose recommended he not work. He was to continue anti-inflammatories and anxiety medicine. PX3.

On September 3, 2015, Petitioner returned to Dr. Ambrose and reported ongoing back pain of 7/10, as well as numbness in his lower extremities which was unchanged and which occurred a couple times a day. Examination showed tenderness to palpation in the lumbar spine and muscle trigger points. Straight leg raise was positive bilaterally. Osteopathic manipulation and therapy was performed, and a second trigger point injection was administered. On September 9, 2015, Petitioner followed up and continued to report pain of 7/10. He indicated he was about the same since his last injection and still had radicular pain into the groin bilaterally. Exam was unchanged. Osteopathic manipulation and therapy was performed, and a third trigger point injection was administered. Petitioner was to follow up later that week. PX5. The Arbitrator notes this is the final treatment record from Dr. Ambrose.

Dr. David Kennedy

Petitioner was examined by Dr. David Kennedy on November 24, 2015, at the request of his attorney. Dr. Kennedy testified by way of deposition on October 26, 2016. He is a Board Certified Neurosurgeon. Dr. Kennedy testified he obtained a history from Petitioner that he had inadvertently stepped on a live electrical wire at work on March 7, 2015. He did not recall the voltage involved but was thrown to the ground and had a brief loss of consciousness. He complained of numbness, tingling, and burning in his hands and feet, as well as vertigo and light sensitivity. Petitioner also complained of some pain in his right lumbar region and right trapezius. He had no bowel or bladder dysfunction, gait disturbance or weakness, and no neurologic deficits. Petitioner reported he had been treating with Dr. Talley, a chiropractor, and that he had no prior problems. PX1.

Dr. Kennedy conducted a physical examination and noted limitation in motion in the cervical and lumbar spine regions. Straight leg raise was negative, motor and sensory exams were normal, and reflexes were normal. Dr. Kennedy reviewed the head CT scan, which showed no signs of acute intracranial process. He reviewed the lumbar MRI and noted a small prolapse at L4-5. He noted, "I do not see any significant nerve root impingement." His diagnostic impression was electrocution and concussion. He recommended Petitioner see Dr. Daniel Phillips, a neurologist, for evaluation of his numbness and tingling, which he opined may be a lingering effect from the electrocution. Dr. Kennedy opined that Petitioner's symptoms of light-headedness and light sensitivity were compatible with post-concussive syndrome. He opined it was likely due to tonic contraction of the muscles during the electrocution, and he believed Petitioner would benefit from trigger point injections. He recommended Petitioner see Dr. Gheith for the injections. Dr. Kennedy opined that Petitioner was not at maximum medical improvement and that his current symptoms and need for treatment were related to his work

accident. He opined that the treatment previously given by Dr. Ambrose was reasonable, necessary, and related to Petitioner's work injury, including the injections. PX1.

Dr. Kennedy testified that Petitioner's neurological exam was normal, in terms of motor, sensory, and reflex function. However, he continued to complain of numbness and tingling, which Dr. Kennedy noted could be radicular symptoms or, more likely in Petitioner's case, a residual effect on the nerves by virtue of the electrocution. He testified that Petitioner's lumbar MRI was not very remarkable and showed no nerve root compression or other abnormality. As such, he excluded the lumbar spine as the cause of Petitioner's radicular symptoms. Rather, he believed Petitioner's numbness, tingling, and burning in the hands and feet were due to nerve injury by virtue of the electrocution. He did not believe Petitioner needed surgery. Dr. Kennedy testified that as of November 24, 2015, Petitioner had not returned to work since his accident, which he opined was due to injuries sustained in the accident. PX1.

On cross-examination, Dr. Kennedy agreed that at the time Petitioner was examined he was taking only one medication, which was clonazepam for anxiety, irritability, and the like. He did not disagree with the Physicians' Desk Reference, which indicated that use of clonazepam could cause irregular heartbeat, shortness of breath, stomach and digestive problems, headaches, tremors, twitching, numbness and tingling in the hands and feet, sleep problems, and fatigue. Dr. Kennedy testified he did not know the amount of amperage or voltage in the electric wire which Petitioner stepped on, and agreed that the information could be relevant to his overall condition and potential injury. Dr. Kennedy testified that to the best of his recollection, Petitioner did not have any entrance or exit wounds related to the live wire he stepped on. Regarding Petitioner's complaints of light sensitivity, tinnitus, and vertigo, Dr. Kennedy testified that from his review of records it was not clear as to when Petitioner started experiencing these problems. He testified that his review of the emergency record from Anderson Hospital showed an exam of Petitioner's head at that time showed no evidence of trauma. PX1.

Dr. Kennedy testified that he took no measurements of Petitioner's ranges of motion and used his best professional estimate as to what the motion should have been versus what he observed. Petitioner's estimated 50% reduced cervical and lumbar range of motion was based on an active rather than a passive motion, meaning he was asked to move until he felt discomfort. Dr. Kennedy acknowledged that he did not conduct any passive range of motion testing. He testified that Petitioner had no sciatic nerve involvement, no evidence of nerve root or disc involvement, and no evidence of any abnormal motor exam, muscle atrophy, or fasciculation/twitch. He testified that these results generally cleared any issues regarding the cervical spine. With regard to the lumbar spine, Dr. Kennedy testified Petitioner's gait pattern and coordination were normal, and his MRI showed only a small prolapse of L4-5, which was not of any clinical significance. His conclusion was that Petitioner had sustained an electric shock and may have some post-concussion syndrome issues, by his subjective complaints. He opined that Petitoner's cervical and lumbar tenderness and range of motion limitations were due to muscle spasm from the electrical shock. He acknowledged, however, that he did not mention in the physical findings section of his report that Petitioner had muscle spasms upon examination. PX1.

Dr. Kennedy testified that he did not know whether Petitioner had followed up with either Dr. Phillips or Dr. Gheith, as he had recommended. He did not make a recommendation that Petitioner be seen by an ophthalmologist regarding the light sensitivity. He was not aware that Petitioner had migraine headaches, and agreed that light-headedness and light sensitivity can be associated with migraine headaches. PX1.

Dr. Kennedy testified he had not seen Petitioner since his examination on November 24, 2015. At that time he opined that Petitioner could not work. He acknowledged, however, that he did not know what Petitioner's job duties included, only that he was an inspector for an environmental remediation company. Although he did not believe Petitioner should work, he opined that light activity was reasonable. Petitioner could sit, stand, and walk as tolerated but should not walk on uneven surfaces or use ladders, and should not lift or carry more than 10 pounds. Dr. Kennedy conceded that his term "off work" was not a definitive statement that Petitioner could do nothing, but rather he was limited in what he should do. PX1.

Dr. Andrew Zelby

Petitioner was evaluated by Dr. Zelby on April 8, 2016, at the request of Respondent pursuant to Section 12. He testified by way of deposition on January 23, 2017. He is a Board Certified Neurosurgeon specializing in spine surgery. Dr. Zelby testified that Petitioner gave a history that he was bent forward pushing a wire with his right hand and also kicking the wire with his right foot when he was electrocuted. He did not know where the current entered his body because he passed out immediately. A co-worker was nearby and helped him get up. He rested at the job site and when he got back to the hotel three hours later he reported the incident to his boss, who would not allow him to go to the hospital. He and his co-workers drove eight or nine hours back home that evening and he went to the emergency room where he was evaluated, treated, and released. RX1.

Dr. Zelby testified that Petitioner complained he was lethargic and light-headed, and had headaches, tingling throughout his whole body, neck pain, low back pain, heart palpitations, and random twitching in different parts of his body. Petitioner reported he had seen a chiropractor for three or four months, which took away a little of the back pain, and had several injections, the most recent about five months prior. Petitioner reported that his symptoms were constant. He was able to put on his socks and shoes, but was not able to drive and had not driven since the accident. He denied any prior problems or similar symptoms. He denied any ongoing medical problems, was taking no medications, and was not a smoker. He reported he had lost 15 pounds over the past year, had a sleep disorder, and some sexual dysfunction. He advised he could sit for less than an hour, stand for less than an hour, and walk for two blocks. He rated his pain at 8/10 on a constant basis. Dr. Zelby testified, however, that his impression was that Petitioner rested and moved comfortably with no pain behaviors during the exam, which would suggest that Petitioner's description was not an accurate representation of his pain. RX1.

Dr. Zelby testified he completed a detailed neurologic examination. Petitioner's speech was fluent and his cognition was intact. His cranial nerves, fundi, face sensation, hearing, and cerebellar function were all normal. His position sense was normal, with no left or right confusion. There was no abnormality with spatial or higher cognitive recognition. Examination

of the cervical spine was normal, though Petitioner did complain of mild tenderness with deep palpation. Range of motion was normal, Hoffman's test was normal, and loading of the cervical spine did not elicit pain. Examination of the thoracic spine was normal with no tenderness. Examination of the lumbar spine was normal, though Petitioner did complain of mild tenderness with deep palpation in the lower lumbar region. Range of motion was normal and squatting was normal. Lying straight leg raise was positive in the back only, sitting straight leg raise was negative, and reverse straight leg raise was negative. There was no sciatic notch tenderness. Toe walking, heel walking were normal, Patrick's and Faber's tests were normal, and gait and posture were normal. There was no scoliosis and no paraspinal muscle spasm. Petitioner's strength, sensation to pain, vibratory sensation, and reflexes in the upper and lower extremities were all normal. Measurement of the extremities reveled they were symmetric and without atrophy. Dr. Zelby testified that inconsistent behavioral responses were positive for diminished pain on distraction. RX1.

Dr. Zelby testified that for someone who experienced an electric shock such as that described by Petitioner, a CT scan of the head would be important in looking for an acute abnormality, as would subsequent MRI scans. In Petitioner's case, all of the test results, the spine exam, and the neurologic exam were normal, which indicated no sequelae from electric shock. Dr. Zelby testified he found inconsistent behavior responses on the reflex examination, which were positive for diminished pain on distraction. He explained that it was inconsistent because Petitioner reported no back pain with a sitting straight leg raise, but reported back pain with a lying straight leg raise. He testified that the reason that is inconsistent is because, as it relates to the spine and to the nerves, those two are the same test and should elicit the same response. As such, the disparity in response is inconsistent. RX1.

Dr. Zelby testified he reviewed Petitioner's head CT scan which showed no acute abnormalities. He also reviewed the lumbar MRI which showed (1) some degenerative disc disease at L4-5 and L5-S1 with trace loss of disc space height; (2) a broad-based bulging disc without stenosis at L3-4; (3) a broad-based bulging disc at L4-5 that was modestly more prominent to the right; (4) trace effacement of the ventral CSF to the right and perhaps trace right lateral recess stenosis; (5) a broad-based paracentral left disc protrusion at L5-S1 with a partial thickness annular tear; and (6) mild to moderate posterior displacement of the left SI nerve root. Dr. Zelby testified that, given the MRI results, he would have been looking for exam findings consistent with an S1 radiculopathy, which would be symptoms down the back of the leg going into the side or bottom of the foot and an absent ankle or Achilles reflex on the left side. However, Petitioner "had no symptoms or findings on exam that were even remotely suggestive of a left S1 radiculopathy". As such, he concluded that the MRI findings were causing no symptoms or neurologic infirmity, were clinically of no consequence or concern, and highlighted the lack of relationship of the MRI abnormality to anything about Petitioner's condition. RX1.

Dr. Zelby testified he reviewed Petitioner's records from Anderson Hospital, Dr. Talley, and Dr. Ambrose. Based upon review of the records and his own physical examination, he opined that Petitioner sustained a mild electrical injury, as well as a soft tissue spinal strain and concussion as a result of his fall. He noted that Petitioner had a constellation of complaints, which he (Petitioner) attributed to his reported electrical injury a year earlier, but his examination

was completely normal. Although there was a protrusion at L5-S1 on the MRI, there was no suggestion that this abnormality was caused or made symptomatic by his injury. RX1.

Dr. Zelby opined that the electrical injury itself was mild, not associated with any burns at an entry or exit point, and not associated with any focal neurologic dysfunction. He noted this type of incident could cause numbness and tingling because of the effects of the electricity on the neural elements, but resulted in no permanent condition or infirmity. Dr. Zelby testified that Petitioner's reported loss of consciousness and fall could have resulted in a concussion, but his normal neurologic exam and normal head CT scan showed no sequelae of any trauma. Any symptoms from concussion would typically resolve within three to four months and would have completely resolved within six months at the latest. Dr. Zelby further testified that the soft tissue muscular spinal strain associated with Petitioner's fall would have typically been much better within four to six weeks and completely resolved within eight to twelve weeks. He noted it was conceivable that Petitioner suffered another spinal strain after his rear-end motor vehicle accident at the beginning of May 2015, but that his symptoms from that incident would have resolved in a similar timeframe. RX1.

Dr. Zelby testified that his conclusion was that Petitioner had a constellation of complaints that were completely inconsistent with the objective medical findings and had no identifiable medical basis, and in addition he had an objectively normal neurologic exam and a normal spine exam. He opined that Petitioner's reported persistence and severity of symptoms was inconsistent with the objective medical findings and inconsistent with the natural history of his medical condition. He believed four to six weeks of chiropractic care or physical therapy was reasonable, but opined there were no objective findings to indicate that the injections were reasonable or necessary. RX1.

Dr. Zelby opined there was no medical basis to suggest that Petitioner required any additional treatment, including pain management, injections, or surgery. He further opined that Petitioner reached maximum medical improvement by the beginning of September 2015, and that he was safely qualified to work full duty without increased risk for injury. He based his MMI date on the fact that a minimal concussion, which is what Petitioner sustained, was usually better within three to four months, but could linger for up to six months. With regard to Petitioner's ability to work during those six months, Dr. Zelby testified that four to six weeks off work to recover was reasonable, followed by light duty of lifting 10 pounds frequently and 20 pounds occasionally. He would restrict Petitioner to ground work only for about three months. By three months post-accident, he would allow medium physical labor and by six months he would allow heavy labor with no restrictions. RX1.

On cross-examination, Dr. Zelby noted that Petitioner reported he had not driven any vehicle since his work accident, but testified that there was no medical reason to suggest that Petitioner was not safely qualified to drive a car or a truck. Dr. Zelby was asked if sexual dysfunction could be indicative of S1 radiculopathy and he testified that neurologic sexual dysfunction would require S2, S3, or S4 involvement, but that the S1 distribution had nothing to do with sexual function. When asked if he found any trigger points upon examination of Petitioner, he testified there were none. With regard to Petitioner's electrical injury, Dr. Zelby testified that on the spectrum of electrical injuries, his was classified as mild. Dr. Zelby

acknowledged that Petitioner continued to complain of numbness and tingling, but testified that his neurologic exam was normal and there was thus no identifiable medical basis for his complaints. He noted Petitioner's complaints were "inconsistent with what I find on his exam, inconsistent with what I find on his diagnostic studies, and inconsistent with what I know about the nervous system and electrical injuries". RX1.

Respondent's Exhibit 8 is a group exhibit consisting of three surveillance videos and three corresponding surveillance reports. The Arbitrator viewed the videos in their entirety.

On **April 23, 2015**, Petitioner was filmed throughout the morning hours, as he drove a gold Chevy pickup truck, fueled the truck at a gas station, danced momentarily in front of his house, carried a baby carrier on multiple occasions, and walked. He performed all of these activities without any signs of pain or discomfort. He was also filmed for about 23 minutes as he and another male appeared to be working on the engine of his truck, with the hood up. He was seen leaning over the front of the truck and reaching into the engine area several times, for several minutes at a time. At one point he did so while simultaneously holding the baby carrier. He was also seen several times leaning into the cab of the truck, bent at the waist, reaching across the width of the seat and reaching onto the floorboard. The gold truck he drove bore a sign or magnet on the driver's door which read, "Dugan Construction, Inc. Roofing, Siding, Tree Removal, Decks, & Spring Yard Clean Ups". The Arbitrator notes that throughout the day Petitioner was observed wearing white or light-colored sunglasses. The sunglasses were sometimes perched on top of his head, and sometimes covering his eyes. The Arbitrator also notes that Petitioner testified that his son Carter was born on March 3, 2015. The Arbitrator further notes that the man seen in this video is the same man who testified at arbitration and identified himself as Petitioner.

On **November 29 and November 30, 2016**, surveillance shows a young woman with long dark hair going from her residence to a maroon van, putting two children (one about 7 or 8 years old and the other an infant in a carrier) into the van and driving off. The Arbitrator notes that the surveillance report lists this as the residence of Petitioner and his girlfriend, which Petitioner confirmed at hearing. The van is registered to Brittany Hewitt, who Petitioner testified was his girlfriend. The Arbitrator concludes, therefore, that the woman shown in the video is Brittany Hewitt, Petitioner's girlfriend.

On **December 13, 2016**, Petitioner was filmed from approximately 8:15 a.m. to 1:25 p.m. This video is quite long and shows Petitioner to be quite physically active. From about 8:30 to 8:50 a.m., Petitioner and another man are seen at a gas station with the same gold Chevy pickup truck as was seen in the first video. Petitioner is wearing black sweat pants, rain boots, a grey sweatshirt with a hood, and a red and white hat. The other man is wearing an orange or red crewneck sweatshirt and a black hat. The hood of the pickup is up and both men appear to be working on the engine area. Petitioner is seen several times bending over the front passenger side of the truck and reaching into the engine area, as well as bending over and reaching into the cab of the pickup. He is also seen walking across the parking lot. He performed all of these activities without any signs of pain or discomfort.

At approximately 9:30 a.m., Petitioner is seen at a private residence, backing the gold pickup truck into a side yard. The man previously seen wearing the orange or red sweatshirt exited the truck and directed Petitioner to back up in order for a flat-bed trailer with short sides to be hooked up to the truck. Petitioner then exited the truck and is seen wearing the same clothes as described above. He is also seen wearing black or dark sunglasses for a short time. A third man exited the truck as well. From about 10:08 to 10:20, Petitioner is seen picking up and carrying several tree branches from the back yard of the residence to the trailer parked in the side yard. He then throws the branches into the trailer. The other two men are in the back yard, mostly out of view, but appear to be cutting branches off of a tree.

At 10:21 a.m. a young woman with long dark hair arrives. The Arbitrator notes this is the same woman filmed on November 29 and 30, who exited from Petitioner's residence and drove off in the maroon van registered to Brittany Hewitt. The Arbitrator, therefore, concludes that the woman seen in the video on December 13 is Petitioner's girlfriend, Brittany Hewitt. The woman and Petitioner are seen talking for two to three minutes, and then Petitioner is seen bending over and leaning into the driver's side of the cab of the truck. The man wearing the orange or red sweatshirt approached Petitioner, started smoking a cigarette, and stood by the truck for a couple of minutes. At 10:30 Petitioner and Ms. Hewitt stood at the passenger door of the truck. He bent over and reached into the truck, pulled out some money, and handed it to Ms. Hewitt. The two of them briefly kissed, and Ms. Hewitt left.

After Ms. Hewitt left, Petitioner retrieved a chainsaw from the truck and yanked on the starter a total of 13 times. He then used the chainsaw to cut up the branches that were piled in the trailer. He leaned over and reached with the chainsaw to cut the branches into smaller pieces, then climbed into the trailer and continued cutting. He is seen leaning over, bending down to about ankle height, stomping down the branches, and reaching with his arms as he operated the chainsaw. This took place for five to seven minutes. At about 10:37 a.m., the man wearing the orange or red sweatshirt is seen, and a close up of his face is observed. The Arbitrator notes the man strongly resembles the man in Petitioner's Exhibits 7 and 8, identified by Petitioner as his brother Gary. He is seen at various times throughout the video smoking cigarettes. Petitioner continued to carry branches from the backyard, throw them onto the trailer, and cut them up with the chainsaw. Some of the branches were quite large and appeared to be heavy, given the obvious effort by Petitioner to carry them and thrown them on top of the pile on the trailer.

At approximately 11:02, Petitioner leaned into the back seat and floor of the truck, then into the front seat and floor, appearing to look for something. He then walked over to another truck, a dark green Ram truck parked on the driveway. He leaned into the cab and came out with a pair of white or light-colored sunglasses, which he proceeded to put on. The Arbitrator notes the sunglasses were the same or similar to those worn by Petitioner in other videos.

Continuing until approximately 1:00, Petitioner continued to carry branches from the backyard, throw them onto the trailer, and cut them up with the chainsaw. The Arbitrator notes that the pile on the trailer continued to grow higher as time went on, causing Petitioner to have to reach high above his head to throw branches on and to cut them up with the chainsaw. At the completion of the tree trimming, Petitioner threw two straps over the top of the pile on the trailer. He then secured the straps to the other side, pulled each strap tightly, and ratcheted each one

until it was as tight as it could go, thereby securing the branches onto the trailer. The video ended at approximately 1:25 p.m.

The Arbitrator notes that throughout the video taken on December 13, 2016, Petitioner was observed to be very physically active, as described in detail above. At no time did he appear to be in any pain or discomfort, or be limited in his abilities.

On **March 9, 2017**, surveillance video shows Petitioner coming out of his house wearing white sunglasses. He then picks up a small child, about 2 years old. Shortly thereafter a young woman with long dark hair came out of the house, and everyone proceeded to get into a maroon van and leave. The Arbitrator notes this is the same woman shown in other videos, identified as Petitoner's girlfriend Brittany Hewitt, and this is the same maroon van shown in previous videos. Later in the video the van returns home and Petitioner is seen carrying the small child into the house. On **March 10, 2017**, surveillance video shows Petitioner getting into the same maroon van, driving away, and returning sometime later. White sunglasses are seen perched on top of his head.

At the time of hearing, Petitioner viewed parts of each of the videos, including the video from December 13, 2016. He thereafter testified that he did not see himself in any of the videos. He testified he did not own white sunglasses, but that his brother Gary did, and that Gary was the person who took over his business. He then identified his brother Gary in Petitioner's Exhibits 7 and 8. As stated above, the Arbitrator notes that the man in the orange or red sweatshirt on December 13, 2016, strongly resembles the man in Petitioner's Exhibits 7 and 8, identified by Petitioner as his brother Gary. Despite Petitioner's denial and assertion to the contrary, the Arbitrator concludes as a finding of fact that the man seen in the various videos and described above as "Petitioner" is, in fact, Petitioner Justin Dugan.

CONCLUSIONS OF LAW

The Arbitrator hereby incorporates by reference the above Findings of Fact, and the Arbitrator's and parties' exhibits are made a part of the Commission's file. After review of the evidence and due deliberations, 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 which arose out of and in the course of Petitioner's employment by Respondent, the Arbitrator finds the following:

To obtain compensation under the Illinois Workers' Compensation Act, a claimant must show by a preponderance of the evidence that he suffered a disabling injury arising out of and in the course of his employment. 805 ILS 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).

The Arbitrator finds that Petitioner met his burden of proof in establishing that an accident occurred which arose out of and in the course of his employment. In so concluding, the Arbitrator finds significant that Petitioner gave a consistent history of the accident to all of the

treating and examining physicians, as well as at trial. Although Respondent disputed the accident, no evidence was presented to support the position or to rebut Petitioner's testimony and the medical records.

<u>In support of the Arbitrator's decision relating to issue (E), whether timely notice of the accident was given to Respondent, the Arbitrator finds the following:</u>

The Arbitrator finds that Petitioner provided timely notice of the accident to Respondent. In so concluding, the Arbitrator finds significant that Petitioner testified he reported the accident right away to his supervisor Andy and he also advised all of his treating and examining physicians, as part of his history, that he reported the accident right away. Although Respondent disputed notice, no evidence was presented to support the position or to rebut Petitioner's testimony and the medical records.

<u>In support of the Arbitrator's decision relating to issue (F), whether Petitioner's current condition of ill-being is causally related to the injury, the Arbitrator finds the following:</u>

A claimant has the burden of proving by a preponderance of the credible evidence all elements of the claim, including that any alleged state of ill-being was caused by a workplace accident. *Parro v. Industrial Commission*, 260 Ill.App.3d 551, 553 (1st Dist. 1994). Liability cannot be premised upon imagination, speculation, or conjecture, but must arise from facts established by a preponderance of the evidence. *Illinois Bell Tel. Co. v. Industrial Comm'n*, 265 Ill.App.3d 681, 685 (1st Dist. 1994).

The Arbitrator finds that Petitioner failed to prove by a preponderance of the evidence that that his current condition of ill-being is causally related to his work accident of March 7, 2015. In so concluding, the Arbitrator finds significant the lack of any medical treatment since September 9, 2015, the inconsistencies between Petitioner's subjective complaints and his objective findings, and the inconsistencies and lack of credibility in Petitioner's testimony when compared to the other evidence.

Petitioner sought medical treatment on the day of his accident, and followed up with Dr. Talley two days later. He treated with Dr. Talley fairly consistently from March 9, 2015, through July 6, 2015, and received chiropractic manipulation and physical therapy. He also treated with Dr. Ambrose, who he saw on March 13, 2015, but not again until July 6, 2015. He followed up on September 1, 3, and 9, but did not return to Dr. Ambrose after that. He underwent three trigger point injections by Dr. Ambrose, on September 1, 3, and 9. Petitioner sought no treatment from any provider after September 9, 2015. The Arbitrator is mindful that Petitioner was examined by Dr. Kennedy on November 24, 2015; however, this was at the request of his attorney for evaluation purposes only, and he was not advised by Dr. Kennedy to return. In addition, Dr. Kennedy recommended he see neurologist Dr. Phillips and pain specialist Dr. Gheith. It does not appear from the record that Petitioner did so.

Dr. Zelby obtained a thorough history from Petitioner, reviewed his treating records and diagnostic studies, and conducted an exhaustive examination on April 8, 2016. He noted that

although Petitioner's lumbar MRI did have some positive findings, none of his complaints correlated with those findings. As such, the findings were incidental and not germane. Dr. Zelby explained and emphasized several times throughout his testimony that Petitioner had "a constellation of complaints" for which there were no objective findings, either on examination or on diagnostic studies. With regard to Petitioner's complaints of continued numbness and tingling in particular, Dr. Zelby testified that the complaints were inconsistent with the findings on exam, inconsistent with the findings on the diagnostic studies, and inconsistent with what he knows about the nervous system and electrical injuries.

Dr. Zelby opined that Petitioner sustained (1) a mild electrical injury with no resulting permanent condition; (2) a concussion from his loss of consciousness and fall, which would have resolved no later than six months post-accident, and which resulted in no sequelae per the CT scan and examination; and (3) a soft tissue muscular spinal strain from the fall, which would have resolved no later than three months post-accident. He opined that Petitioner reached maximum medical improvement at "the beginning of September 2015", or six months post-accident. The Arbitrator notes that this correlates with Petitioner's last date of treatment, which was September 9, 2015.

The Arbitrator finds Dr. Zelby's opinions and explanations thereof to be both credible and persuasive.

As to Petitioner's credibility, throughout much of Petitioner's testimony, the Arbitrator found him to be evasive, contradictory, and lacking in veracity. Several times he refused to answer questions on cross-examination, until instructed by the Arbitrator to do so. He was shown pictures taken from his Facebook page of him and his son getting ready for and attending a Cardinals game. When asked questions about the pictures and that day, his answers were primarily "I don't know" or "I don't remember". When asked what he does on a daily basis he stated, "I do nothing really". At the time of hearing, however, the Arbitrator observed that his hands were calloused and that he had grease around his fingernails. When asked if he owned Dugan Construction he stated that he used to, but gave the company to his brother after he was hurt. Yet, he was shown on videotape on more than one occasion driving a gold Chevy truck with a sign on the door advertising Dugan Construction. When asked whether he sought any treatment following his exam by Dr. Kennedy, he testified he had not, because Respondent refused to pay for treatment. He went further and testified that the only way he could get the MRI "was to go down and get Medicaid". However, the records from Gateway Regional Medical Center, where the MRI was done, show that it was actually billed to and paid by Harmony Health, and that Petitioner was the named insured. In addition, records from Anderson Hospital on the day of the accident show Petitioner's insurance as Illinois Medicaid, indicating that Petitioner was already a Medicaid recipient at the time of the accident and was not required to obtain it in order to get needed medical treatment following the accident.

With regard to Petitioner's lack of credibility, however, the Arbitrator finds most telling his complete denial that he was the person shown in any of the surveillance videos. He was seen carrying an infant seat within a few weeks of his son's birth, wearing white sunglasses. He was seen walking with, riding in a van with, talking with, giving money to, and kissing a young woman identified as his girlfriend. He was seen working for nearly four hours dragging and

throwing tree branches and cutting them up with a chainsaw. The Arbitrator observed Petitioner in close proximity during a lengthy trial. After viewing the surveillance videos in their entirety, the Arbitrator finds that they are indisputably of Petitioner.

Based on the foregoing and the record in its entirety, the Arbitrator finds that Petitioner failed to prove by a preponderance of the evidence that his current condition of ill-being is causally related to his work accident of March 7, 2015. The Arbitrator further finds that Petitioner was at maximum medical improvement on September 9, 2015, that being his last medical treatment, in concurrence with Dr. Zelby's opinions regarding same.

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:

Under Section 8(a) of the Act, a claimant is entitled to recover reasonable medical expenses, the incurrence of which are causally related to an accident arising out of and in the scope of employment and which are necessary to diagnose, relieve, or cure the effects of the claimant's injury. *Absolute Cleaning/SVMBL v. Ill. Workers' Compensation Comm'n*, 409 Ill.App.3d 463, 470 (4th Dist. 2011).

In light of the Arbitrator's findings with respect to issues (C) and (F), the Arbitrator finds that medical services rendered from March 7, 2015, through September 9, 2015, were reasonable and necessary in Petitioner's care and treatment relative to his accident of March 7, 2015. In light of the Arbitrator's finding that Petitioner was at maximum medical improvement on September 9, 2015, the Arbitrator finds that any and all bills for medical services rendered beyond that date are denied. Respondent is liable for the following medical bills as set forth in Petitioner's Exhibit 6, subject to the medical fee schedule as provided in Sections 8(a) and 8.2 of the Act, and subject to presentation on the appropriate HCFA forms with the appropriate codes included. Respondent shall receive credit for any prior payments. The Arbitrator notes that Respondent did not claim a credit under Section 8(j).

1. Center for Advanced Medicine/Dr. Ambrose, 3/13/15-9/9/15	$ 3,533.00
2. Illinois Medicaid, for Anderson Hospital, 3/7/15	$ 288.45
3. Gateway Regional Medical, 8/27/15	$ 3,632.21
4. Gateway Regional Medical, 8/28/15	$ 1,158.84
5. Talley Chiropractic, 3/9/15-7/6/15	$ 7,161.12
TOTAL	**$15,773.62**

In support of the Arbitrator's decision relating to issue (K), Petitioner's entitlement to prospective medical care, the Arbitrator finds the following:

In light of the Arbitrator's finding above with respect to issue (F), the Arbitrator finds that Petitioner is not entitled to ongoing medical care.

In support of the Arbitrator's decision relating to issue (L), Petitioner's entitlement to temporary total disability benefits, the Arbitrator finds the following:

In order to be eligible for temporary total disability benefits, a claimant must prove not only that he did not work, but also that he was unable to work. *City of Granite City v. Industrial Comm'n*, 279 Ill.App.3d 1087, 1090 (5th Dist. 1996). The period of temporary total disability encompasses the time from which the injury incapacitates the claimant until such time as the claimant has recovered as much as the character of the injury will permit, i.e., until the condition has stabilized. *Gallentine v. Industrial Comm'n*, 201 Ill.App.3d 880, 887 (2nd Dist. 1990).

The Arbitrator finds that Petitioner is not entitled to receive temporary total disability benefits for any period of time.

The Arbitrator notes that there was no testimony by Petitioner, or any other person with knowledge, as to what Petitioner's job duties were or the hours he worked. There was no evidence as to the amount of walking, climbing, standing, stooping, bending, or lifting that Petitioner was required to do in the performance of his work. There was no testimony as to the tools Petitioner worked with or the weight of any such tools. There was no testimony as to the amount of or weight of any lifting or carrying he was required to do. There was no testimony or other evidence regarding any of the duties, responsibilities, or physical requirements of Petitioner's job with Respondent.

Petitioner testified that at no time from March 7, 2015, through the date of hearing on May 23, 2017, did he ever seek employment. He testified he did not look for work because he was in pain, which the surveillance videos clearly contradict. There is no evidence to suggest that he ever approached Respondent with regard to returning to work, whether for light duty or full duty. Petitioner's testimony that he did not work because of pain does not, in and of itself, entitle him to temporary total disability benefits.

Turning to the medical evidence, the records from Anderson Hospital clearly establish that Petitioner was examined on the date of the accident. However, he was discharged with no restrictions noted as to his activity, whether it be for work or daily life, and no indication that he could not work.

Thereafter, Petitioner was seen by Dr. Talley on 30 separate occasions between March 9 and July 6, 2015. Dr. Talley's records show that Petitioner appeared to have been examined on each occasion and his subjective complaints were noted, as were the examination results and recommendations. Petitioner testified that Dr. Talley told him to stay off work. The Arbitrator finds, however, that the records from these 30 visits are devoid of any reference whatsoever that Petitioner could not work or that he was placed on restrictions.

As noted in the Findings of Fact, Dr. Talley's records included an undated summary narrative of Petitioner's work accident, his complaints, and his treatment by Dr. Talley. It also contained a statement that Petitioner had been unable to work since his accident and should remain off work another one to two months. Given the detail contained in Dr. Talley's daily notes, made contemporaneous with his treatment, the Arbitrator finds that this summary narrative was not actually a treating record, but rather was prepared by Dr. Talley as an ex post facto statement regarding Petitioner's inability to work. As such, the Arbitrator gives it no weight.

The Arbitrator then turns to the records of Dr. Ambrose, who suggested on September 1, 2015, that Petitioner could not work because of his discomfort when attempting to lift any object that weighed greater than his son, which was about 20 pounds. Prior to that date, Petitioner had been seen by Dr. Ambrose on four other occasions, and on none of those occasions did his treating records reference an inability to work. There is no evidence that Dr. Ambrose was aware of any of Petitioner's job duties or physical demands. As such, his opinion that Petitioner was unable to work was based not only on incomplete information, but on a complete ***lack of*** information. In addition, Petitioner's self-serving statement to Dr. Ambrose with regard to his physical limitation does not appear to have been medically verified. Given the Arbitrator's findings above with regard to Petitoner's veracity, the Arbitrator is not inclined to give credence to his statement to Dr. Ambrose that he could not lift more than 20 pounds.

With regard to Dr. Kennedy's testimony, the Arbitrator notes that, like Dr. Talley and Dr. Ambrose, he had no information whatsoever as to Petitioner's job duties or physical demands. As such, his opinion that Petitioner was unable to work was based not only on incomplete information, but on a complete ***lack of*** information, and the Arbitrator finds it has no merit.

The Arbitrator recognizes that Dr. Zelby opined that it would not be unreasonable for Petitioner to have been off work for a short period of time immediately following his accident. However, neither Dr. Talley nor Dr. Ambrose, contemporaneous with their treatment of Petitioner immediately following his accident, and with knowledge as to his job duties and physical demands, kept him off work.

Based on the foregoing and the record in its entirety, the Arbitrator finds that Petitioner is not entitled to temporary total disability benefits.

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

DONNA RUCH,

Petitioner,

vs. NO: 17 WC 017386

CITY OF CHICAGO,

19IWCC0274

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, propective medical care, temporary total disability, and temporary 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).

The Commission hereby notes and corrects clerical errors in the 19(b) Decision and Order. On page 3, paragraph 3 the Order is hereby corrected to read that Respondent shall authorize and pay for the left SI joint radiofrequency ablation recommended by Drs. Bardfield and Soto, as well as all necessary ancillary and post-procedure medical care. On page 9, paragraph 4 of the Decision, Dr. "Dome" is corrected to Dr. Domb. On page 14, paragraph 4 of the Decision the last sentence is corrected to read left SI joint dysfunction. All else is affirmed and adopted.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed July 9, 2018 is hereby corrected as stated herein and otherwise affirmed and adopted.

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

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

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

No bond 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: JUN 5 - 2019
SM/msb
o-5-/01/19
44

Stephen J. Mathis

Douglas McCarthy

SPECIAL CONCURRENCE/DISSENT

I concur with the majority in all aspects of its decision other than its order to compel Respondent to authorize medical treatment. This issue was previously addressed by the Court in *Hollywoood Casino-Aurora, Inc. v. Illinois Workers' Compensation Commission*, 2012 IL App (2d) 110426WC, which is dispositive. The Court noted "Assuming for the sake of analysis that this provision of the Act [Section 8(a)] is sufficiently broad so as to include a requirement that an employer authorize medical treatment for an injured employee in advance of the services being rendered, the fact still remains that there is no provision in the Act authorizing the Commission

to assess penalties against an employer that delays in giving such authorization." *Id.* at ¶ 19. Ordering Respondent to authorize medical treatment is meaningless where no enforcement mechanism exists under the Act. In accordance with Section 8(a) of the Act and the Court's holding in *Hollywood Casino*, I would order Respondent to provide and pay for the awarded medical expenses and/or treatment.

L. Elizabeth Coppoletti

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

RUCH, DONNA
Employee/Petitioner

Case# **17WC017386**

19IWCC0274

CITY OF CHICAGO
Employer/Respondent

On 7/9/2018, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 2.08% 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:

2208 CAPRON & AVGERINOS PC
STEPHEN J SMALLING
55 W MONROE ST SUITE 900
CHICAGO, IL 60603

0010 CITY OF CHICAGO LAW DEPT
D TAYLOR CHITTICK
30 N LASALLE ST SUITE 800
CHICAGO, IL 60602

19IWCC0274

STATE OF ILLINOIS)

)SS

COUNTY OF COOK)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

Donna Ruch
Employee/Petitioner

v.

City of Chicago
Employer/Respondent

Case # **17 WC 17386**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Steven Fruth**, Arbitrator of the Commission, in the city of **Chicago**, on **December 29, 2017**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. [ ] Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?

B. [ ] Was there an employee-employer relationship?

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

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

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

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

G. [ ] What were Petitioner's earnings?

H. [ ] What was Petitioner's age at the time of the accident?

I. [ ] What was Petitioner's marital status at the time of the accident?

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

K. X **Is Petitioner entitled to any prospective medical care?**

L. X **What temporary benefits are in dispute?**

X **TPD** ☐ Maintenance X **TTD**

M. ☐ Should penalties or fees be imposed upon Respondent?

N. ☐ Is Respondent due any credit?

O. Other:

FINDINGS **19IWCC0274**

On the date of accident, **August 3, 2015**, Respondent *was* operating under and subject to the provisions of the Act.

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

On this date, 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 **$54,114.00**; the average weekly wage was **$1,040.65**.

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.

ORDER

Respondent shall pay Petitioner temporary total disability benefits of **$693.77**/week for **11 & 3/7** weeks, commencing **August 4, 2016** through **October 23, 2016**, as provided in §8(b) of the Act.

Respondent shall pay Petitioner temporary partial disability benefits of **$476.53/**week for **61 & 3/7** weeks, commencing **October 24, 2016** through **December 29, 2017**, as provided in §8(a) of the Act.

Respondent shall authorize and pay for the left SI join radiofrequency ablation recommended by Drs. Bardfield and Soto, as well as all necessary ancillary and post-procedure medical care.

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

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

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

19IWCC0274

Signature of Arbitrator

July 6, 2018
Date

JUL 9 - 2018

INTRODUCTION

This matter proceeded to hearing before Arbitrator Steven Fruth. The disputed issues were: ***F:*** Is Petitioner's current condition of ill-being causally related to the accident?; ***K:*** Is Petitioner entitled to prospective medical care and services?; ***L:*** What temporary benefits are in dispute? TTD TPD

After close of proofs, the parties submitted an Agreed Motion to Supplement the Record, which had office notes of Dr. Benjamin Domb for December 17, 2015 and February 16, 2016 attached, which were inadvertently omitted from Petitioner's Exhibit #4.

FINDINGS OF FACT

Since June 2, 1989 Petitioner Donna Ruch had been a Paramedic for Respondent City of Chicago. On June 15, 2015 Petitioner began a training program to become a Firefighter-Paramedic with Respondent. Firefighter Paramedic training is an 8-week program.

On August 3, 2015, Petitioner was using a stair-chair to transport a 250-lb. dummy up 3 flights of stairs with another trainee. This was a timed test that Petitioner had failed twice before. Petitioner was at the top of the chair going up the stairs backwards. As she went up the first flight of stairs she felt a pop in her right hip. Petitioner continued to the first landing. As she started to ascend the second flight of stairs, her leg collapsed beneath her and she was unable to bear weight on her leg.

Petitioner had failed the timed chair lift test twice before her accident. The August 3, 2015 was Petitioner's third attempt to pass that test.

Petitioner was transported by ambulance to Rush University Medical Center emergency department on August 3. Her examination included x-rays of the right hip and right femur, which noted a benign appearing right inferior sacral defect and early osteoarthritis in the right hip. Petitioner was referred to Dr. Fardon of Midwest Orthopedics at RUSH.

Petitioner consulted Dr. David Fardon at Midwest Orthopedics at RUSH on August 6, 2015. Petitioner presented on crutches complaining of buttock pain. She had been taking Norco and icing her buttock, which provided only limited relief of her symptoms. On physical examination Dr. Fardon noted acute distress over the right hip. Petitioner could walk without crutches but had to stay up on her right forefoot and not

put her heel down. She was very tender over her right sacroiliac area but not particularly so over her trochanters. Slow, cautious movements of the hips were not painful, but active resisted flexion and rotation of the hip were painful. Pain was centered posteriorly in the buttock and over the sacroiliac areas and did not radiate down the legs. Dr. Fardon reviewed the August 3 x-rays, noting the same benign discontinuity at the cortex of the distal sacrum on the right side. Dr. Fardon diagnosed an acute lumbar sprain/strain but referred her for a bone scan to make sure the lesion of the sacrum had any clinical significance. Petitioner was taken off work.

Petitioner began physical therapy at Sports and Ortho–Edison Park August 12, 2015. She was seen in 28 sessions. Petitioner had plateaued and was discharged to home exercise program November 10, 2015.

On August 27, 2015 Dr. Fardon reviewed the bone scan with Petitioner. The scan noted some focal inflammation but Dr. Fardon could not see any destructive change or anything that would explain Petitioner's symptoms. Symptoms continued to be around the right hip with tenderness at the ischial tuberosity and at the back of the trochanter. She was working with a physical therapist and had progressed. She reported she was doing "great" so far. Dr. Fardon ordered an MRI of the hip to "see if we can have a better handle on this", considering a referral to a hip subspecialist depending on the results of the MRI. Dr. Fardon noted Petitioner's pain precluded her from working.

The September 10, 2015 right hip MRI showed a pincer type deformity of the right hip joint with associated chronic labral tearing and fraying, as well as focal regions of increased bone marrow signal ala adjacent to SI joints, most likely representing degenerative change. There was no evidence of muscle tear or strain.

Petitioner saw Dr. Shane Nho at Midwest Orthopedics at RUSH September 28, 2015 for her right hip pain. Petitioner recounted her right hip injury while training on August 3, 2015. She described carrying a 250-pound dummy upstairs with a chairlift and felt a pop in the posterior hip with a pinching sensation. She had been referred to Dr. Fardon to rule out back involvement. Dr. Nho noted that while Dr. Fardon had found evidence of bony edema he did not think Petitioner's spine was contributing to her symptoms and referred her for a hip workup and management.

On exam Petitioner reported right hip pain in the mid buttock area and denied any radiating symptoms. She had physical therapy and was using anti-inflammatories and Tramadol to help her sleep as needed. Dr. Nho reviewed the MRI, noting a chondral labral injury with some mild bony edema in the sacroiliac region. Hip flexion was normal but extension, external rotation, and internal rotation were diminished. Muscle strength was normal except for hip abduction. Petitioner had a positive subspine (impingement sign), positive trochanteric pain sign, positive FABER, and

positive FADIR impingement signs. She was tender to palpation over the greater trochanter and ischium but had mild tenderness the SI joint region.

Dr. Nho suspected a labral tear versus symptomatic bony edema in the sacral region. Dr. Nho recommended a diagnostic intraarticular hip cortisone injection because Petitioner's symptoms were not very straightforward. Dr. Nho kept Petitioner off work.

Dr. Nho wrote a note September 28, 2015 confirming that Petitioner was not at MMI and that her diagnosis/treatment was causally related to the alleged industrial accident.

Dr. Nho performed the intra-articular right hip joint injection on October 5, 2015.

Dr. Nho saw Petitioner next on October 17, 2015. Petitioner reported that her 4/10 pre-injection pain reduced to 3/10 for a few days but then returned to 4/10. Dr. Nho noted her physical examination to be unchanged and his impression to be right buttocks pain. Dr. Nho noted a marginal response to the intra-articular injection and commented that her pain seems to be localized around the ischium. He referred Petitioner to Dr. Sheila Dugan for an evaluation of her pelvic floor to determine if any dysfunction there could be contributing to Petitioner's pain and symptoms. Dr. Nho did not recommend any sort of surgery, contemplating other options and possible diagnoses, and noted that he would see Petitioner back again after she was evaluated by Dr. Dugan.

Dr. Sheila Dugan of Rush University Physical Medicine and Rehabilitation saw Petitioner on November 30, 2015. Petitioner had seen Dr. Fardon who focused on her low back and had referred her for physical therapy. Dr. Dugan noted Sport and Ortho was concerned about hip pathology. The September MRI showed a labral tear and fraying. Petitioner's specific complaints were not noted.

On examination Dr. Dugan noted Petitioner ambulated with no significant dysfunction. She could walk on toes and heels and could do a unilateral squat. Petitioner did have some right pelvic pain with heel walking on the right. Dr. Dugan noted a tight and tender levator ani muscle. She assessed a levator spasm and muscle pain. Dr. Dugan recommended physical therapy noting a tight and tender levator ani muscle.

Dr. Dugan further noted that Petitioner was working toward retaking her exam to become a City of Chicago Firefighter-Paramedic and needed to process to lunges, lifting, etc., in order to return to the fire academy. Dr. Dugan prescribed Valium suppositories nightly. During message communication with Petitioner on December 3 and 4, 2015, Dr. Dugan advised Petitioner to "use the suppositories nightly and over time the PT may

feel a difference in the amount of muscle tension in your pelvic floor. Dr. Dugan noted that both the medication and the physical therapy should be helpful with an added benefit from doing them both.

On December 4, 2015 Petitioner contacted Dr. Dugan's office to request a letter stating that her condition is related to a work-related injury, in particular referencing the "tender levator ani." Dr. Dugan wrote a letter to the Chicago Fire Department noting that Petitioner had a tight and tender right levator ani. Dr. Dugan stated the lifting injury caused overuse of her pelvic floor muscles on the right. Dr. Dugan noted that Petitioner was to start Valium suppositories, "PT" for manual therapy, neuromuscular re-ed, and therapeutic exercise" to address her pain and dysfunction. Dr. Dugan noted that Petitioner's ob-gyn history is not the cause of her pain but rather the findings of painful tight muscles are due to them being overworked during her lifting task.

Petitioner began physical therapy at Kamin Physical Therapy December 8, 2015 on referral by Dr. Dugan. The referring diagnosis was pelvic floor muscle spasm and pain Petitioner gave a history of an injury August 3, 2015 during fire department testing when she heard a pop in the right buttock with severe pain while lifting a stair-chair with a 250-pound dummy. Petitioner was treated through February 13, 2016. It was noted then that Petitioner had also been diagnosed with right hip all labral tear. The therapist noted demonstrated functional improvement. Petitioner had decreased pelvic floor muscle pain and strength. However, there was no improvement in her right hip and deal pain. The therapist opined that Petitioner's pelvic floor dysfunction/muscle spasm and pain where the result of the lifting injury and that the right hip/gluteal pain was the result of the right hip labral tear

On December 17, 2015 Petitioner saw Dr. Benjamin Domb of Hinsdale Orthopaedics for a second opinion. Petitioner gave a history of her accident on August 3, 2015. She complained of right hip and gluteal pain. Examination of the right hip noted positive findings of anterior impingement and posterior instrument. Log roll, lateral impingement, Ober's test, resisted internal rotation, LT test, internal and external stamping were all negative. Dr. Dome noted the September 10, 2015 MRI showed a pincer type deformity with a labral tear. He related petitioner's condition to her accident in August 2015 during fire academy training.

Dr. Domb performed a diagnostic ultrasound of Petitioner's right hip which indicated a right hip labral tear was the leading source of her pain. Dr. Domb performed an ultrasound guided corticosteroid injection of the right hip. He noted that there was no pain after the injection, leading to the conclusion that the pain was intra-articular. Dr. Domb opined that the mechanism of injury, the timing of the pain, the area of the

pain, and the complete relief after the injection lead us to the conclusion that her pain is coming from the labral tear that occurred during the fire academy training.

Dr. Domb recommended physical therapy. If conservative care failed he recommended arthroscopic labral repair versus debridement versus reconstruction.

Dr. Dugan saw Petitioner again on January 13, 2016. Dr. Dugan noted that Petitioner had an unsuccessful injection in her hip with Dr. Nho. Petitioner had had a second opinion with Dr. Domb, who performed an intra-articular injection under ultrasound which was successful in eliminating her pain.

The January 25, 2016 physical therapy note, signed off on by Dr. Domb on February 2, 2016, documented a labral tear and a pincer deformity.

Petitioner was seen by Dr. Domb's nurse practitioner Stephanie Rabe February 16, 2016, complaining of severe right hip and right lower extremity pain which inhibited daily activities. Pain was worse with heavy lifting and squatting. Examination of the right hip showed pain limiting ranges of motion. After apparent consultation with Dr. Domb NP Rabe noted Petitioner's failure to improve with physical therapy, activity modification, and injections. Dr. Dome believed Petitioner was a candidate for a right hip arthroplasty with labral repair versus debridement versus reconstruction with autograft.

On February 29, 2016 Dr. Domb performed a right hip arthroscopy. The surgery included labral repair, which was independent of the acetabuloplasty that he also performed. In the acetabuloplasty Dr. Domb elevated the capsule from the pincer lesion and used a bur to trim the acetabular rim. In addition to the labral repair and the actebuloplasty, Dr. Domb debrided the iliopsoas bursa and removed damaged cartilage overlying the femoral head-neck junction. Dr. Domb also debrided the peritrochanteric compartment and performed a trochanteric bursectomy.

Petitioner had her initial post-operative physical therapy evaluation at Sports and Ortho on March 2, 2016. During physical therapy it was noted that Petitioner was working extremely hard to prepare herself for passing the Chicago Fire Department examination and that she was almost there. On April 20, 2016 Petitioner reported that her original pain is completely gone, her current pain she is having is different than that pain.

On May 31, 2016 Petitioner saw Dr. Domb's nurse practitioner, Stephanie Rabe. Petitioner had groin pain and hip flexor pain that was unimproved with therapy. Dr. Domb had recommended a diagnostic ultrasound and injection of the right hip, which was performed May 31. Petitioner reported a significant reduction in pain following the injection. Petitioner was kept off work.

On July 7, 2016 Petitioner saw Nurse Practioner Rabe for post-surgical follow-up. She had right hip pain but Petitioner's primary complaint was left sacroiliac [SI] joint pain. Therapy including sacral manipulation had given some relief. A diagnostic ultrasound of the right hip for right hip pain and a lidocaine and Celestone trochanteric bursa injection were performed. It was noted that overall pre-surgical right hip symptoms had significantly improved. It was thought she would benefit from some continued physical therapy. A referral to Dr. Bardfield was considered if SI joint pain persisted. Petitioner was kept off work.

The July 13, 2016 physical therapy note recorded that Petitioner is engaged in dummy drags, part of the requirement to pass the firefighter academy testing. It was noted that Petitioner's SI joint pain was still at 4/10 and that she was going to see her pelvic floor specialist tomorrow. The July 15, 2016 physical therapy note recorded that Petitioner had seen a pelvic floor specialist who did some muscle energy techniques, massaged gluts, and adductors, which made Petitioner seem to feel better. Petitioner reported she felt better and the SI joint went completely away. That morning, the SI joint pain returned.

The July 18, 2016 physical therapy note recorded Petitioner's right lateral hip pain was 1/10 on the pain scale with no more pinching in the front of the leg. On July 20 it was noted that Petitioner's objective was to return to work. The physical therapy note from August 3 states that Petitioner had no SI joint pain. When she returned on August 24 she complained of severe left SI joint pain which had not resolved.

On August 30, 2016 the physical therapist noted that the focus was on the right hip up to "6/24", when after attempting to jog on the treadmill Petitioner reported severe left SI joint pain. Since that time, this pain had not gone away. Her right hip pain had completely resolved and she had close to normal motion and strength in the right hip. The note further states that "[w]e are rehabbing her back to a job which requires heavy lifting, pulling, pushing and carrying." The therapy note from August 5, 2016 lists a section entitled "CFD testing:" and notes "Dummy drag: did have pain in the right shoulder . . ." as well as other lifting and carrying requirements that Petitioner was close to but had not quite mastered.

On August 8, 2016 Petitioner saw Dr. Steven Bardfield on referral from Dr. Domb for low back pain going to the left glute and left hip. Dr. Bardfield noted that Petitioner began to experience focal pain in her left SI joint region after doing some activities during work conditioning. Dr. Bardfield's impression was left SI joint dysfunction. Dr. Bardfield recommended physical therapy and SI joint injections. He hoped to reduce the inflammation to allow physical therapy to be more effective in stabilizing the region and diminishing pain. Petitioner was kept off work.

On August 23, 2016 Dr. Domb's nurse practitioner noted that while Petitioner's hip was doing well, her greatest complaint was with her ongoing SI joint pain. Petitioner was diagnosed with right hip bursitis and SI joint dysfunction. Petitioner was released to return to work on August 23, 2016 with restrictions pertaining only to the right hip with notation to see Dr. Bardfield for any restrictions pertaining to the SI Joint dysfunction. Petitioner's restrictions pertaining to her hip were no lifting greater than 5-10 lbs., sitting as comfort allows, no bending past 90°, no squatting, and no climbing.

On September 7, 2016 Petitioner saw Dr. Bardfield who noted that she did not obtain relief from her left sacroiliac joint injection. He recommended that Petitioner continue with physical therapy. Dr. Bardfield noted Petitioner was unable to return to work.

The therapy record from September 30, 2016 notes that Petitioner was status post right labral repair and that that pain had fully resolved with improved range of motion and strength but that Petitioner had developed left SI joint pain.

On October 6, 2016 Petitioner saw Dr. Bardfield complaining of low back pain going into the left glute and left hip and occasionally into the left thigh. She had completed physical therapy and noted slight improvement. Lumbar range of motion was limited by 20%. Both hips had full and pain-free motion. Right and left straight-leg raise were negative. There was tenderness over the paraspinals and left SI joint. The therapist had given her a sacral iliac stabilization belt. Dr. Bardfield noted instability of the SI joint. He diagnosed left SI joint dysfunction with instability. Petitioner was prescribed additional physical therapy and recommended to continue off work in the interim.

On October 24, 2016 Petitioner began employment with the Smith Perry Eye Center in Hinsdale as a surgical technician.

On November 17, 2016 Petitioner saw Dr. Bardfield with the same complaints as October 6. Findings on clinical exam were essentially the same although lumbar motion was now limited by 15%. Dr. Bardfield continued with his diagnosis of left SI joint dysfunction but added hypomobility status post right hip arthroplasty. Dr. Bardfield referred her to a pain specialist, Dr. Soto, and recommended Petitioner continue off work.

On December 2, 2016 Petitioner had an initial evaluation at Millennium Pain Center at Presence Resurrection Medical Center with Dr. Eliezer Soto. Her primary complaint was constant left SI joint pain. Dr. Soto ordered an MRI of the "[s]acro & pelvic" area in addition to a left SI joint steroid injection. Petitioner was unable to tolerable an SI joint injection on December 27, 2016. The December 22, 2016 MRI of

the SI joints was unremarkable. Dr. Soto injected Petitioner's left SI joint January 10, 2017. On January 30 Petitioner reported that the injection provided 90% relief but only for one day. A left SI joint radiofrequency ablation was recommended pending a surgical opinion.

On February 24, 2017 Petitioner consulted Dr. Benson Yang of Northwestern Neurological Associates. Petitioner complained of left SI joint pain since end of June 2016. She developed SI joint pain after right hip surgery. The pain resolved initially with corrective exercises for a couple of weeks, but Petitioner then had constant pain with exacerbations with sitting and going up stairs. Petitioner reported some relief with Dr. Soto's SI joint injections. Dr. Yang incorporated the MRI report in his chart. He opined that the left SI joint may be the pain generator. Dr. Yang recommended continued pain management and physical therapy. The doctor suggested joint fusion as an alternative.

On March 2, 2017 Petitioner returned to Dr. Domb's nurse practitioner Stephanie Rabe. Petitioner reported her hip was doing very well. Petitioner complained of occasional intermittent lateral hip pain, worsened with weather changes, but that other than that, her hip was doing "excellent". Petitioner continued to see Dr. Bardfield and Dr. Soto for pain management. A nerve ablation was recommended. On March 2, 2017 Petitioner was found at MMI regarding her right hip and was returned to regular work and activity with no restrictions regarding her right hip.

On March 7, 2017 Dr. Soto performed a left SI joint radiofrequency ablation. Petitioner followed up with Dr. Soto and Dr. Eric Jeffries. On May 15, 2017 Dr. Soto planned to repeat the left SI joint radiofrequency ablation.

On July 20, 2017 Petitioner saw Dr. Bardfield following an injection and radiofrequency ablation to the left sacroiliac area. It was noted that her pain level was down to 3/10 and that she was to schedule with the pain specialist for a radiofrequency ablation to a slightly different area. Dr. Bardfield considered this reasonable given the pain reduction she had with the prior ablation. It was noted that the Petitioner was in a walking boot and on crutches due to surgery on the right foot.

Dr. Bardfield's diagnoses were left SI joint dysfunction and hypermobility status post right hip arthroplasty. Dr. Bardfield recommended Petitioner see Dr. Soto and continue physical therapy followed by work conditioning and then hopefully a functional capacity evaluation to determine whether or not she is able to do her job activities as a paramedic in training. He noted that Petitioner was unable to return to work.

On November 8, 2017 orthopedist Dr. Jesse Butler examined Petitioner's lumbar spine at Respondent's request pursuant to §12 of the Act. Dr. Butler conducted a thorough review of Petitioner's medical care beginning with Dr. Fardon, physical therapy, MRIs, Dr. Nho, Dr. Dugan, Dr. Domb, NP Rabe, and Dr. Bardfield. Dr. Butler noted Petitioner's diagnosis of right labral tear which led to Dr. Domb's arthroscopic labral repair, acetabuloplasty, iliopsoas bursectomy, femoroplasty, capsular release, endoscopic trochanteric bursectomy, and debridement February 29, 2016. He also noted Petitioner's diagnosis of left sacroiliac SI joint dysfunction and sacroiliitis and treatment with injections and radiofrequency ablation.

Dr. Butler's examination was limited to Petitioner's lumbar spine. Dr. Butler diagnosed the right hip labral tear related to Petitioner's work injury. He noted that Petitioner did not sustain any injury to the lumbar spine. He noted that Petitioner had developed left sacroiliitis during her rehabilitation in June 2016.

Dr. Butler opined that there was no causal relationship between the work-related accident and an injury to Petitioner's lumbar spine. He opined that Petitioner had no current disability or impairment relating to her lumbar spine. Dr. Butler further opined that Petitioner was at MMI and that there was no objective basis for work restrictions relating to any lumbar spine injury. Finally, Dr. Butler opined that Petitioner did not require additional diagnostic testing or treatment for her lumbar spine.

Dr. Butler offered no opinion regarding Petitioner's right SI joint diagnosis or treatment.

Petitioner testified that she still has left SI joint pain. She testified that the radiofrequency ablation contemplated in Dr. Bardfield's July 20, 2017 report had not been performed as of the time of trial.

Following Petitioner's initial injury on August 3, 2015 she was paid full salary for the first year according to the union contract, as is customary for police and fire fighter trainees. Petitioner was discharged from employment with the City on August 3, 2016. Petitioner does not claim any benefits under the Act for time lost from work for this year-long period. Petitioner received benefits from her own long term disability policy starting in October 2015. Respondent did not contribute to this private policy.

On August 3, 2016, following her discharge, Petitioner purchased COBRA health insurance. Respondent did not contribute to the premiums for the Cobra policy.

CONCLUSIONS OF LAW

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

It was not genuinely disputed that Petitioner sustained a torn labrum in her right hip that was causally related to her work-related accident.

During a training exercise which required a two-man lift of a 250 pound dummy up stairs within a specified time, Petitioner felt a pop and immediate pain in her right hip. Following her accident Petitioner presented immediately with objective symptoms which led to diagnostic studies confirming that injury. After failed conservative care, which included therapy and injections, the torn labrum required surgery on February 29, 2016. The chain of events circumstantial evidence clearly established the causal connection of the right hip labral tear to the work accident on August 3, 2015. It is noteworthy that Respondent's §12 examining orthopedist, Dr. Butler did not address Petitioner's right hip injury at all.

The genuinely disputed issue is whether Petitioner's diagnosed left sacroiliac dysfunction is causally related to her work accident on August 3, 2015. Petitioner had generalized complaints in her sacroiliac region at the outset of her post-accident medical care. Her SI joint complaints did become specifically documented on the left side until July 2016, when her right hip issues apparently resolved. Petitioner's left SI joint complaints were coincidental to her right hip post-operative therapy as she tried to regain function sufficient to complete her paramedic training.

The Arbitrator did not find a causation opinion documented in her treating medical records relative to the diagnosed left SI joint dysfunction. Nonetheless, a reasonable inference can be drawn from the chain of events circumstantial evidence that Petitioner sustained a left SI joint injury that was masked by her right hip labral tear or that she sustained the SI joint injury during the physical therapy intended to cure or relieve the effects of her right hip labral tear. Either scenario is sufficient to prove causation. Again, it is noteworthy that Respondent's §12 examining orthopedist, Dr. Butler did not address Petitioner's left SI joint injury at all. Dr. Butler assessed Petitioner's lumbar spine only. Any opinion by him is irrelevant to Petitioner's lefr SI joint dysfunction.

Accordingly, the Arbitrator finds that Petitioner proved that her left SI joint dysfunction is causally related to her work accident on August 3, 2015.

K: Is Petitioner entitled to prospective medical care and services?:

In light of finding that Petitioner proved that her left SI joint dysfunction was causally related to her work accident, the Arbitrator finds that Petitioner proved that she

is entitled to the prospective medical care recommended by her treating physicians, namely a second radiofrequency ablation.

Drs. Bardfield and Soto have both recommended another ablation. Deference is often given to the opinions of treating physicians whose goals are cure or relief their patient's problems. Although there was a §12 examination, the examiner, Dr. Butler, did not address or assess Petitioner's SI joint complaints. Dr. Butler's opinions were limited to petitioner's lumbar spine and therefore are irrelevant Petitioner's left SI joint and the necessity of another ablation.

L: What temporary benefits are in dispute? TTD, TPD

Petitioner claims entitlement to TTD benefits from August 4, 2016 through October 23, 2016 and TPD benefits from October 24, 2016 through December 29, 2017 (ArbX #1). On August 23, 2016 Dr. Domb's NP Rabe returned Petitioner to work with 5-10 pound lifting and no bending past 90° restrictions regarding her right hip, with no indication of understanding whether those restrictions could or would be accommodated. At that time, Petitioner was no longer totally disabled regarding her right hip. However, Petitioner was still under the care of Drs. Bardfield and Soto for her SI joint dysfunction, neither of whom had released Petitioner to return to work as a paramedic and who continued to treat her after August 23.

Petitioner began working at Eye Surgery Center of Hinsdale on October 23, 2016. On March 2, 2017 Dr. Domb's NP Rabe placed Petitioner at full duty with no restrictions for the right hip, again without any indication of understanding whether she could return to work as a paramedic with her SI joint dysfunction. Petitioner was still under active care with Drs. Bardfield and Soto for her SI joint dysfunction, neither of whom had released Petitioner to return to work as a paramedic and who continued to treat her after March 2.

Without taking Petitioner's SI joint dysfunction into consideration, NP Rabe's opinions regarding Petitioner's ability to return to work with and without restrictions are not persuasive.

Petitioner's Exhibit #9 was payroll records from Eye Surgery Center of Hinsdale from October 23, 2016 through December 16, 2017, with two 2-week pay-periods missing. Petitioner testified that the missing two pay-periods were for time off for her foot surgery. From the pay-period beginning January 1, 2017 and through December 16, 2017 Petitioner worked hours varying from 6.75 hours to 58.25 hours, at $20.00 per hour. Petitioner earned a total of $10,050.00 through December 16, 2017. Ordinarily, computing average weekly wage from the last 52 weeks of work would involve simple

arithmetic. Computing AWW with two missing pay-periods invites speculation. Even so, calculating from the last confirmed 26 pay periods equates to $325.86 AWW.

Therefore, the Arbitrator finds Petitioner is entitled to TTD benefits commencing August 4, 2016 through October 23, 2016, 11 & 3/7 weeks, at a rate of $693.77 per week. The Arbitrator further finds that Petitioner had an AWW differential of $714.79, for a rate of $476.53 per week. The Arbitrator finds that Petitioner is entitled to TPD benefits from October 24, 2016 through December 29, 2017, 61 & 3/7 weeks, at a rate of $476.53 per week.

Steven J. Fruth, Arbitrator

July 6, 2018
Date

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

JANICE HINDMAN,

Petitioner,

vs. NO: 16 WC 37776

19IWCC0275

SOI / BIG MUDDY CC,

Respondent.

DECISION AND OPINION ON REVIEW

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

In so finding, the Commission strikes the Arbitrator's finding that "Petitioner failed to prove accident as a matter of law" instead finding that although Petitioner was in the course of her employment, she failed to present sufficient evidence to prove that her accident arose out of her employment.

"To obtain compensation under the Act, a claimant bears the burden of showing, by a preponderance of the evidence, that he has suffered a disabling injury which arose out of and in the course of his employment. [citations omitted]. 'In the course of employment' refers to the time, place and circumstances surrounding the injury." *Sisbro Inc. v. Industrial Commission*, 207 Ill. 2d 193, 203, 797 N.E.2d 665 (2003). "Arising out of" speaks to risk- is the risk encountered by the employee a risk incidental to the employment as not all injures suffered while at work are compensable. See *e.g. Brady v. Louis Ruffolo & Sons Construction Company*, 143 Ill. 2d 542, 552, 578 N.E.2d 921 (1991) ("This court has previously declined to adopt the positional risk doctrine, believing that the doctrine would not be consistent with the requirements

expressed by the legislature in the Act"). "To satisfy this requirement it must be shown that the injury had its origin in some risk connected with, or incidental to, the employment so as to create a causal connection between the employment and the accidental injury." *Sisbro* at 203.

"There are three types of risks to which employees may be exposed: (1) risks that are distinctly associated with employment; (2) risks that are personal to the employee, such as idiopathic falls; and (3) neutral risks that do not have any particular employment or personal characteristics. [citations omitted]." *Adcock v. Illinois Workers' Compensation Commission*, 2015 IL App (2d) 130884WC, ¶ 31. Further, an injury which results from a neutral risk requires the employee to show he was exposed to the risk to a greater degree than the general public. *Springfield Urban League v. Illinois Workers' Compensation Commission*, 2013 IL App (4th) 120219WC, ¶ 27. "Injuries resulting from a neutral risk generally do not arise out of the employment and are compensable under the Act only where the employee was exposed to the risk to a greater degree than the general public." *Springfield Urban League v. Illinois Workers' Compensation Commission*, 2013 IL App (4th) 120219WC, ¶ 27.

Petitioner's fall occurred "in the course of" her employment as the fall was sustained on Respondent's premises. Petitioner fell on the sidewalk while walking to her car at day's end. T. 11. However, Petitioner failed to prove her injuries "arose out of" her employment.

In *Dukich v. Illinois Workers' Compensation Commission*, the court noted "accidental injuries sustained on property that is either owned or controlled by an employer within a reasonable time before or after work are generally deemed to arise out of and in the course of employment when the claimant's injury was sustained as a result of the *hazardous condition* of the employer's premises. [citations omitted]." (Emphasis added). 2017 IL App (2d) 160351WC, ¶ 40. Such hazardous conditions are deemed employment risks.

In this case, Petitioner failed to prove she encountered a hazardous condition *i.e.* an employment risk. Petitioner testified she fell on an incline or uneven surface on the sidewalk. T. 12. Petitioner clarified that uneven referred to one part of the sidewalk being higher than the other. T. 35. Petitioner testified no defect was apparent in the sidewalk and no cracks were present. T. 34. Petitioner's Exhibit 2, a photograph of the area where Petitioner fell, depicts a sidewalk which inclines on either side to allow for wheel chair access. In accordance with Petitioner's testimony, Ms. Reed testified the sidewalk was in good condition and no defects were present. T. 40. Based upon said testimony, Petitioner failed to present evidence that the sidewalk was defective or hazardous.

Analyzing the facts under a neutral risk analysis leads to the same conclusion. The sidewalk where Petitioner fell was sloped as it allowed for handicapped access. Petitioner failed to present evidence that the handicapped area where she fell was anymore hazardous or different than handicapped areas traversed by members of the general public on a daily basis. There is no evidence that this sidewalk and its slope presented any distinct hazard to Petitioner. Moreover, there is no evidence Respondent required Petitioner to utilize this particular path or route to access her vehicle.

19IWCC0275

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed September 17, 2018, is hereby affirmed and adopted with the clarification noted above.

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.

Since the Respondent is the State of Illinois, there is no review of this decision in the Circuit Court.

DATED: JUN 6 - 2019

Maria E. Portela

Thomas J. Tyrrell

L. Elizabeth Coppoletti

SE/
O: 2/27/19
49

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

HINDMAN, JANICE
Employee/Petitioner

Case# **16WC037776**

SOI/BIG MUDDY CC
Employer/Respondent

19IWCC0275

On 9/17/2018, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 2.26% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

4075 FISHER KERHOVER COFFEY ET AL
JASON E COFFEY
1300 1/2 SWANWICK ST POB 191
CHESTER, IL 62233

0502 STATE EMPLOYEES RETIREMENT
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0558 ASSISTANT ATTORNEY GENERAL
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0498 STATE OF ILLINOIS
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100 W RANDOLPH ST 13TH FL
CHICAGO, IL 60601-3227

1350 CENTRAL MANAGEMENT SERVICES
BUREAU OF RISK MANAGEMENT
PO BOX 19208
SPRINGFIELD, IL 62794-9208

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

SEP 17 2018

STATE OF ILLINOIS)
)SS.
COUNTY OF Jefferson)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Janice Hindman
Employee/Petitioner

v.

SOI/ Big Muddy CC
Employer/Respondent

Case # **16** WC **37776**

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 **Edward Lee**, Arbitrator of the Commission, in the city of **Mt. Vernon**, on **July 12th, 2018**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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. [ ] Is Petitioner entitled to any prospective medical care?

L. [x] What temporary benefits are in dispute?
[ ] TPD [ ] Maintenance [x] TTD

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

N. [ ] Is Respondent due any credit?

O. [ ] Other ______

FINDINGS

On the date of accident, **11/16/16**, Respondent *was* operating under and subject 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 with relation to the need for surgery.

In the year preceding the injury, Petitioner earned $65,473.37; the average weekly wage was $1259.10.

On the date of accident, Petitioner was **60** 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, extended benefits paid from N/A and $ for other benefits, for a total credit of $, .

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

ORDER

Petitioner has failed to meet her burden of proof and thus shall be barred from recovery. Petitioner failed to prove accident as a matter of law. Thus, the Petitioner claim is denied and all other issues are moot.

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

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

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

Signature of Arbitrator

9/14/18
Date

SEP 17 2018

Findings of Fact

This matter was heard in Mt. Vernon. The issues were accident, temporary total disability, medical expenses, medical, prospective medical care and the nature and extent of the injury.

Petitioner worked for Pinckneyville Correctional Center at the time of trial but the incident in question occurred on her first day on the job at Big Muddy Correctional Center. Her position at the time was working in the mail room and she was in training.

She testified on direct examination there was a parking lot on site with designated parking for visitors of inmates but the employees' park in this lot as well. On the day in question she parked on the right hand side of the parking lot. She walked by the most direct path into the facility and she took the same pathway at the end of the day. Petitioner testified as she was walking out a co-worker, Barb Conyers, that had transferred with her yelled at her, asking what time they needed to be there the next day for training. According to Ms. Hindman, "And I looked up, and I was talking to her, and I did not see the incline—or the uneven sidewalk. And I ended up stepping with my right—left foot on the lower part and my right foot ended up hitting the higher part, and it threw me, and I ended up falling. .." She further testified she looked up when called .

Petitioner proffered a set of pictures that Ms. Hindman confirmed were of the facility in question, Petitioner's Group Exhibit #1. Petitioner drew a line on the photograph of the sidewalk indicating the location of her fall.

Ms. Hindman did return to her employment after treating for her injuries and testified she is able to perform her job duties and doesn't have any restrictions. She has NOT been told she can't perform her job duties and this has not impacted her future earnings capacity. She is currently working at Pinckneyville Correctional Center.

On cross examination Petitioner admitted suffering from Cellulitis which as she explained, "Cellulitis is where your legs will swell, and my cellulitis is associated---I have lupus." But she said this doesn't cause problems with her legs or extremities. She testified she gets the cellulitis around her ankles, it turns into sores. She stated it does not affect her ability to walk or her mobility.

Again on cross she testified the public does have access to the parking lot in question. She testified, "Nobody has an assigned parking spot unless you are like the warden or..." She said it was a nice day with no snow or rain. The pavement was not wet and the weather was clear. When Ms. Conyers called to her petitioner was facing her. Ms. Hindman testified she continued walking toward Ms. Conyers when she was called. When asked about a defect in the pavement, she testified, "the sidewalk that I'm talking about is uneven, where one part is a little bit higher, and it goes down a little bit."

When asked:

Q: Ma'am, is there any defect in that sidewalk?

A: I have never said there was a defect. ...

Q: Is there a crack in the sidewalk, ma'am?

A: I've never said there was a crack in it.

Q: Is there anything beyond smooth concrete of a sidewalk?

A: One side is higher than the other side.

On redirect examination Ms. Hindman's testimony was the right side of the parking lot is designated for employees and visitors. The left side is designated for employees only. But on recross examination she admitted she too had parked on the right side of the parking lot where visitors can park on the date in question.

The respondent called Ms. Terri Reed to testify in the case. Ms. Reed is currently the work comp coordinator at IYC-Harrisburg and prior to that position she worked at Big Muddy Correctional Center for approximately 18 months. She was the business administrative specialist and Ms. Hindman's direct supervisor. Ms. Reed was shown the photographs that Ms. Hindman testified regarding. She stated she was familiar with the location of the fall. She stated, "the sidewalk is in good condition." She was not aware of any defects or cracks in the sidewalk. She characterized the location as a wheelchair ramp with a slight incline. She was not aware of anything out of the ordinary at that particular location.

Petitioner parked in a parking lot open to the public. There is no defect in the sidewalk, neither visible in the picture nor according to the testimony of Ms. Hindman. There was no ice, snow, or water on the sidewalk. Indeed it was a clear nice day. A yellow warning area is plainly visible in the photographs proffered by Petitioner leading up to and literally inches and or a couple of feet away from the location of her fall. The location is a wheelchair ramp with a slight incline. It is difficult to ascertain exactly how petitioner fell on such a location? The best scenario is that Petitioner simply was not paying attention. She did not stop when called to by her co-worker but instead kept walking while looking at her co-worker. Petitioner was leaving for the day. There is no testimony or evidence she was doing anything at the direction of her employer at the time of the fall. The employer bears not fault for Petitioner's fall and or injuries. Claim denied for failure to prove an accident occurred resulting in injury.

Conclusions of Law:

Petitioner has failed to meet her burden of proof and thus shall be barred from recovery. Petitioner failed to prove accident as a matter of law. Thus, the Petitioner claim is denied and all other issues are moot.

STATE OF ILLINOIS	)	
	) SS.	
COUNTY OF COOK	)	

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Sheila Irvine Lane,

Petitioner,

vs. NO: 16WC 38967

Kickert School Bus Lines, **19IWCC0276**

Respondent.

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed November 16, 2017, 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 $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: JUN 6 - 2019
o042319
DS/jrc
046

Thomas J. Tyrrell

Maria Portela

DISSENT

I respectfully dissent, in part, from the majority as I would have affirmed but modified rather than affirmed and adopted the Decision of the Arbitrator.

Petitioner, on August 16, 2016, stepped into a pothole on Respondent's premises and subsequently fell to the ground, injuring her right hand, right hip, and right knee in the process. She initially sought treatment at the emergency department of Community Hospital in Munster, Indiana, on August 18, 2016 before following up with Dr. Joseph Thometz of Bone and Joint Physicians on August 24, 2016. She had previously received treatment for both her knees from Dr. Thometz.

Dr. Thometz, after examining Petitioner on August 24, 2016, focused his attention on her right knee, noting the injury to her right hip had resolved and the injury to her right hand had largely resolved. He diagnosed her with a right knee strain, finding her August 16, 2016 accident aggravated the significant degenerative arthritis in her right knee. He prescribed physical therapy, a work restriction that precluded her from driving a school bus, and a change in her medication. Petitioner was also ordered by Dr. Thometz to return for a reexamination in three weeks.

Petitioner returned to Dr. Thometz on September 19, 2016. He noted Petitioner complained of diffuse soreness about her right knee and of fatigue in her right knee at end of the workday but found her right knee demonstrated improved range of motion. Dr. Thometz renewed his prescription of physical therapy and the prohibition against driving a school bus and again changed her medication. Dr. Thometz ordered Petitioner to return for a reexamination in three weeks.

Petitioner was reexamined by Dr. Thometz on October 10, 2016. Petitioner reported to Dr. Thometz that she experienced some improvement but also continued swelling and discomfort. After discussing treatment options, Petitioner opted to proceed with a knee arthroplasty of her right knee. Dr. Thometz ordered her to return to physical therapy for one additional session, to continue not driving a school bus, and to return in three weeks. Petitioner did not return to Dr. Thometz after three weeks nor, incidentally, did she return to physical therapy for that last session.

Petitioner underwent a Section 12 examination conducted by Dr. Kevin Walsh on December 11, 2016 and related to him that she was experiencing pain that ranged from 2/10 at its best to 9/10 at its worse and a history that little improvement was derived from physical therapy. After examining her and reviewing her medical records, he concluded that Petitioner suffered a strain and contusion as a result of her August 16, 2016 accident and also that her current symptoms were unrelated to that accident. Her current symptoms, according to Dr. Walsh, were attributable exclusively to the preexisting osteoarthritis in Petitioner's right knee. He did not believe that Petitioner's August 16, 2016 accident caused, aggravated, or accelerated the right knee discomfort for which he saw Petitioner on December 11, 2016. Dr. Walsh, like Dr. Thometz found the injuries to Petitioner's right hip and right hand had resolved.

Petitioner presented to her primary care physician, Dr. Bruce Parisi of Horizon Health Care Associates, on December 28, 2016, seventeen days after Petitioner was seen by Dr. Walsh for a complaint unrelated to her right knee. Dr. Parisi did not record Petitioner making any comment about her right knee. Petitioner indicated, on a form she completed for Dr. Parisi, that she had not fallen in the past year. More significantly, Dr. Parisi noted Petitioner had normal range of motion in all her joints. The range of motion testing failed to elicit any complaint of pain from her. This visit to Dr. Parisi marked the last time Petitioner received any medical attention per the medical records entered into evidence.

It is the histories and findings, as related above, that leads to the conclusion that the Decision of the Arbitrator should be affirmed but modified. Petitioner is entitled to temporary total disability benefits and compensation for medical expenses but not as was awarded in the Decision of the Arbitrator.

Petitioner's abandonment of treatment for her right knee with Dr. Thometz after October 10, 2016, her failure to complain about her right knee to Dr. Parisi on December 28, 2016, and her apparent failure to seek any further treatment even after seeing Dr. Parisi leads to the

conclusion that Petitioner achieved maximum medical improvement for the injuries relatable to her August 16, 2016 accident as early as December 11, 2016 when she was examined by Dr. Walsh or as late as December 28, 2016 when she presented to Dr. Parisi without complaining about her right knee. Given this, Petitioner should be found entitled to temporary total disability benefits only through December 28, 2016 and not entitled to the right knee arthroplasty as recommended by Dr. Thometz. This matter, therefore, should be remanded to the Arbitrator for a further proceeding for a determination of compensation only for permanent disability, if any.

Deborah L. Simpson

Deborah L. Simpson

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF 19(b)/8(a) ARBITRATOR DECISION

IRVINE LANE, SHEILA
Employee/Petitioner

Case# **16WC038967**

KICKERT SCHOOL BUS LINES
Employer/Respondent

19IWCC0276

On 11/16/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.36% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in 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 McHARGUE, JAMES P LAW OFFICE
MATTHEW C JONES
123 W MADISON ST SUITE 1000
CHICAGO, IL 60602

0208 GALLIANI DOELL & COZZI LTD
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20 N CLARK ST SUITE 825
CHICAGO, IL 60602

19IWCC0276

STATE OF ILLINOIS)

)SS.

COUNTY OF **COOK**)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(B)/8(A)

SHEILA IRVINE LANE
Employee/Petitioner

Case # **16** WC **38967**

v.

Consolidated cases: **D/N/A**

KICKERT SCHOOL BUS LINES
Employer/Respondent

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Molly Mason**, Arbitrator of the Commission, in the city of **Chicago, IL**, on **October 19, 2017**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. [ ] Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?

B. [ ] Was there an employee-employer relationship?

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

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

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

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

G. [ ] What were Petitioner's earnings?

H. [ ] What was Petitioner's age at the time of the accident?

I. [ ] What was Petitioner's marital status at the time of the accident?

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

K. [x] Is Petitioner entitled to any prospective medical care?

L. [x] What temporary benefits are in dispute?
[ ] TPD [ ] Maintenance [x] TTD

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

N. [ ] Is Respondent due any credit?

O. [ ] Other ______

FINDINGS

On the date of accident, **August 16, 2016**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**32,054.36**; the average weekly wage was $**616.43**.

On the date of accident, Petitioner was **53** years of age, *single* with **0** dependent children.

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

Respondent shall be given a credit of $**0.00** 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

Prospective Medical

Respondent shall authorize and pay for the right total knee replacement as recommended by Dr. Thometz.

Temporary Total Disability
Respondent shall pay Petitioner temporary total disability benefits of $410.94/week (based on the stipulated average weekly wage of $616.43, Arb Exh 1) for 31 3/7 weeks, from December 17, 2016 through July 24, 2017, as provided in Section 8(b) of the Act

Medical benefits

Pursuant to the stipulation of the parties (Arb Exh 1), Respondent shall pay Petitioner's outstanding medical bills from Bone and Joint Physicians/Ridge Rehabilitation, pursuant to the fee schedule or negotiated rate, as provided in Sections 8(a) and 8.2 of the Act.

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

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

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

19IWCC0276

Molly C Mason

Signature of Arbitrator

11/14/17

Date

ICArbDec19(b)

NOV 16 2017

Summary of Disputed Issues

The parties agree Petitioner sustained an accident while working for Respondent on August 16, 2016. Petitioner contends this accident permanently aggravated an underlying right knee arthritic condition and brought about the need for a total knee replacement. Respondent maintains the accident only temporarily aggravated the knee. The disputed issues include causal connection, temporary total disability from December 17, 2016 through July 24, 2017 and prospective care, with Petitioner seeking an award of the recommended knee replacement surgery. Respondent accepted liability for certain incurred medical expenses. Arb Exh 1.

Arbitrator's Findings of Fact

Petitioner testified she began working as a school bus driver for Respondent about three years before August 2016. In July 2014, she received a promotion and became Respondent's safety compliance officer. Her duties in that job included hiring, training and reviewing drivers' permits and licenses. She continued driving a school bus after the promotion. She drove different routes each morning and afternoon. She performed her safety compliance duties during the interval between her morning and afternoon routes. T. 8-11. She worked ten to twelve hours per day and typically spent four of those hours driving. T. 11-12. During the remaining six to eight hours, she moved around Respondent's facility, which was about 4,800 square feet in size. She left her desk to retrieve files from the training department, get paperwork and interact with drivers. T. 12.

Petitioner testified she did not hold a job before she started working for Respondent. She was a homemaker. T. 12.

Petitioner acknowledged undergoing treatment for right knee problems before her August 16, 2016 work accident. She saw both Dr. Parisi, her primary care physician, and Dr. Thometz, for these problems. She first saw Dr. Thometz for her right knee in 2003, at which point he drained fluid from the knee and administered some injections. In August of 2007, Dr. Thometz operated on her right knee. Following this surgery, he discharged her without restrictions in September 2007. She returned to him in 2008, at which point he aspirated her right knee. PX 2. She next saw him in 2013. [The doctor's records reflect he saw Petitioner three times in 2013, with the last of these visits taking place on April 15, 2013. On January 28, 2013, he noted the results of a recent right knee MRI, performed on January 19, 2013. On right knee examination, he noted an effusion, valgus alignment, full extension, flexion to 120 degrees, tenderness along the lateral joint line and some pain with bounce testing. He ordered Orthovisc injections, noting that Petitioner "would like to try continued conservative measures." On March 11, 2013, he noted a mild effusion of the right knee. He aspirated fluid from the knee and injected it with Xylocaine and Depomedrol. He directed Petitioner to return in one month. On April 15, 2013, he noted improvement following the right knee aspiration/injection and indicated Petitioner was "now having difficulty with her left knee" and wanted to try the same measures on that knee. On left knee examination, he noted a mild effusion, full extension, flexion to 120 degrees, some slight tenderness. On right knee re-examination, he noted a mild effusion and no local tenderness. He aspirated fluid from the left knee and injected it with Xylocaine and Depomedrol. He indicated that Petitioner "will return when having difficulty." He did not see Petitioner again until after the work accident. PX 2.]

On direct examination, Petitioner testified that neither Dr. Parisi nor Dr. Thometz took her off work for any right knee problem prior to the August 16, 2016 accident. She also testified that Dr. Parisi did not have her on any knee-related medication before the accident. T. 21-23. [Dr. Parisi's records reflect he prescribed a right knee MRI on January 11, 2013, after noting "meniscal findings" on examination, injected Petitioner's right knee with Depomedrol on August 7, 2014, prescribed arthritis-related medication on January 11, 2016 and noted that Petitioner denied any knee pain on April 27, 2016. PX 4.] She indicated that Dr. Thometz did not broach the idea of any additional right knee surgery between her last visit to him in 2013 and the August 16, 2016 work accident. T. 23.

Petitioner testified she had a "good range of motion" and "very minimal" swelling in her right knee before the August 16, 2016 accident. The frequency of the swelling varied, depending on how much she had to walk or sit at work. She typically noticed swelling only once a week or once every two weeks. T. 24. She denied taking any oral medication for her right knee before the work accident. She addressed her right knee symptoms via Epsom salt, rubbing the knee with alcohol and/or rest. T. 24-25. Before the accident, she had no difficulty driving a school bus or performing her other assigned duties. T. 25.

Petitioner testified that on August 16, 2016, shortly before her accident, she was on her way back to the office, after retrieving some paperwork from her assigned bus, when she stepped into a pothole with her left foot. Her left foot "got caught up" in the pothole, causing her to lose her balance and fall. Her paperwork "went flying" and she went down on her right side, striking her right hand, knee and hip on impact. T. 13-14. After she fell, she experienced pain in her "whole right side" but primarily in her right knee. With the help of a co-worker, she got to her feet, collected the paperwork, went into the office, reported the accident to her manager and completed some paperwork. T. 15. [Notice is not in dispute. Arb Exh 1.] She managed to finish the workday, since the accident took place only about fifteen minutes before she was scheduled to leave. T. 15. When she woke up the next morning, her right hip was "okay but bruised" and her right knee was stiff and somewhat swollen. She went to work and worked the entire day, while continuing to experience right knee stiffness and swelling. T. 16.

On the evening of August 18, 2016, Petitioner sought care at Community Hospital's Emergency Room. T. 17. A history in the Emergency Room records reflects Petitioner reported "pain and bruising to right hip and knee s/p trip and fall on Tuesday." PX 1, p. 21. The examining physician, Dr. Goodwin, noted complaints of pain in the right hand, hip and knee. He indicated Petitioner reported being able to walk on her right leg but complained of lateral pain when bending her right knee. He noted that Petitioner reported taking 800 mg of Ibuprofen.

On right hip examination, Dr. Goodwin noted tenderness, no deformity and a normal range of motion. On right knee examination, he noted lateral joint tenderness, a normal range of motion and no swelling, deformity or erythema. On right hand examination, he noted tenderness, a normal range of motion and no swelling. PX 1, p. 4.

Dr. Goodwin ordered X-rays of the right hip and right knee. The right hip X-rays showed mild arthritic changes and no acute osseous abnormalities. The right knee X-rays revealed severe degenerative changes with tricompartmental osteophytes, a "tiny joint effusion" and no acute osseous abnormalities. The doctor noted "+sig arthritis in R knee." He provided Petitioner with a knee sleeve and directed her to follow up with an orthopedic surgeon. T. 17. He did not prescribe any medication. PX 1

On August 24, 2016, Petitioner saw Dr. Thometz, the orthopedic surgeon who had treated her right knee in the past. T. 18. The doctor's history reflects he had last seen Petitioner in April 2013 for her left knee. The history also reflects that Petitioner complained of right knee pain, popping and intermittent swelling, as well as some right hip pain, secondary to falling at work on August 16, 2016. The doctor noted that Petitioner's "foot got stuck in a hole" and twisted. He indicated that Petitioner "had been doing well with her knee prior to her injury" but was now taking prescription Ibuprofen without much relief.

On right knee examination, Dr. Thometz noted flexion to about 100 degrees, discomfort with attempts at terminal extension, with Petitioner lacking about 5 to 7 degrees, a mild to early moderate effusion, no apparent bruising, tenderness along the medial and lateral joint lines and pain deep in the knee with bounce testing. On right hip examination, he noted painless hip rotation.

Dr. Thometz opined that the work fall caused a right knee strain and aggravated Petitioner's underlying degenerative arthritis. He switched Petitioner from Ibuprofen to Etodolac, prescribed physical therapy and released Petitioner to light duty with no bus driving. He directed Petitioner to return in three weeks. PX 2.

On September 9, 2016, Petitioner began a course of physical therapy at Orthopedic & Rehabilitation Specialists. PX 3.

Petitioner returned to Dr. Thometz on September 19, 2016. She reported some improvement secondary to therapy but was still experiencing some diffuse soreness through the knee, especially by the end of a workday. She reported being on light duty and using a knee brace. On right knee examination, Dr. Thometz noted a small effusion, flexion to about 110 degrees, full extension and mild tenderness laterally. He switched Petitioner to Meloxicam and prescribed additional physical therapy. He again restricted Petitioner to light duty. PX 2.

In a report dated October 5, 2016, Petitioner's physical therapist indicated Petitioner was "unable to stand for one hour, run or hop" and having "severe difficulty with usual hobbies." PX 3.

Petitioner saw Dr. Thometz again on October 10, 2016, with the doctor noting persistent complaints of "swelling and discomfort laterally," despite some benefit from therapy. On re-examination, he noted a moderate effusion, flexion to 120 degrees with tenderness laterally and full extension. He addressed causation and treatment options as follows:

> "When she fell, she aggravated her underlying degenerative arthritis and [is] having continued difficulty. I discussed the options, including injections versus surgical correction. She is limited in her walking and activities [sic] that she wishes to proceed with knee arthroplasty."

Dr. Thomez indicated he would schedule the arthroplasty "pending approval." He recommended that Petitioner complete another session of physical therapy. He continued the light duty restrictions and directed Petitioner to return to him in three weeks. PX 2.

Petitioner did not return to Dr. Thometz thereafter. Under cross-examination, she explained she did not return because workers' compensation did not authorize additional care. T. 56.

At Respondent's request, Dr. Walsh conducted a Section 12 examination of Petitioner on December 8, 2016. See further below for a summary of the doctor's findings and opinions.

On direct examination, Petitioner testified her employment by Respondent came to an end on December 16, 2016. Respondent terminated the employment relationship. T. 28.

On December 28, 2016, Petitioner saw Dr. Parisi, with the doctor noting complaints of sinus congestion and coughing for two weeks. He did not note any knee complaints. He diagnosed an acute upper respiratory infection and prescribed a Z-Pak. PX 4.

Dr. Thometz testified by way of evidence deposition on May 11, 2017. Dr. Thometz testified he is a fellowship-trained, board certified orthopedic surgeon. He first obtained board certification in 1992. PX 5, p. 6. He was recertified in 2002 and 2012. PX 5, p. 6. Thometz Dep Exh 1. He devotes about 30% of his practice to knee issues. PX 5, p. 6. He performs about 70 knee replacements annually. He performs some revisions as well, but not many. PX 5, p. 7.

Dr. Thometz acknowledged his independent recollection of Petitioner is "very limited." He relied on his records while testifying. PX 5, p. 7.

Dr. Thometz testified he first saw Petitioner on October 29, 2003, at the referral of her primary care physician, Dr. Parisi. On that date, Petitioner complained of pain throughout her right knee, primarily on the lateral, or outside, aspect of the knee. Petitioner also complained of some locking in the knee. Her treatment up to that point consisted of one injection, which provided about five months of relief, and Celebrex. She described generalized aching in her joints and some stiffness in her hands. PX 5, pp. 14-15.

Dr. Thometz testified that, at Petitioner's first visit, he reviewed a right knee MRI performed on October 9, 2003. He testified this study showed an effusion, patellofemoral arthropathy, a subchondral cyst, advanced chondromalacia changes through the lateral compartment with edema through the lateral tibial plateau, extrusion of the lateral meniscus with evidence of tearing through the anterior horn and small medial compartment osteophytes. PX 5, pp. 15-16. Because Petitioner was experiencing some locking, which is frequently associated with tearing of the meniscus, he recommended an arthroscopy but explained to Petitioner that this surgery would not eliminate her arthritis. He discussed the possibility of addressing the arthritis via Synvisc injections. Petitioner told him she wanted to confer with her husband before deciding what course to take. PX 5, p. 16. Petitioner returned to him on November 26, 2003 but had decided against surgery as of that date. Petitioner returned to him again in June 2007. He operated on her right knee on August 9, 2007, performing a right knee arthroscopy, partial synovectomy, partial lateral meniscectomy, debridement of the lateral femoral condyle and a synovial biopsy. The surgery revealed that Petitioner "had advanced chondromalacia change of her patellofemoral joint" along with "advanced chondromalacia through the lateral compartment with an area of exposed bone," a complex lateral meniscus tear and some synovitis. During the surgery, he removed the damaged portion of the lateral meniscus and the unstable areas of arthritis. PX 5, pp. 17-18.

Under cross-examination, Dr. Thometz testified he reviewed X-ray reports in addition to his own records and Dr. Walsh's report. PX 5, p. 26. Petitioner had a degenerative right knee condition in 2003 which has worsened over the last fourteen years. PX 5, p. 27. A person can develop such a

condition in the absence of trauma. PX 5, p. 28. The condition can progress to the point where the person needs a knee replacement, in the absence of trauma. PX 5, p. 28. It is probably true that the majority of people who need knee replacements have underlying conditions that progressed in the absence of trauma. PX 5, p. 28. Trauma can aggravate osteoarthritis, either temporarily or permanently. PX 5, pp. 28-29. The right knee MRI Petitioner underwent in 2003 showed advanced chondromalacia in the lateral compartment, even though Petitioner was only 40 at that time. PX 5, p. 30. With a 40-year-old, it is preferable to defer a knee replacement, although some patients have no choice but to undergo this procedure. PX 5, p. 31. In 2003, Petitioner had tearing and extrusion, or pushing out, of the lateral meniscus. She also had spurring, which is not typical for a 40-year-old. PX 5, pp. 31-32. Based on Petitioner's presentation in 2003, it seemed likely she would require a replacement at some point. At that time, he recommended a scope and Synvisc, which she declined. PX 5, pp. 32-34. Petitioner's condition in 2003 was not trauma-related. PX 5, pp. 34-35. When Petitioner returned to him, in 2007, there had been "some progression" of her right knee condition, again without any trauma. PX 5, pp. 35-36. The osteophytes in the medial compartment had developed into advanced arthritic changes. He again recommended an arthroscopy and Petitioner agreed. In his 2007 operative report, he documented "bone on bone" changes. Such changes are indicative of end stage arthritis. PX 5, p. 39. The report also references "end synovitis" but this is probably a dictation error. PX 5, p. 40. Following the 2007 surgery, he again recommended Synvisc injections for the arthritis. When he discharged Petitioner at that point, he gave her medication to be taken as needed and noted a mild effusion. PX 5, pp. 41-42. The mild effusion was "likely related to the osteoarthritis." PX 5, p. 42. At that time, the range of right knee motion was 0 to 110 degrees. He would attribute the lack of flexion to the recent surgery because, a year later, Petitioner had flexion of 120 degrees. PX 5, p. 43. In 2008, he drained synovial fluid from the knee and again recommended injections, albeit Orthovisc, which is made by a different company. PX 5, p. 45.

Dr. Thometz testified that Petitioner's repeat right knee MRI of January 19, 2013 showed an irregularity consistent with a complex tear in the posterior horn of the medial meniscus. He did not see this tear when he operated in 2007. PX 5, pp. 45-46. The tear developed in the absence of trauma. PX 5, p. 46. The tear could be related to either osteoarthritis or meniscal degeneration. PX 5, p. 46. If the radiologist who interpreted the 2013 MRI was correct when he noted loose bodies measuring up to 1.1 centimeters, such loose bodies would be fairly significant in size. PX 5, p. 48. However, he does not think there were loose bodies, since no such abnormalities showed up on the X-rays Petitioner underwent in August 2016. PX 5, pp. 48-49. Loose bodies can develop with or without "bone on bone" contact. PX 5, p. 49. A person who has large osteophyte formations in the knee at age 48 or 49, there is a high probability that the person will go on to have a total knee replacement at some point in his life. PX 5, p. 51. He agrees with the radiologist's diagnosis of mucoid degeneration of the anterior collateral ligament. You can develop mucoid degeneration with or without osteoarthritis but it is indicative of wear and tear on the ligament. The development of mucoid degeneration is multi-factorial. Genetics can be a factor. PX 5, p. 53. He did not offer another arthroscopy in 2013 because it "would have been of questionable benefit." Petitioner told him she could not get approval for the previously discussed injections. Some patients just do not want to undergo injections. There is no proof that such injections slow the progress of osteoarthritis but they can result in less pain and greater function. PX 5, p. 55.

Dr. Thometz agreed he did not review any records concerning the treatment Petitioner underwent right after the work accident. A doctor who did review these records would "not necessarily" be in a better position to address causation. Petitioner clearly had enough complaints to prompt the providers to order X-rays of the knee and hip. Those providers "obviously felt there was some degree of trauma." PX 5, pp. 56-57. If Petitioner indeed aggravated her underlying arthritis in the

work accident, you would "perhaps" see some restriction of knee motion and/or swelling. PX 5, p. 58. When he examined Petitioner on August 24, 2016, he saw an effusion and a decreased range of motion but no bruising. PX 5, p. 59. The range of motion subsequently improved with treatment. The right knee X-rays taken at the Emergency Room after the accident showed no evidence of trauma to the extent they showed no fracture. PX 5, p. 59. X-rays do not show acute changes such as a torn ligament. There are a lot of things X-rays do not show. PX 5, p. 59. Petitioner's Emergency Room X-rays showed no evidence of bony trauma. PX 5, pp. 59-60. At the August 24, 2016 visit, he changed Petitioner's medication and recommended physical therapy. Petitioner followed these recommendations and reported improvement at the next visit, although she was still experiencing knee soreness at the end of the workday. PX 5, p. 61. Before the therapy, she could not fully extend the knee. Afterward, she could. PX 5, p. 61. Her flexion had also improved to 110 degrees. The only finding at that visit was mild tenderness but he recommended more therapy. PX 5, pp. 61-62. As of the next visit, on October 10, 2016, Petitioner had returned to baseline in the sense she had full extension and 120 degrees of flexion. PX 5, p. 62. However, her symptoms had not resolved and her function was still significantly limited. This is why he does not view the accident as only temporarily aggravating the underlying condition. He found it reasonable at this point to recommend a knee replacement. The recommendation was not based solely on Petitioner's age. It is hard for him to say that, as of October 2016, a knee replacement was inevitable. Instead, he would say it was likely Petitioner would need this procedure. PX 5, p. 63. There was "certainly progression" of Petitioner's osteoarthritis over time, between 2003 and 2016. PX 5, p. 64.

Dr. Thometz acknowledged he saw Petitioner only three times after the work accident. He has not seen her since October 2016 and does not know what her condition has been since that time. It appears he last refilled a prescription, for Meloxicam, in September 2016. He does not know whether the fact she has not requested more refills means the accident merely temporarily aggravated her condition. PX 5, p. 65.

On redirect, Dr. Thometz testified he did not discuss the possibility of knee replacement surgery with Petitioner in either 2007 or 2013, despite the "bone on bone" changes that were documented. Petitioner was happy enough with her function that the subject of the surgery did not come up. PX 5, p. 66. It is possible that Petitioner has not asked for pain medication refills since September 2016 because she has been less active. A knee that has "bone on bone" changes will be more painful with increased activity. PX 5, pp. 66-67. If the work accident merely resulted in a temporary aggravation, he would expect Petitioner to be back at work and performing the activities she performed before the accident. PX 5, p. 67.

Dr. Walsh testified by way of evidence deposition on August 15, 2017. RX 2. Dr. Walsh testified he is a board certified orthopedic surgeon. He has practiced orthopedic surgery since 1988. RX 2, p. 4. The knee is the most common joint he operates on. RX 2, p. 5. A knee arthroscopy is the surgery he most commonly performs. He performs hundreds of them. RX 2, p. 6. He performs about 140 knee replacements per year. RX 2, p. 6. Every day he treats patients with knee osteoarthritis. Osteoarthritis is degenerative joint disease. The joint wears out, which results in pain and sometimes swelling, stiffness, loss of motion and loss of function. RX 2, p. 6. Osteoarthritis is a progressive, incurable disease. RX 2, p. 7. Patients typically are more symptomatic in the joints that bear weight. 800,000 knee replacements are performed in the United States each year and the numbers are rising. RX 2, p. 7. Osteoarthritis is associated with aging. You move your knee 3 to 5 million times annually. Over time, the joint simply wears out. Two thirds of the patients who undergo knee replacements are female. Women typically develop osteoarthritis at a younger age than men. RX 2, p. 8.

Dr. Walsh testified that osteoarthritis can sometimes be aggravated by trauma. Such aggravations can be temporary or permanent. RX 2, p. 8.

Dr. Walsh testified he examined Petitioner on December 8, 2016, at Respondent's request. He first obtained a history from Petitioner and then physically examined her. Petitioner told him she fell in a parking lot at work in August 2016, landing on her right knee, hip and hand. She told him she cut her right palm. She reported the accident and went home. She sought care after her symptoms worsened. RX 2, p. 11. Petitioner also reported having undergone a right knee arthroscopy for a torn meniscus in 2007. Petitioner was wearing a brace when she presented to his office. She also told him she had a family history of osteoarthritis. She complained of 2-5/10 pain in her right knee, worsened by walking, standing, long car rides and bending forward. She reported taking Meloxicam and Aleve. RX 2, pp. 12-13.

Dr. Walsh testified that, when he examined Petitioner, he noted a valgus, or knock-kneed, deformity of the right knee, patellofemoral crepitation or grinding, no medial or lateral instability, full extension, flexion to 125 degrees, the ability to walk without assistance, negative McMurray's, tenderness along the lateral and medial joint lines, no quadriceps atrophy and resistance to squatting below 80 degrees due to pain. RX 2, pp. 13-14. The progression of Petitioner's osteoarthritis has caused collapse of the lateral compartment. The collapse is causing Petitioner to become more knock-kneed over time. RX 2, p. 14. A person who has mild osteoarthritis is less likely to be knock-kneed. RX 2, p. 14. A valgus deformity is significant. Petitioner's extension was normal. Flexion can be as much as 135 to 140 degrees. As arthritis progresses, knee motion typically decreases. You lose flexion but not typically extension with a valgus knee. 125 degrees of flexion is normal for a person with significant osteoarthritis. RX 2, p. 15. Petitioner has no atrophy because she is still relatively young and using her knee. RX 2, p. 16.

Dr. Walsh testified he reviewed the pre-accident records, which date back to 2003. Dr. Thometz diagnosed right knee osteoarthritis in 2003. Petitioner had three right knee MRIs before the work accident. The third MRI, performed in 2013, showed advanced tricompartmental osteoarthritis, greatest in the lateral compartment. Arthritis that is most severe in the lateral compartment will lead to a person looking knock-kneed because the outside of the knee collapses down. The MRIs showed a "discoid" meniscus, meaning a meniscus that is filled with cartilage and larger than a typical meniscus. The second MRI, performed in 2007, was read as showing severe degenerative joint disease and a large joint effusion. "Patients can have flare-ups of their osteoarthritis in the absence of trauma and usually do. Most patients present with flare-ups which are not associated with any traumatic event." RX 2, pp. 20-21. "Bone on bone" changes produce pain, swelling, grinding and deformity. RX 2, p. 23. Petitioner had such changes in two out of three compartments in 2007. At that point, her right knee was "shot" and was only going to get worse. RX 2, pp. 23-24. The radiologist who interpreted the 2013 right knee MRI felt the condition of the knee had worsened slightly. RX 2, p. 24. Dr. Thometz noted a valgus deformity in 2013. He ordered Orthovisc. RX 2, p. 25. After Petitioner's last pre-accident visit to Dr. Thometz, in 2013, she saw her primary care doctor for her right knee. That doctor diagnosed her with arthritis and performed intra-articular injections. As of 2016, before the work accident, Petitioner was taking medication for the knee. RX 2, p. 25. The earliest post-accident records reflect that Petitioner complained of her right hip, knee and hand. The examining physician noted no acute abnormalities. Right knee X-rays showed severe degenerative changes with tricompartmental osteophytes and a tiny effusion. On right knee examination, the physician noted no swelling, deformity or erythema and a normal range of motion. He diagnosed a right knee sprain and contusions of the right hip and thigh. RX

2, pp. 26-27. If the accident truly aggravated an underlying condition, you would expect to see examination findings consistent with an aggravation. RX 2, p. 27. If the trauma was severe enough to aggravate the knee, you would expect to see the patient having difficulty walking and seeking care on an emergent basis. You would also expect to see significant limitation of motion and significant swelling. There was nothing on Petitioner's Emergency Room examination that would suggest an aggravation that might ultimately result in a knee replacement. RX 2, p. 28. When Dr. Thometz examined Petitioner on August 24, 2016, he noted a "mild early moderate effusion" as well as tenderness over the medial and lateral joint lines but no bruising or instability. He diagnosed a right knee strain. He opined that the accident aggravated the underlying arthritis. He prescribed Etodolac and physical therapy. He released Petitioner to light duty. Dr. Walsh found Dr. Thometz's diagnosis of a right knee strain to be reasonable. RX 2, p. 30. Petitioner reported improvement when she returned to Dr. Thometz on September 19, 2015. She had full extension at that point, along with flexion to 110 degrees and mild tenderness laterally. Dr. Thometz prescribed more therapy and again imposed light duty. Petitioner's range of motion at the next visit, on October 10, 2016, was the same as it had been in 2013. By that visit, Petitioner had returned to baseline. RX 2, pp. 32-33. When Petitioner saw her primary care doctor on December 28, 2016, the doctor did not note any right knee complaints. RX 2, p. 33.

Dr. Walsh opined that Petitioner's right knee osteoarthritis pre-existed the work accident. The accident did not aggravate or accelerate the osteoarthritis. "At best, the injury described by [Petitioner] would have been a knee strain." RX 2, p. 34.

Dr. Walsh testified he noted no inconsistencies or symptom magnification when he examined Petitioner. Petitioner reported 9/10 pain. This report was "somewhat elevated" compared with most people who have osteoarthritis but her examination findings were consistent with that condition. RX 2, p. 35. It was reasonable for Petitioner to undergo Emergency Room care following the work fall. It was also reasonable for her to see Dr. Thometz and undergo some therapy at his direction. Dr. Walsh testified the work accident did not bring about the need for care beyond that point. Petitioner "did not require work restrictions as a result of her work injury." She "could certainly drive a school bus" and work as a safety compliance officer. RX 2, p. 36. As of his examination, Petitioner was at maximum medical improvement in terms of the work accident. RX 2, pp. 36-37.

Under cross-examination, Dr. Walsh testified it would have been reasonable to offer Petitioner a knee replacement as of his examination. He would not say it was necessary for her to have the knee replaced at that time but it would have been reasonable to offer her the surgery based on the significant, "bone on bone" osteoarthritis and her pain complaints. It is always the patient's choice whether to undergo replacement surgery. Some patients prefer injections but injections are associated with various risks, including infection, accelerating arthritic changes and osteoporosis. RX 2, pp. 38-39. It would have been reasonable to offer Petitioner knee replacement surgery in 2013, if she felt she had sufficient pain to warrant such surgery. RX 2, p. 39. Dr. Thometz's notes do not state that he offered Petitioner a knee replacement in 2013 but his previous notes indicate he told her an arthroscopy would not cure her knee arthritis. RX 2, pp. 39-40. Dr. Parisi's records reflect Petitioner discussed her knee condition with him. He cannot recall how many visits Petitioner made to Dr. Parisi between 2013 and 2016. He recalls reviewing three of Dr. Parisi's notes, one of which postdated his examination. RX 2, p. 41. It is his understanding Petitioner fell onto her right knee. A direct blow to the knee can possibly exacerbate underlying osteoarthritis. RX 2, p. 42. However, he does not believe the work fall accelerated or exacerbated Petitioner's right knee condition. As a scientist, he would not rely on reported symptoms alone in determining whether an acceleration or exacerbation occurred. RX 2, p. 42.

Dr. Walsh did not recall testifying on July 25, 2017 in a case called Zemrish v. Ray Graham Association. After reviewing the transcript, he acknowledged he testified in that case (at page 23, line 23) that he would use the term "exacerbation" to mean an increase in symptomatology. RX 2, p. 45. In Petitioner's case, he does not know whether the records establish that her symptoms increased after the work fall. He acknowledges Petitioner did not see Dr. Thometz between early 2013 and August 2016. RX 2, pp. 45-46.

On redirect, Dr. Walsh testified he does not recall Petitioner's counsel asking him the difference between exacerbation and acceleration.

Petitioner testified she has not seen Dr. Thometz since October 10, 2016. When she saw the doctor on that date, he recommended a total knee replacement and no additional therapy. He kept her on light duty. T. 28. She wants to undergo the replacement surgery. T. 28. No additional treatment has been authorized since Dr. Walsh examined her in December 2016.

Petitioner denied working in any capacity between the time Respondent terminated her, on December 16, 2016, and July 24, 2017. In July 2017, she began working as a hair stylist at a J. C. Penney salon. At the salon, she greets customers, makes appointments and performs hair styling. She sits on a stool while styling hair. Her right knee bothers her when she is at work. The knee starts to swell by the end of a workday. At work, she has to walk to and from the shampoo bowl and supply station. T. 31. She currently takes Tylenol and Aleve two or three times daily for her right knee pain. She has not obtained any prescription refills from Dr. Thometz. She has worn a brace on her right knee every day since she obtained the brace about a year ago. The brace provides support when she stands or walks. T. 32-33. She moves around without the brace "very minimally." She limps and her right knee is "starting to bow inward." T. 33. She has to take stairs one at a time due to right knee pain and instability. She notices catching and locking in her right knee "all the time." During the three years before the work accident, she did not notice any issues with stairs and was not experiencing locking or catching in her right knee. T. 34.

Under cross-examination, Petitioner testified that no specific accident or injury prompted her to see Dr. Thometz for her right knee in 2003. T. 37-38. After Dr. Thometz examined her in 2003, he recommended right knee surgery but she told him she did not want to undergo this. T. 38. Dr. Thometz also recommended Synvisc injections but she did not undergo these injections. T. 39. When she next saw Dr. Thometz, in 2007, she told him her right knee problems had grown progressively worse over the preceding three and a half years. T. 39. No specific injury prompted her to return to Dr. Thometz in 2007. T. 40. At that time, she complained to the doctor of swelling, popping and deep pain in her right knee. He again recommended surgery and she agreed to proceed. T. 40. After the surgery, she complained of right knee pain that was related to the healing process. She could not recall whether Dr. Thometz again recommended Synvisc injections after the surgery. T. 42-43. She recalled returning to Dr. Thometz in 2008, at which point he drained fluid from her right knee. No injury prompted her to return to the doctor at that time. T. 43. She did not see Dr. Thometz again until 2013 but, on August 22, 2012, she complained of bilateral knee pain to her primary care physician, Dr. Parisi. She could not recall whether she again voiced this complaint to Dr. Parisi on January 11, 2013. If the doctor's records document this complaint, she would not dispute the accuracy of the records. T. 44. The doctor started her on Celebrex and Aleve at that time. T. 44.

Petitioner testified the lot where she fell had a gravel surface. She landed on her right knee. T. 51. In response to a question asking whether there were any scrapes, marks or bruises on that knee, she initially said "yes." T. 51. When asked whether those scrapes, marks or bruises were still present when she went to the Emergency Room on August 18, 2016, she stated: "I had scrapes and bruises on my hand and bruise on my hip mainly." T. 51. She would dispute the accuracy of the Emergency Room records if the examining physician noted no right knee swelling and no marks, scrapes or bruises on the right knee. T. 52. She testified she was not able to move her right knee in a normal fashion at the Emergency Room. If the records state she exhibited a full range of right knee motion, she would disagree. T. 52. She is sure she still had some marks, scrapes and bruises on the knee when she saw Dr. Thometz on August 24, 2016. T. 52-53. If Dr. Thometz testified he saw no marks or other signs of trauma on the right knee, she would say her right knee was swollen and had "a few scrapes but no severe tearing of the tissue" at that point. T. 53. She would not, however, dispute the doctor's sworn testimony. T. 53. If the doctor's records state she could fully straighten her right knee as of September 19, 2016, following some therapy, she would disagree. T. 54. She did not return to Dr. Thometz after October 10, 2016 because "they denied any further treatment through [her] job." T. 56. She did see Dr. Parisi after that date but "not solely for" her knee. Dr. Parisi is her primary care physician. T. 56-57. Dr. Thometz prescribed Meloxicam for her right knee on October 10, 2016 but she never filled this prescription. T. 57. She did not discuss her right knee with Dr. Parisi when she saw him on December 28, 2016. T. 57. She did not raise the subject of her right knee to the doctor on that date. T. 57. Over a relevancy objection, she denied being terminated by Respondent due to falsifying a document relating to her CDL license. An "administrative error" occurred when she recertified for her CDL permit. T. 58. She made a mistake on a document. Respondent characterized the mistake as falsification. T. 58-59. In her current job as a hair stylist, she is on her feet "off and on." She sits on a stool while styling her clients. T. 59. She would agree that she is unable to sit the entire time while cutting and styling hair. T. 59. She "possibly" used the word "catching" when she explained her right knee symptoms to Dr. Thometz after the work accident. T. 59-60.

On redirect, Petitioner testified that workers' compensation did not authorize additional medication after her last visit to Dr. Thometz in October 2016. T. 60. She saw Dr. Parisi in December 2016 due to sinus or cold symptoms. At that visit, he may have asked her how she was doing overall. T. 61. She saw Dr. Parisi in January 2016 due to a urinary tract infection. T. 61. She also saw him for wrist arthritis in 2013. He prescribed Aleve for this condition and also recommended Celebrex. T. 62-63. She experienced improvement following her right knee arthroscopy in 2007. T. 63.

Under re-cross, Petitioner acknowledged that, despite the fact she improved after the 2007 surgery, she continued taking Aleve and underwent right knee drainage and injections before the August 2016 work accident. T. 63-64.

Respondent did not call any witnesses at the hearing.

Arbitrator's Credibility Assessment

Respondent asserts Petitioner was not forthright about the extent of her pre-accident right knee symptoms. The Arbitrator, having carefully reviewed the treatment records, views Petitioner's pre-accident right knee treatment as intermittent and symptom driven. Drs. Thometz and Parisi did, at times, note significant right knee complaints but successfully addressed those complaints via a 2007 arthroscopy and subsequent aspirations and/or injections. According to the records in PX 2, Dr. Thometz rendered no knee-related care between April 2013 and August 24, 2016. There is no evidence

indicating he recommended any additional right knee surgery between the 2007 arthroscopy and the work accident. Dr. Parisi administered a right knee injection in August 2014 but this was two years before the accident. On January 11, 2016, he noted that Petitioner wanted to "discuss her arthritis and possibly increase[e] the dose of her medication" but he did not specifically note increased knee complaints. On extremity examination, he noted a "full range of motion of all joints." On April 27, 2016, only four months before the accident, he noted that Petitioner denied knee pain. PX 4.

The Arbitrator found credible Petitioner's testimony that, during the three years she worked for Respondent before the accident, she was physically able to drive a school bus four hours each day and move around Respondent's facility, as needed, during the rest of her shift. No one contradicted this testimony.

Petitioner's description of her accident was also credible and unrebutted. The accident was not minor. Petitioner stepped into a pothole in a gravel parking lot. Her left foot "got caught up in" the pothole, causing her to lose her balance and fall, striking her right side, hip, knee and hand in the process. While Respondent attempted to minimize the severity and sequelae of this event, it failed to offer into evidence the "employee injury report" it provided to Dr. Walsh. The doctor provided a summary of this report, stating that Petitioner "stumbled and fell onto her right side, injuring her right hand, hip and back." He noted that the report documented "cuts, swelling and bruising." The Emergency Room records of August 18, 2016 reflect Petitioner reported "pain and bruising to right hip and knee s/p trip and fall on Tuesday." PX 2. The Emergency Room physician's electronic note does not mention the word "bruising" but it does document lateral joint line tenderness. The Arbitrator finds persuasive Dr. Thometz's testimony that this physician would not have ordered right hip and knee X-rays had he not believed there was "some degree of trauma." PX 5, p. 57.

Respondent also asserts Petitioner returned to baseline after the accident. In support of this assertion, Respondent points to the fact that Petitioner did not return to Dr. Thometz after October 10, 2016 and was eventually able to resume working in July 2017. The Arbitrator finds credible Petitioner's testimony that it was lack of authorization that prevented her from returning to Dr. Thometz. Also credible was Petitioner's testimony that she has been able to work as a hair stylist since July 2017 because she wears a knee brace and performs at least some of her duties while sitting on a stool.

<u>Did Petitioner establish that her work fall of August 16, 2016 aggravated her underlying right knee condition and contributed to the need for replacement surgery?</u>

The Arbitrator finds that the undisputed work fall of August 16, 2016 aggravated an underlying right knee osteoarthritic condition and contributed to the need for the replacement surgery Dr. Thometz has recommended. In so finding, the Arbitrator relies on Petitioner's credible description of the mechanism of injury, the chain of events and Dr. Thometz's opinions. Overall, the Arbitrator finds Dr. Thometz's opinions as to causation and work capacity more persuasive than those expressed by Dr. Walsh. Dr. Thometz saw Petitioner on numerous occasions, before and after the work accident, while Dr. Walsh examined her once.

The Arbitrator also relies on <u>Schroeder v. IWCC</u>, 2017 Ill.App.LEXIS 350, a recent case in which the Appellate Court reinstated the Commission's causation finding. The causation-related evidence presented in <u>Schroeder</u> was less compelling than that presented in the instant case. The claimant in <u>Schroeder</u> was a truck driver who injured her back in December 2013, about six months after she resumed working for Swift Transportation following a long hiatus during which she underwent two back

surgeries. In January or February 2013, about five months before she resumed working for Swift, she returned to one of her lumbar spine surgeons, Dr. Yazbak, due to "a lot of back pain" and numbness in her feet. As of March 2013, Dr. Yazbak was considering performing a lumbar fusion but the claimant declined, indicating she wanted to return to work. Swift hired her back, subject to some limitations relating to medication she was taking for fibromyalgia. Following the accident, Dr. Yazback kept her off work. He performed a fusion in 2014. At his deposition, he testified that some of Petitioner's symptoms changed and/or worsened after the accident, prompting him to perform a different kind of fusion than the one he had discussed with Petitioner in March 2013. He testified the sequelae from the work accident "made proceeding with surgery more appropriate, more viable." Under cross-examination, he conceded that X-rays and MRI scans taken before and after the accident were "not terribly different." Swift's examiner, Dr. Lami, like Dr. Walsh in the instant case, opined that the accident resulted in only a transient worsening of symptoms and did not bring about the need for additional surgery. The arbitrator, in reliance on Dr. Lami, found that the accident resulted in only a temporary aggravation of a longstanding degenerative condition. A unanimous Commission (Lamborn, Tyrrell and Brennan) reversed, observing that the arbitrator failed to note that the claimant was able to work full-time for a period of months before the accident but was unable to return to truck driving following the accident. The trial court set aside the Commission's decision. The Appellate Court reinstated the decision, holding that the Commission properly applied a "chain of events" analysis. Citing Sisbro, Inc. v. Industrial Commission, 207 Ill.2d 193, 205 (2003), the Court went on to state that, if it were to apply this analysis only where the claimant was in a condition of absolute good health, that application "would contradict years of Illinois precedent concerning pre-existing conditions." Petitioner, like the claimant in Schroeder, was able to drive a commercial vehicle, despite her pre-existing condition, prior to the accident and was unable to do so afterward, per Dr. Thometz. Unlike the claimant in Schroeder, Petitioner had not been told she required a major operation several months before the accident. It was not until after the accident that Dr. Thometz broached the idea of replacement surgery. As noted above, the causation-related evidence in the instant case is more compelling than that presented in Schroeder.

Is Petitioner entitled to temporary total disability benefits?

The parties agree Petitioner left Respondent's employment, at Respondent's request, on December 16, 2016. The termination took place about a week after Dr. Walsh's Section 12 examination. As of the termination, Petitioner was still subject to light duty, per Dr. Thometz, and had been told by the doctor that she needed to have her right knee replaced.

The Arbitrator has found in Petitioner's favor on the issue of causation and has elected to rely on the causation-related opinions voiced by Dr. Thometz. While Dr. Walsh did not agree with those opinions, he did not take issue with Dr. Thometz's surgical recommendation. He acknowledged that Petitioner is a candidate for knee replacement surgery.

The Arbitrator finds that Petitioner's causally related right knee condition was unstable as of the December 16, 2016 termination. Interstate Scaffolding v. IWCC, 236 Ill.2d 132 (2010). The Arbitrator views the instant case as distinguishable from Holocker v. IWCC, 2017 IL App (3d) 160363WC, in that the accident was affecting Petitioner's work capacity as of the termination. At no time after the accident did Dr. Thometz alter the "no bus driving" restriction he first imposed on August 24, 2016.

The Arbitrator finds that Petitioner was temporarily totally disabled from December 17, 2016 through July 24, 2017, a period of 31 3/7 weeks.

Is Petitioner entitled to prospective care in the form of a right total knee replacement?

The Arbitrator has found that Petitioner established causation as to the need for the right total knee replacement Dr. Thometz has recommended. Respondent's examiner, Dr. Walsh, agreed that it would be reasonable for Petitioner to undergo this procedure. The Arbitrator awards Petitioner prospective care in the form of the recommended right total knee replacement.

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 down	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Christopher Johnson,

Petitioner,

vs. NO: 16 WC 31607

Mel-O-Cream Donuts International, **19IWCC0277**

Respondent.

DECISION AND OPINION ON REVIEW

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

The Commission corrects the "Order" section found on page two of the Arbitrator's decision to show an award of temporary "total" (not "partial") disability from 10/4/16 through 12/13/16 (not "12/14/16"), for a total of 10-1/7 weeks (not 10 weeks). This period corresponds to the period outlined by the Arbitrator on page six of his decision.

In addition, the Commission corrects the "Findings" section found on page two of the Arbitrator's decision to show Petitioner's age as 32 (not 52) on the date of accident. This is the age stipulated to by the parties on the Request for Hearing form.

Finally, the Commission corrects page 6 of the Arbitrator's decision to show that Petitioner was entitled to TTD from 10/4/16 through and including 12/13/16, for a period of 10-1/7 weeks (not 10 weeks).

All else is otherwise affirmed and adopted.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed 1/25/18, with corrections, 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 the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $11,200.00. 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: JUN 6 - 2019
o: 04/09/19
TJT/pmo
51

Thomas J. Tyrrell

Maria E. Portela

Deborah L. Simpson

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

.NSON, CHRISTOPHER
Employee/Petitioner

Case# **16WC031607**

MEL-O CREAM DONUTS INTERNATIONAL
Employer/Respondent

19IWCC0277

On 1/25/2018, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.61% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in 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 LAW OFFICES OF MARK N LEE LTD
KEVIN MORRISSON
1101 S SECOND ST
SPRINGFIELD, IL 62704

0210 GANAN & SHAPIRO PC
ELAINE NEWQUIST
120 N LASALLE ST SUITE 1750
CHICAGO, IL 60602

STATE OF ILLINOIS)
)SS.
COUNTY OF Sangamon)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Christopher Johnson
Employee/Petitioner

Case # 16 WC 031607

v.

Consolidated cases: ______

Mel-O-Cream Donuts International
Employer/Respondent

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Edward Lee**, Arbitrator of the Commission, in the city of **Springfield**, on **December 21, 2017**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **September 28, 2016**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$40,219.40**; the average weekly wage was **$773.45**.

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

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

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

ORDER

Based on the above, the Arbitrator concludes Petitioner sustained 40% loss of use of a left ring finger, 10.8 weeks at a rate of $535.79 as a result of his injury to his left ring finger pursuant to Sec 8(e) 8 of the Act

Respondent shall pay Petitioner temporary partial disability benefits of $515.89/week for 10 weeks, commencing 10/04/2016 through 12/14/2016, as provided in Section 8(a) of the Act.

Respondent shall pay reasonable and necessary medical services, as provided in Sections 8(a) and 8.2 of the Act and per the findings in the attaché decision, subject to a credit of $15,623.02 pursuant to Section 8(j).

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

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

Carl Lee
Signature of Arbitrator

1/22/18
Date

JAN 25 2018

Findings of Fact

Petitioner is 33 year's old, unemployed and a former employee of Respondent. On the date of September 28, 2016 Petitioner was an employee of Respondent, Mel-O-Cream Donuts and had been employed with them periodically the last few years. Petitioner worked as a production associate, a job that required him to fill the donuts, clean machinery, run lines and generally deal with donut production.

On September 28, 2016, a Wednesday, Petitioner testified that he was finishing punching donuts and had to clean a pump when he was cleaning the pump his left ring finger got sucked into the pump which resulted in him severing his finger.

Petitioner admitted he left work at that time, at around 5:30 p.m., which his shift ended at 11:30 p.m. but did not report his injury to any supervisor. Petitioner testified he did not retrieve his finger and did not report his injury because he "freaked out." Petitioner was scared that if he reported his injury he would get fired and he liked his job with Respondent.

An emergency room visit was offered into evidence by Petitioner that recorded on September 28, 2016 Petitioner was cleaning a machine and cut his left ring finger off approximately one hour prior to his visit. It was noted that Petitioner suffered a partial amputation on that date. The visit was noted at 19:20 military time or 7:20 pm.

Petitioner underwent surgery on his finger two days later on September 30, 2016, a Friday. Dr. Mailey performed a debridement and surgical preparation of open facture of the left ring finger on that date. Petitioner was to follow up in 10 days to two weeks.

The following Monday, October 3rd, 2016, Petitioner eventually returned to work. Petitioner admitted he initially told his employer and MOHA he injured himself at home. Petitioner testified that he did reported his injury as work related on Monday and saw MOHA but the records reflect that he did not see MOHA until the following day on October 4th, 2016, a Tuesday. However, Petitioner also testified that he did admit his injury was work related until after he saw MOHA.

The October 4, 2016, MOHA record reflects that Petitioner was present for a fitness for duty examination. The record reflects that when Petitioner returned to work his left ring finger was bandaged and splinted. It recorded that Respondent was concerned that they had an occurrence in which a tip of a finger was found inside a donut jelly container. Mel-O-Cream did confirm with the coroner's office that the tip of the finger was a human finger.

The report also document that Petitioner stated to them that he smashed his left ring finger with a hammer, but that the records in questions reflected that Petitioner had got his finger caught in machinery at work. Petitioner was then placed under work restrictions and was to follow up with Dr. Mailey. Respondent was informed that Petitioner denied he injured himself at work and due to HIPPA concerns they could not share

Petitioner returned on October 19, 2016, to MOHA. Petitioner reported that on that date he had reported to his employer that he actually injured the tip of his finger was amputated by machinery while he was at work on September 28, 2016. It also reports that Petitioner reported to OSHA about his work related injury. Petitioner denied at history of communicable disease other than MRSA which occurred previously. Petitioner released medical information to his employer which allowed his employer access to his medical including his memorial hospital records.

Petitioner was instructed to follow up with Dr. Mailey and Petitioner gave permission for Mel-O-Cream to see his lab results.

In the employment file submitted at the time of trial an internal investigation performed by a Laura Davis was submitted. Said reports details that on October 3rd, 2016, Mel-O-Cream discovered a foreign material in the Graco Pump. After investigating it was discovered that the material was a fingertip. Petitioner in the meantime had attempted to call of that Monday due to an injury roofing over the weekend. However, due to his lack of FMLA, Petitioner was advised he must come in. Petitioner then denied that he had hurt himself at work.

On October 4th, 2016, it was noted that Petitioner's finger was bandaged but the company was checking employee's hands. Petitioner then reported that he had injured his hand on September 30, 2016, while roofing at home. After reporting to MOHA, Petitioner was confronted that they said his story did not add up. Petitioner reported that he did at home but if he was going to get fired then he was going to get fired.

A co-worker Justin West wrote a statement that Petitioner had cut his finger while cleaning the pump but it was hearsay. Another employee Brian Grant, thought Petitioner had burned his hand on Tuesday or Wednesday at 5pm to 6pm. Mr. Grant saw Petitioner cleaning the pump and heard him "yelp." Petitioner then admitted he did it at work to OSHA. Petitioner was then suspended and a workers' compensation claim was opened on October 7th 2016.

On October 4, 2016, Petitioner's returned to Dr. Mailey who examined Petitioner's left hand and opined he was doing well but to keep his hand covered and elevated with a three week return.

Petitioner returned to Dr. Mailey on October 25, 2016, with some pain and tenderness but improvement. Petitioner was to start gentle rom exercise but no heavy lifting with return to see the doctor in four weeks.

Petitioner final date of treatment was on December 13, 2016 during that exam he complained of moderate pain, throbbing sensation, and sharp stabbing pain of the volar aspect of the finger. Petitioner reported he had not returned to work due to his termination. Petitioner was to return in six months, which he testified he did not do, but to begin desensitization therapy. Petitioner was given a light duty slip for his left hand but reported he never followed up.

On the date of trial Petitioner testified that his finger gets cold and he still has pain and he has difficultly with gripping. Petitioner testified he lost full grip strength in his left hand due to sensitivity. Petitioner is currently unemployed and has worked part time jobs but he is under no permanent restrictions on his left hand.

Conclusions of Law

In regard to disputed issues (C, E, F), the Arbitrator makes the following conclusions of law:

The Arbitrator concludes that Petitioner did suffer a work related injury that arose out of and in the course of his employment on September 28, 2016, and that Respondent was given notice as required by the Workers' Compensation act, this conclusion is based upon the following reasoning;

Respondent's own employment file on Petitioner demonstrated that they knew of the accident and further other employees were aware that Petitioner had injured his left hand while cleaning the GRACO pump. One co-employee even reported that he heard Petitioner yelp when cleaning the pump on the day in question. Even if the manner in which Petitioner was cleaning the pump was against a safety violation Petitioner was performing a work activity as required by his employment during his injury. This is conclusion supported by the findings of *Heyman Distributing Co. v. Industrial Commission, 376 Ill. 90, 32 N.E. 2d 894 (1941)*. The court found that when an employee is attempting to do work he is employed to do but is violating a rule as to the manner of doing it compensation will be award.

While it is concerning that Petitioner did not report his injury immediately, Respondent's own investigation concluded Petitioner suffered injury and opened a workers' compensation claim on the accident in question well within the 45 day reporting period. Further, even in spite of Petitioner's statements the Memorial Medical records submitted show a story consistent with the investigation performed by Respondent. Petitioner treated almost immediately for his injury,

reported it as work related to his provider and had surgery on his hand two days later. The Arbitrator also notes that Respondent's other employees found said fingertip in the pump later which collaborates Petitioner's testimony.

While Petitioner not reporting his injury in a timely fashion and even admitting to lying about his injury is concerning it does not bar Petitioner from his workers' compensation claim. The overwhelming evidence supports that Petitioner suffered a work related injury on that day and per his testimony he was afraid of reporting said injury to Respondent. Petitioner's recorded response about being fired to the employer in their investigation supports his state of mind at the time. The initial medical records, respondents' own investigation, both support the conclusion that the injury occurred at work.

Concerning his false statements to his employer, Petitioner admitted he did make those statements but upon examination the Arbitrator finds that these statements do not bar his collection of benefits as Petitioner's statements about hurting himself at home on a Saturday are not reflected in the medical records submitted at the time of trial.

In regard to disputed issues (J), the Arbitrator makes the following conclusions of law:

Petitioner sought emergency room medical and followed all directions from his providers. All medical submitted seemed reasonably necessary to treat his condition therefore the Arbitrator awards benefits as follows subject to Respondent's credit and the fee schedule;

1. Memorial Medical Center; $13,648.75
2. SIU healthcare: $8,946.00
3. MOHA: $792.00
4. Associated Anes. Springfield:$1,080.00

Subject to the credit established by Respondent in the amount of $15,623.02.

In regard to disputed issues (K), the Arbitrator makes the following conclusions of law:

Respondent's employment file documents that Petitioner was terminated for cause but was still under work restrictions from 10/4/2016-12/13/2016 per his treating physicians and therefore is entitled to 10 weeks of Temporary Total Disability benefits. Petitioner did not voluntarily leave the work force and Respondent was unable to accommodate him therefore Petitioner is entitled to benefits.

In regard to disputed issues (L), the Arbitrator makes the following conclusions of law:

The Arbitrator takes note of Section 8.1(b) which sets forth the criteria for determining permanent partial disability.

1) The parties did not submit an impairment rating. The Arbitrator gives this no weight.

2) Petitioner is unemployed. Petitioner testified that since leaving his employment with Respondent he has not found work; the arbitrator affords this little weight to this factor.

3) The Petitioner was 32 years old at the time of his injury. There was no evidence submitted on the impact of his age and the Arbitrator will not speculate. Accordingly, the Arbitrator gives no weight to this factor.

4) This injury may have impacted Petitioner's earning potential as he is unemployed. The arbitrator gives this factor little weight.

5) At Memorial Hospital on September 28, 2016, Petitioner reported he had caught his left ring finger in a machine at work. He was diagnosed with a tuft amputation and a crush injury. The finger was bandaged and Petitioner was directed to follow up with Dr. Mailey for a flap closure procedure. (Pet.Ex.#3) On September 30 Petitioner returned to Memorial where Dr. Mailey performed a flap closure procedure on the left ring finger. He was directed to change the bandage daily and cleanse the wound with saline solution. (Id.) The Petitioner's ongoing subjective complaints were corroborated in the medical records. Petitioner still has some pain and numbness in his left ring finger consistent with his last date of treatment. The Arbitrator gives this factor significant weight in favor of the Petitioner.

Based on the above, the Arbitrator concludes Petitioner sustained 40% loss of use of the left ring finger, 10.8 weeks, pursuant to Sec 8(e) 8 of the Act.

STATE OF ILLINOIS	)	
	) SS.	
COUNTY OF MADISON	)	

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

GREGORY BUCKNER,
Petitioner,

19IWCC0278

vs.

NO: 17 WC 29385

ZOIE, LLC,
Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of causal connection, temporary total disability, and medical expenses both current and prospective, and being advised of the facts and law, reverses the Decision of the Arbitrator, finds the Petitioner sustained his burden of proving his current condition of ill-being of his lumbar spine was causally related to a work accident, and 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).

I. FINDINGS OF FACT

A. Accident

Petitioner testified that he was 41 years old and worked for Respondent as a laborer as of September 28, 2017. He explained that his job involves heavy work requiring him to shovel and work with concrete.

Petitioner testified he sustained an accident on September 28, 2017. He testified that his supervisor, Edward Everding (Mr. Everding), directed him to dig out some rock. As Petitioner was

doing that, "Ed swung his bucket and hit" him in the back. Petitioner testified that he was knocked to one knee. The incident occurred on his first day of work for Respondent after they began work. Petitioner explained that there was a mark on his orange shirt "across [his] back, [his] left to right." Petitioner acknowledged that diesel grease can result from any contact with the bucket of the bobcat, and that he did not ask for medical treatment at the time of the accident.

A series of text messages were exchanged between Petitioner and Mr. Everding relating to the incident at work between September 28, 2012 and October 10, 2012. Petitioner testified that on Sunday, when he returned from an emergency department, he informed Mr. Everding that he had seen a doctor and had to take a couple of days off to rest his back.

A September 28, 2017 text message from Mr. Everding states "[h]ope your doing okay first time I ever did that I know sorry doesn't make it right but I'm sorry." Petitioner responded he was alright and that "black men don't bruise."

On October 1, 2017, Petitioner sent a text message to Mr. Everding stating that his back was "killing" him and he needed to rest it the next day. On October 2, 2012, Mr. Everding asked Petitioner if he would be alright for the next day, and Petitioner responded he would be there. Mr. Everding then left him some instructions for the next day.

Petitioner testified that he did not work on the following Monday and did work full shifts on Tuesday, Wednesday, and Thursday.

B. Testimony of Edward Everding

Mr. Everding was called by Petitioner as a witness. He testified that he currently works for Respondent and previously worked for XL Contracting (XL) for about four years, which performed concrete and asphalt work. While Mr. Everding was with XL, he worked with Petitioner, whom he characterized as a good employee. He went to Respondent as a working foreman/supervisor because it was a better opportunity. Mr. Everding testified that he asked Petitioner to move to Respondent with him because "he was very dependable." He noted that in this type of work it was difficult with people showing up on time and performing job duties.

On September 28, 2017, Mr. Everding testified that he was with Petitioner filling trenches with asphalt. Mr. Everding was on a skid loader and, as he turned the loader, the side of the steel bucket struck Petitioner. He got out of the loader and asked Petitioner whether he was OK. Petitioner responded affirmatively and continued working. Right after the accident, Mr. Everding noticed markings of diesel fuel on the clothing of Petitioner's right shoulder. He explained that Petitioner had his back to the loader at the time of the accident.

Mr. Everding testified that the accident occurred on a Thursday and he believed that Petitioner came to work on that Friday and did "fine." Petitioner did not ask for medical attention at the time, finished his shift, and worked the entire shift the next day. He testified that he and Petitioner

exchanged text messages over the weekend and discussed Petitioner's condition. Mr. Everding acknowledged apologizing for hitting Petitioner with the bucket and checked to see how he was doing.

In texts over the weekend, Mr. Everding explained that Petitioner did not indicate that he was going to a hospital. He testified that he did not know that Petitioner saw a doctor until he filed the instant claim. Petitioner did not work the Monday after the accident, but worked a full shift that Tuesday, Wednesday, and Thursday. Mr. Everding did not notice anything unusual during those days; "everything was the same, he was like he always was[]" and Thursday was his last day of work for Respondent.

Mr. Everding acknowledged that while he worked with Petitioner at XL and for Respondent, sometimes Petitioner "hunched over" prior to this accident. He also acknowledged that, during their prior employment at XL, Petitioner was always complaining he had back problems. However, he did not recall Petitioner missing any time from work due to low back problems prior to this accident.

Edward Everding was re-called as a witness by Respondent. He testified that when he sent the initial text to Petitioner after the accident he thought he initiated [physical] contact with Petitioner. However, the next day he had a conversation with Mr. Hasty, who indicated that Petitioner was getting out of the hole and backed into the bucket.

Mr. Everding testified that he never saw fresh diesel on Petitioner's low back, but did see a diesel mark on Petitioner's shoulder/arm. He also thought Petitioner wore a yellow shirt. He also testified that Petitioner did not get knocked to the ground in the accident; that is, that he did not see any part of Petitioner's body hit the ground. Notwithstanding, Mr. Everding acknowledged that given his vantage point it could be possible that Petitioner went down on one knee.

C. Testimony of Jason Hasty

Jason Hasty (Mr. Hasty) was called by Petitioner as a witness. He testified that he performed labor for Respondent for little over a year. Previously, he worked for XL and moved to Respondent because it was a "better situation." Mr. Hasty testified that he knew Petitioner for about three years and acknowledged that Petitioner was a good employee, hard-working, and very dependable.

Mr. Hasty witnessed the accident and explained that he was located about eight feet away from Petitioner at the time. He testified that Mr. Everding was in the skid-steer putting asphalt into the hole. Petitioner was told to get out because they were ready to fill the hole, and when Petitioner "stepped back out of the hole he hit the front of the bucket" "with part of his right arm, like a tricep (*sic*) or bicep or whatever." The Arbitrator noted Mr. Hasty indicating to his shoulder.

Mr. Hasty testified that Petitioner was wearing an orange shirt and that the bucket left a diesel fuel stain. However, he also explained that one "could barely walk up to [the bucket] and brush

against it and it would leave a big [diesel] stain." After the accident, Mr. Hasty asked Petitioner whether he was "OK or if he needed any kind of help or to call 911." Petitioner responded he was okay.

Mr. Hasty was aware that Petitioner had prior back problems. He explained that "[s]ometimes [Petitioner] would complain saying his back hurt and sometimes he would sit down on the ground and lay back and stretch and grab around his hip area." He testified that, from time to time, Petitioner talked about his back problems while they worked at XL stating "[s]ometimes in between trucks when we'd catch a break, he would stretch his back." When Mr. Hasty came to work for Respondent, he explained that Petitioner was already working there, still talking about his back problems, and trying to stretch his back on the ground.

Mr. Hasty was re-called by Respondent. He testified that Petitioner was not knocked to the ground in the accident; the only part of Petitioner's body that touched the ground was his feet. The incident stuck out in his mind because Petitioner claimed to have gotten hurt in the accident, and he explained that he would have remembered if Petitioner worked the next day because "[Petitioner] would have been talking about it or something." However, he testified that it was also possible that Petitioner went to work the following day on another crew. Mr. Hasty also acknowledged that he told Petitioner to get out of the way immediately before he came into contact with the bucket.

D. Testimony of Virgil Knight

Virgil Knight (Mr. Knight) was called by Petitioner as a witness. He worked with Petitioner at XL and Respondent. He acknowledged that Petitioner was a good, dependable, employee. While at XL, he saw that Petitioner "was always stretched out, laying down wanting to stretch out his back and complaining about back pain." However, he did not recall Petitioner ever missing work prior to this accident.

He also saw Petitioner laying down and stretching while at Respondent. About a week or 10 days prior to this accident, Mr. Knight testified that Petitioner told him "he was having really bad back problems," and asked him what he should do. Mr. Knight recommended a chiropractor. However, Petitioner never mentioned that he ever went to a doctor or a chiropractor.

Mr. Knight did not see Petitioner's accident, or see or talk to Petitioner after the accident.

E. Testimony of Ebony Buckner

Ebony Buckner (Mrs. Buckner) was called by Petitioner as a witness. Mrs. Buckner, Petitioner's wife of 21 years, testified that he occasionally complained about his back and went to a doctor both before and after the accident. She helped treat his back with massages, heat, and ice. However, he never missed work because of his back prior to the accident. She testified that his back "had gotten a lot worse" after the accident and he could barely do anything like he used to

do, he was always in pain, and he could barely walk around well. On the evening of the accident, Petitioner came home in pain and his orange shirt was stained on the lower part of the left side.

Mrs. Buckner knew that a laborer's work is strenuous because she is a laborer. She knew that Petitioner stretched out his back at work on occasion. However, Petitioner's condition was "absolutely worse since the accident" in various ways.

Mrs. Buckner acknowledged that Petitioner took narcotic pain medication and had leg pain prior to his accident. She went with him for pretty much all of the doctor appointments for his lower back as well as an emergency room visit. He treated with Dr. Shuman, Dr. Gornet, and Dr. Mohyuddin. However, Mrs. Buckner did not believe that Petitioner was referred to a spine surgeon prior to this accident. With regard to Petitioner's visit with Dr. Shuman on September 18, 2017, Mrs. Buckner testified that she accompanied her husband and the intake form was signed by Petitioner noting his back as the main complaint. She thought Petitioner was just going to first meet his doctor and tell him all the things that were going on.

Mrs. Buckner acknowledged that Petitioner worked the day after the accident and did not seek medical attention on Saturday. Petitioner also worked the following Tuesday, Wednesday, and Thursday. She was "pretty positive" that Petitioner wore an orange shirt to work on the day of the accident, and acknowledged that he frequently came home with stains on his shirt.

F. Pre-Accident Medical Treatment

Petitioner acknowledged that the first time he sought treatment for his back was in 2010. The medical records reflect that, on November 2, 2010, Petitioner presented to Dr. Klein with low back pain for four weeks. Dr. Klein noted he probably just strained his back and prescribed Naprosyn. X-rays were negative.

Five years later, on October 27, 2015, Petitioner underwent a lumbar MRI due to a one-year history of low back pain. It showed facet hypertrophy causing mild foraminal stenosis at L4-5 and mild-to-moderate foraminal stenosis at L5-S1 with early degenerative desiccation at that level. Petitioner disagreed that in October 2015 he reported he hurt his back at work because of repetitive work. However, Petitioner acknowledged that the first time he went to an emergency department for back pain was in October 2015.

On December 31, 2015, Petitioner presented to Dr. Muhyuddin for chronic back pain without sciatica. He denied any injury. Cluster headaches were also included in current problems. He was taking Hydrocodone with some relief of back pain. His MRI was not available for review. Petitioner requested a referral to pain management but did not follow through with it.

Petitioner also acknowledged that on December 25,2015, he was referred to an orthopedic surgeon in an emergency department, but he did not follow up because he could manage the pain. Petitioner testified that he did not tell anybody he had been told to see an orthopedic surgeon.

The medical records reflect that, on January 20, 2016, Petitioner presented to Physician's Assistant (PA) Krupska-Buckley at St. Anthony Medical Center complaining of 10/10 back pain. They reviewed MRI findings and discussed treatment options. Petitioner wanted to start with physical therapy and possibly a TENS unit. He had not had physical therapy or chiropractic treatment and was using Vicoprofen for relief. Petitioner was provided information on medial branch blocks and radiofrequency ablation. He wanted to recover from the pain and return to work.

On February 2, 2016, Petitioner was initially evaluated by physical therapy for 10/10 low back pain with occasional radiation into the right leg. He worked laying asphalt but was not working due to the weather. He reported no injury. Petitioner reported that he was working very hard one day and did not notice pain at the time but "the next day it was really hurting" and was worsening. He was going back to work in April and needed for his back to improve.

By March 10, 2016, at physical therapy Petitioner reported he has really been hurting. He felt he was doing better, but was called in for tree removal and after a few days of that work he could not move without pain. This is the last treatment note and he reported making some progress in physical therapy, but self-discharged.

Petitioner testified that Dr. Mohyuddin was his previous primary care physician, whom he last saw in July 2017. The medical records reflect that Petitioner then established primary care with Dr. Shuman on September 18, 2017 as reflected in his medical records. Among other issues at that time, Petitioner reported pain in the lower-mid back down the right leg. He was taking Zolpidem and Hydrocodone. Petitioner testified that he saw Dr. Shuman once prior to the accident. He denied that he told Dr. Shuman that his function was limited because of his back pain.

Petitioner acknowledged that he had back problems prior to his accident, which included a visit 10 days earlier with Dr. Shuman with a primary complaint related to his back among other conditions. Petitioner also acknowledged that he took narcotic pain medication for his back prior to the accident at work. He further acknowledged that he previously had difficulty sleeping and with prolonged sitting/standing due to low back pain.

Notwithstanding, while Petitioner admitted to previous right-sided back and leg pain, he testified that he never had left leg pain. Petitioner explained that the accident worsened his condition and he could not "continue to labor with the pain" he was now experiencing. Petitioner also testified he never filed a workers' compensation claim previously and never lost time at work due to back or leg pain.

G. Post-Accident Medical Treatment

On October 4, 2017, Petitioner returned to Dr. Shuman. He reported that he was hit by a bucket on a bobcat six days earlier. Dr. Shuman noted that Petitioner had increased pain and a reduction

of functionality after the accident. Dr. Shuman diagnosed right low back pain with sciatica and placed Petitioner off work until October 9, 2017.

Petitioner and Mr. Everding also had text message exchanges during Petitioner's initial days of treatment. On October 6, 2017, Petitioner sent a text message to Mr. Everding stating that he had to rest his back that day. Mr. Everding responded that was up to him, but the work they were doing that day would not be that strenuous.

On October 8, 2017, Mr. Everding inquired whether Petitioner would be able to work the next day via text message. Petitioner responded that he had to get his back checked out. Mr. Everding indicated he could accommodate him with light work. Petitioner declined stating that he appreciated the offer, but had a doctor's appointment.

On October 9, 2017, Mr. Everding checked in to see how Petitioner was doing via text message. Petitioner responded it did not look good and something was going on with his back. Mr. Everding responded that "sucks."

The medical records reflect an MRI taken on October 9, 2017 showed small disc bulges/protrusions at L4-5 and L5-S1 with foraminal narrowing, perhaps more significant at L5-S1, but without significant impact on the dura.

Also on October 9, 2017, Petitioner presented to Dr. Gornet. He reported being struck in the back and knocked down by a bucket on a bobcat driven by his supervisor. His primary care physician took him off work for several days. Petitioner reported a history of low back pain about two years earlier. He had physical therapy and responded well. Dr. Gornet noted that Petitioner essentially has been working full duty without restrictions as a union laborer until this current event. Dr. Gornet opined that Petitioner's current symptoms were causally related to his work accident.

Dr. Gornet also reviewed the MRI, which he interpreted as revealing a strong suggestion of an annular tear and disc injury at L5-S1, subtle suggestion of an annular tear at L4-5, and likely foraminal stenosis at L5-S1. Dr. Gornet's diagnosis was disc injury at L5-S1 and potentially at L4-5 and aggravation of pre-existing foraminal stenosis at L5-S1. He referred Petitioner for physical therapy and released him to work with a 10-pound limit, no repetitive bending, no repetitive lifting, and ability to alternate between sitting and standing as needed. He also included the additional restriction of "office work only."

The following day, on October 10, 2017, Petitioner informed Mr. Everding via text message that he had messed up discs in his back and needed physical therapy.

Eventually, on December 27, 2017, Dr. Gornet performed a discogram with x-ray interpretation with facet block at L4-5 and L5-S1. The test was negative at L4-5, but there was concordant 8/10 pain at L5-S1. Petitioner was stoic throughout the procedure and showed no

functional overlays. The post-discogram CT showed bilateral full-thickness annular tears at L5-S1 with contrast extravasation into the outermost annular fibers and minimally into the epidural space and a circumferential disc bulge resulting in mild bilateral foraminal stenosis, but no central canal stenosis.

On February 5, 2018, Dr. Gornet noted that the positive discogram at L5-S1 was consistent with Petitioner's subjective complaints. He also noted that the facets appeared OK. Dr. Gornet noted that Petitioner had the choice of living with the condition or having surgery consisting of a disc replacement at L5-S1 versus a fusion. Petitioner indicated that he wanted to proceed with surgery. Dr. Gornet continued Petitioner's work restrictions.

Petitioner last saw Dr. Gornet on April 9, 2018. Dr. Gornet reiterated his opinion that Petitioner's lumbar condition was related to his work accident stating that the accident caused a disc injury at L5-S1, as well as aggravating Petitioner's pre-existing facet arthropathy. He continued to seek approval for disc replacement surgery and continued Petitioner's work restrictions.

On cross-examination, Petitioner acknowledged that he filled out a questionnaire and pain diagram at Dr. Gornet's office. He acknowledged that he reported 10/10 back and right leg pain prior to the accident. He believed it was correct that the only time he brought medical records to Dr. Gornet was once in December. Petitioner did not know whether the records included records from Dr. Mohyuddin. Petitioner also testified that he did not mention to Dr. Gornet that he saw Dr. Shuman 10 days prior to the accident. He told Dr. Gornet to do anything he had to do to get him back to work. Petitioner did not say that to any previous medical provider.

Petitioner testified that he believed that he told Dr. Gornet that he was knocked to one knee, and not solely that his prior back condition amounted to physical therapy two years previously. At his first visit, Petitioner testified that he told Dr. Gornet that he had a previous MRI, but did not recall whether he reported low back pain for a year prior to the MRI. Petitioner also testified that he did not write down the list of his medications because he did not know how to spell them, but he informed Dr. Gornet that he took medications.

As of the hearing, Petitioner testified that he no longer took narcotic pain medication as Dr. Gornet had forbidden it. Petitioner also acknowledged that his medical history included surgery over prior years for unrelated issues with his left rotator cuff, his collar, shoulder, hip, and left wrist for which he also took medication.

Petitioner testified that Dr. Gornet recommended prospective treatment and "maybe surgery," which Petitioner wanted to undergo as soon as possible. Conservative treatment such as injections, physical therapy, pain medication, and rest did not improve his condition. He thought the surgery Dr. Gornet recommended was disc replacement. Petitioner did not have insurance through the union; it ran out because he did not have enough hours.

H. Deposition Testimony of Dr. Gornet

Dr. Gornet testified by deposition on March 26, 2018 and March 30, 2018. He first saw Petitioner on October 9, 2017 with a main complaint of bilateral low back pain radiating down the buttocks, hips, right worse than left, and down the left leg. He reported being struck in the back and knocked down by a bucket on a bobcat driven by his supervisor.

Dr. Gornet understood that Petitioner's primary care physician took him off work for "several days." He tried to return to work but his last day of work was October 5, 2017. Petitioner reported a history of low back pain about two years earlier. Petitioner had physical therapy and responded well and essentially has been working full duty with no restrictions as a union laborer until this current event. On examination, Petitioner had normal strength and no major neurological deficits.

Dr. Gornet reviewed an MRI, which revealed "a strong suggestion of an annular tear and disc injury at L5-S1," "subtle suggestion of an annular tear at L4-5," and likely foraminal stenosis at L5-S1. Dr. Gornet's diagnosis was disc injury at L5-S1 and potentially at L4-5 and aggravation of pre-existing foraminal stenosis at L5-S1.

Dr. Gornet opined that the work accident Petitioner described "at minimum" aggravated his foraminal stenosis or his disc pathology. He noted that the mechanism of injury reported by Petitioner "could easily aggravate or cause further injury to his disc internally." Dr. Gornet also noted that the initial medical records from the emergency department and from Petitioner's primary care physician four days after the accident were consistent with a trauma resulting in increased pain. He stressed that while Petitioner had a preexisting condition he had been able to work and function prior to the instant accident. Dr. Gornet initially recommended conservative care and placed work restrictions on Petitioner.

Dr. Gornet reviewed Dr. Kitchens' Section 12 report and acknowledged Dr. Kitchens' apparent conclusion that Petitioner's 2015 incident was significant because he went to an emergency department and had an MRI. However, Dr. Gornet noted that Petitioner continued to work thereafter and there was no evidence that he was having major problems other than sporadic visits to his doctor. He characterized Dr. Kitchens' opinions as a smoke and mirrors thing. Dr. Gornet specifically cited Dr. Kitchens' statement that the incident did not cause the disc degeneration and explained it was like seeing a flat tire from a nail and concluding that driving did not cause wear on the tire; it's irrelevant.

Dr. Gornet could not explain Dr. Kitchens' conclusion that Petitioner's "being struck by a backhoe, being knocked down, going to the emergency room, having increased pain, requiring treatment" would not be considered an aggravation of his underlying condition. He also disputed Dr. Kitchens' conclusions that Petitioner was at maximum medical improvement and could work full duty. The fact that Petitioner had increased radicular, bilateral pain, which was not present prior to the accident, underscored the fact that his condition changed after the accident at work.

In further review of Dr. Kitchens' report, Dr. Gornet noted that while degeneration can cause annular tears as well as herniations it does not mean that degeneration caused the tears in this situation. He stated that Dr. Kitchens went out of his way to misquote the literature.

Finally, Dr. Gornet disagreed with Dr. Kitchens' opinion that Petitioner was a surgical candidate prior to the accident because the need for surgery is based on a patient's symptoms. He did not see any specific surgery recommended by Dr. Kitchens.

On cross examination, Dr. Gornet testified that he reviewed an MRI from October 27, 2015. He did not know when he received the film and did not believe he referenced that MRI in his notes. Dr. Gornet also reviewed other medical records from before the accident. He had a record from Dr. Shuman from 10 days before the accident, but did not mention that record in his treatment notes.

Dr. Gornet thought it was reasonable to treat conservatively from two-to-six months prior to recommending surgery. However, that would also depend on the trajectory of improvement. If there was no improvement, Dr. Gornet would recommend less time on conservative treatment.

Dr. Gornet was strongly against treating patients with narcotics long-term. He testified that it masks the pain, so now you don't know whether or not you're dealing with issues for persistent back pain or narcotic dependence. Prior to the accident, Petitioner was taking narcotics intermittently, but Dr. Gornet did not know the specifics.

Dr. Gornet testified that, if it was demonstrated that Petitioner could not work his job because of low back pain prior to the accident, it would support that Petitioner had an active significant problem. However, he did not know whether that would change his opinions. In his experience, Dr. Gornet testified that every union laborer has flares of back pain, but the critical issue is whether he could continue to work. He did not know exactly what Petitioner did for Respondent, but union laborers have to lift up to 75 to 100 pounds and do what is required out of the union hall.

Dr. Gornet testified that if Petitioner were not hit, that would change his causation opinion. He noted that Petitioner was knocked to the ground, but he did not know whether that was factually correct. Dr. Gornet also testified that "not being knocked to the ground is not as much or a pertinent issue as being struck suddenly by a bobcat bucket" in the back. Dr. Gornet testified that MRI and CT scans cannot date a particular pathology.

I. Deposition Testimony of Dr. Kitchens

Dr. Kitchens testified by deposition on April 4, 2018. He is a neurosurgeon who sees 50 to 75 patients and averages five surgeries a week. Dr. Kitchens performed a Section 12 medical examination on Petitioner at Respondent's request, reviewed medical records, and issued reports.

Dr. Kitchens testified that Petitioner reported that he was shoveling and got hit in the back with a bobcat bucket. It occurred on a Thursday, he went to work on Friday, his back worsened on Saturday, and went to a hospital on Sunday. He did not work that Monday, but did that Tuesday, Wednesday, and Thursday.

At the examination, Dr. Kitchens testified that Petitioner complained of low back pain into the right leg to about the back of the knee and occasionally down the left leg as well. Petitioner did not report radiating pain in either leg. Petitioner reported a prior history of stiffness in his back but denied any history of leg pain. He also reported prior right-hip pain and that he had pinched nerve in his hip. Petitioner reported previous physical therapy, but that he did not take narcotic pain medication, have any prior workup for his back, or lose time from work prior to the accident.

On examination, Dr. Kitchens noted that Petitioner had normal strength in his legs, normal sensation to light touch and pinprick, normal reflexes, and good lumbar range of motion. Straight leg raises were negative. He reported mild pain with bending and pain in the right hip in a Faber test. On the pain diagram, Petitioner reported 10/10 pain. Petitioner did not appear to be in severe pain during his examination. He did not need any assistance from devices in ambulating in the examination room.

Dr. Kitchens testified that he reviewed medical records dating back from November 2, 2010. A note from an emergency department dated October 20, 2015 indicated that Petitioner had back pain for a year. He was prescribed Flexeril and Tramadol. Dr. Kitchens also saw an MRI from October 27, 2015. Petitioner returned to the emergency department on December 25, 2015, at which time he reported 10/10 low back pain radiating into the right leg. A medical record from January 2, 2016 characterized Petitioner's low back pain as chronic and that he was taking Hydrocodone. At that time, Petitioner was referred to pain management. A note dated January 13, 2016, indicated he was taking Norco and seeking pain management.

Dr. Kitchens continued that a note from January 20, 2016 indicated Petitioner had low back pain with intermittent radiation into the right leg, he was taking Vicoprofen, and was given information about radiofrequency ablation and medial nerve blocks. Records from March 15, 2017 and July 17, 2017 indicate that Petitioner was taking prescription anti-inflammatories and narcotic pain medication. A note from September 18, 2018 indicated Petitioner had low back/right leg pain and referenced sciatica, he was taking Vicoprofen, and his functioning was limited by back/joint pain.

Dr. Kitchens noted that Petitioner went to an emergency department on October 1, 2017. He could move his legs normally, had normal flexion/extension, normal strength, and no numbness.

In the MRIs he reviewed, Dr. Kitchens saw no evidence of any disc herniations. Dr. Kitchens' diagnosis was history of chronic low back pain and degenerative disc disease at L5-S1. Previously, Petitioner had been diagnosed with degenerative disc disease at L5-S1, foraminal stenosis, and chronic low back pain.

Dr. Kitchens opined that the diagnosis of chronic low back pain had no relationship or association with his work accident on September 28, 2017. He found no significant differences in comparing the MRIs from before and after the accident. Dr. Kitchens further opined that the accident did not aggravate or exacerbate Petitioner's low back condition or necessitate the treatment Petitioner received after the accident. However, later in cross examination he testified that he thought Petitioner's initial visit to the emergency department was a legitimate evaluation for an injury.

Dr. Kitchens also opined that discograms were "unreliable and subjective to observer bias." It is dependent on the practitioner and related subjective complaints of patients. Dr. Kitchens cited an article that indicated that annular tears are a normal consequence of degenerative disc disease. He explained that an annular tear is a minor defect within the annulus of the disc while a disc herniation is a complete disruption of the annulus with protrusion of the nucleus from its natural space.

Dr. Kitchens further opined that Petitioner was a surgical candidate prior to the accident based on the diagnosis of chronic back pain, degenerative disc disease/foraminal stenosis at L5-S1, and because conservative treatment had failed. He testified that the surgery that would be performed prior to the accident would be the same as after the accident.

On cross examination, Dr. Kitchens testified that Petitioner cooperated with his exam, did not limit the exam in any way, and answered all his questions. He was aware that Petitioner was a union laborer and acknowledged that he did not describe his work activities in his report. Dr. Kitchens had no information that Petitioner had any previous workers' compensation claims or reported any prior work-related injury. He also acknowledged that Petitioner reported that he was able to work four shifts after the accident but had not worked since. Dr. Kitchens testified that he was not provided with any statements from Petitioner's co-workers.

Dr. Kitchens acknowledged that people who perform heavy labor experience aches and pains from time to time. However, he did not believe that heavy labor affects development of degenerative disc disease. Dr. Kitchens acknowledged that Petitioner had multiple painful conditions other than his low back. In the records he received, Dr. Kitchens acknowledged that there was no mention of back pain between November 2, 2010 to October 20, 2015, and on November 2, 2010 Petitioner did not report radiation into the leg.

Dr. Kitchens also acknowledged that prior to the accident, Petitioner did not mention constant radiating pain or pain in the left leg. He acknowledged that Dr. Shuman saw Petitioner both before and after the accident and he indicated Petitioner had increased pain and reduced functionality after the accident. Dr. Kitchens also testified that surgery had not been recommended before the accident. He acknowledged that there can be an increase in pain without a change in MRI findings and that Petitioner worked full duty prior to the accident. Notwithstanding, Dr. Kitchens testified

that Petitioner's post-accident treatment, except the emergency department visit, was for the diagnosis of degenerative disc disease and not related to the accident.

Dr. Kitchens further acknowledged that the discography showed an annular tear and that Petitioner was symptomatic at L5-S1. Most annular tears are the result of degeneration and not the result of mechanical loading of the disc. Petitioner reported that his physical therapy/chiropractic treatment did not help; in fact, his pain was increasing. Dr. Kitchens would recommend neuroforaminal decompression/fusion at L5-S1.

On redirect examination, Dr. Kitchens responded to a hypothetical question outlining Petitioner's symptoms pre-accident. Dr. Kitchens responded that an MRI would be indicated for the patient and the patient would be a surgical candidate. He did not believe physical therapy would be effective for a patient who had chronic pain and radiculopathy. In Dr. Kitchens' view, Petitioner was clearly symptomatic and in need of treatment other than pain medication at least as of September 18, 2017, 10 days prior to the accident. He testified that patients can receive pain-management treatment from doctors other than pain management specialists.

II. CONCLUSIONS OF LAW

The Arbitrator found that Petitioner had not sustained his burden of proving that the accident on September 28, 2017 caused the current condition of ill-being of his lumbar spine. In support of that finding, the Arbitrator noted that Petitioner had credibility issues in not relating to Dr. Gornet the extent of his prior lumbar condition and that he was taking narcotic pain medication. Based on that inaccurate history, the Arbitrator did not find Dr. Gornet's opinion testimony persuasive. In addition, the Arbitrator noted inconsistencies between Petitioner's testimony and those of his co-workers who witnessed the accident. While Petitioner testified that he was struck by a moving bobcat bucket and was knocked to the ground on one-knee, his co-workers denied that he went to the ground and appeared to dispute the severity of the accident. Finally, the Arbitrator relied on the testimony that the work crew "laughed off" the incident.

The Arbitrator correctly noted that there was some discrepancy in the testimony among witnesses about the severity of the contact. However, all witnesses acknowledged that Petitioner came into contact with the bucket on the bobcat. While Mr. Hasty testified that the contact was minor and that Petitioner initiated the contact, he admitted that he was concerned enough by the accident to ask if 911 should be called. Regardless, the fact that Petitioner had significant pre-existing lumbar pathology would make it more likely that even a relatively minor impact could result in a significant increase in symptomology necessitating treatment and resulting in Petitioner being taken off work and Dr. Gornet's recommendation for surgery.

Petitioner had a significant pre-existing condition of ill-being of his lumbar spine prior to the instant accident. Nevertheless, the record indicates that prior to September 28, 2017, there was no treatment other than conservative treatment for his prior lumbar condition and no surgery was

recommended. Petitioner never missed any work due to his lumbar condition and was able to work in his heavy labor job without restrictions despite that condition.

Furthermore, the opinions of Respondent's Section 12 examiner, Dr. Kitchens, were somewhat inconsistent and are not as persuasive as those of Dr. Gornet given the facts in this case. He testified that the accident neither exacerbated nor aggravated Petitioner's condition and that none of Petitioner's treatment was reasonable and necessary. However, he finally conceded that he believed the initial visit to the emergency department was a legitimate evaluation of his injury. As noted by Dr. Gornet relating to a change in Petitioner's symptomatology and function post-accident, Petitioner's primary care physician, Dr. Shuman, also noted about a week after the accident that it resulted in increased pain and a reduction of Petitioner's functional ability. Petitioner consistently reported the new symptom of bilateral pain radiating into the legs, and an inability to function as he did before the accident.

With regard to temporary total disability, the medical records reflect that Dr. Shuman first placed Petitioner off work on October 4, 2017 through October 9, 2017 followed by Dr. Gornet's work restrictions as of his initial evaluation on October 9, 2017 through his last date of treatment, April 9, 2018. There is no evidence in the record to indicate that Respondent accommodated Petitioner's restrictions as ordered by Dr. Gornet and Petitioner has not been cleared to work full duty through the date of arbitration.

The Commission concludes, based on the totality of the evidence, that the accident on September 28, 2017 aggravated Petitioner's pre-existing condition causing new symptoms and increasing the severity of pre-existing symptoms, which thereafter interfered with his ability to work and required more extensive medical treatment including the surgery recommended by Dr. Gornet. Accordingly, the Commission reverses the Decision of the Arbitrator.

IT IS THEREFORE ORDERED BY THE COMMISSION the Commission finds that Petitioner's sustained his burden of proving that the accident on September 28, 2017 caused the current condition of ill-being of his lumbar spine and the Decision of the Arbitrator dated June 14, 2018 is reversed.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay to the Petitioner the sum of $829.87 per week for a period of 27 & 6/7th weeks, that being the period of temporary total incapacity for work under §8(b), and that as provided in §19(b) of the Act, this award in no instance shall be a bar to a further hearing and determination of a further amount of temporary total compensation or of compensation for permanent disability, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay the sum of $45,382.40 for medical expenses under §8(a) of the Act, subject to the applicable medical fee schedule.

IT IS FURTHER ORDERED BY THE COMMISSION, that Respondent authorize and pay for prospective treatment recommended by Dr. Gornet to treat Petitioner's current condition of ill-being of his lumbar spine.

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

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

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

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

DATED: JUN 6 - 2019

Barbara N. Flores

DLS/dw
O-5/9/19
46

Marc Parker

Dissent

I respectfully dissent from the Decision of the majority. I would have affirmed and adopted the well-reasoned Decision of the Arbitrator in which she found that Petitioner did not sustain his burden of proving his current condition of ill-being of the lumbar spine was causally related to his work accident.

First, there was conflicting testimony regarding the specific circumstances of accident itself. Petitioner testified that the bucket struck him in the lower back with sufficient force to knock him to the ground on one knee. However, the witnesses testified that they did not see Petitioner fall to one knee, they testified that the bucket came into contact with Petitioner's upper arm/shoulder, and one witness testified that Petitioner actually backed into the bucket. In this case the relative credibility of the witnesses was critical in determining the severity of the accident and whether it was sufficient to permanently aggravate Petitioner's underlying condition.

While the Commission acts as original finder-of-fact, as does the Arbitrator, in my opinion the Arbitrator is generally in a better position to assess the credibility of live witnesses and I see no reason to disturb that assessment in this case. In addition, the testimony of the eye witnesses was corroborated by the e-mail correspondences of Petitioner and his supervisor. In those correspondences, Petitioner appeared to downplay the severity of the accident and he never attributed his worsening back condition to the accident.

Second, as pointed out by the majority, it is clear that Petitioner had a significant pre-existing condition of ill-being. However, that significant pre-existent lumbar condition included his report of 10/10 pain, his long-term use of narcotic pain medication, and his referral to pain management and an orthopedic surgeon prior to the accident. In this regard, I agree with the Arbitrator over the majority in assessing the relative persuasiveness in the opinion testimony of Dr. Gornet and Dr. Kitchens. As noted by the Arbitrator, Dr. Kitchens had access to Petitioner's entire pre-accident medical records, which Dr. Gornet did not, and Dr. Gornet was opining under the apparently mistaken assumption that Petitioner was hit in the lower back and with sufficient force to knock him to the ground.

Third, I find persuasive Dr. Kitchens opinion that the accident did not materially change Petitioner's condition. He noted that there was no significant change in the MRI findings prior to and after the accident, the diagnoses were the same, and the type of surgery would be the same. While Dr. Gornet testified that he reviewed the pre-accident MRI, he did not testify that he compared that to the post-accident MRI or that the post-MRI showed any objective worsening of Petitioner's condition. Dr. Kitchens acknowledged that Petitioner did not complain of left-sided leg pain prior to the accident. However, that is only a subjective finding and could simply represent the natural progression of his degenerative disc disease. Similarly, Petitioner's ability to work full shifts for four days after the accident would tend to indicate that Petitioner did not suffer a substantial acute injury in the accident and his worsening condition and eventual inability to perform his job activities was the result of the natural progression of his degenerative disease which happened to be close temporally to the accident.

For the reasons stated above, I would have affirmed and adopted the well-reasoned Decision of the Arbitrator in which she found that Petitioner did not sustain his burden of proving Petitioner's current condition of ill-being of the lumbar spine was causally related to his work accident and denied compensation. Therefore, I respectfully dissent from the Decision of the majority.

DLS/dw
O-5/9/19

Deborah L. Simpson

STATE OF ILLINOIS	)		
	) SS.		
COUNTY OF COOK	)		

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

BERTHA QUIROZ,

Petitioner,

19IWCC0279

vs.

NO: 17 WC 8096

COMPASS GROUP,

Respondent.

DECISION AND OPINION ON REVIEW

Initially, the Commission notes that neither the decision nor the mainframe specifically indicate that the matter was arbitrated under Section 8(a) & 19(b) of the Act, and the decision does not include the *Thomas* remand language. Nevertheless, a petition for hearing under those sections was filed by Petitioner, the Arbitrator ordered prospective treatment, and the Arbitrator did not award any permanency. Therefore, the Commission shall treat the decision as being adjudicated under those sections.

Timely Petition for Review under §§19(b) and 8(a) of the Act 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 benefits, and medical expenses both current and prospective, and being advised of the facts and law, changes the Decision of the Arbitrator as stated below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof. The Commission further remands this case to the Arbitrator for further proceedings for a determination of a further amount of temporary total compensation or of compensation for permanent disability, if any, pursuant to *Thomas v. Industrial Commission*, 78 Ill.2d 327, 399 N.E.2d 1322, 35 Ill.Dec. 794 (1980).

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent shall pay to the Petitioner the sum of $253.00 per week for a period of 5.143 weeks, that being the period of temporary total incapacity for work under §8(b), and that as provided in §19(b) of the Act, this award in no instance shall be a bar to a further hearing and determination of a further amount of temporary total compensation or of compensation for permanent disability, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay the sum of $$1,493.94 for medical expenses from Concentra under §8(a) of the Act, subject to the applicable medical fee schedule.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent authorize and pay for prospective medical treatment recommended by Dr. Wingate to treat Petitioner current condition of ill-being of his lumbar spine.

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

DATED: JUN 6 – 2019

Deborah L. Simpson

Barbara N. Flores

Marc Parker

DLS/dw
O-5/23/19
46

ILLINOIS WORKERS' COMPENSATION COMMISSION

NOTICE OF ARBITRATOR DECISION

19IWCC0279

QUIROZ, BERTHA

Employee/Petitioner

Case# **17WC008096**

COMPASS GROUP

Employer/Respondent

On 5/31/2018, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 2.03% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

2553 McHARGUE & JONES LLC
MATTHEW C JONES
123 W MADISON ST 18TH FL
CHICAGO, IL 60602

1120 BRADY CONNOLLY & MASUDA PC
MARK VIZZA
10 S LASALLE ST SUITE 900
CHICAGO, IL 60603

19IWCC0279

STATE OF ILLINOIS)
)SS.
COUNTY OF COOK)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

BERTHA QUIROZ
Employee/Petitioner

Case # 17 WC 8096

v.

Consolidated cases:

COMPASS GROUP.
Employer/Respondent

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Kurt Carlson** Arbitrator of the Commission, in the city of **Chicago**, on **April 12, 2018.** After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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**

FINDINGS

On **March 13, 2017**, Respondent was operating under and subject to the provisions of the Act.

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

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

Timely notice of this accident was given to Respondent.

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

In the year preceding the injury, Petitioner earned **$15,541.76**; the average weekly wage was **$298.88**.

On September 20, 2013, Petitioner was **57** 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 **$0** under Section 8(j) of the Act.

ORDER

Prospective Medical

Respondent shall authorize and pay for the L4-S1 Transforaminal Lumbar Interbody Fusion as recommended by Dr. Wingate. Respondent is ordered to authorize and pay for the above.

Medical Benefits

Respondent shall pay reasonable and necessary medical services, pursuant to the medical fee schedule, of Concentra $1,493.94 as provided in Sections 8(a) and 8.2 of the Act.

Temporary Total Disability

Respondent shall pay Petitioner temporary total disability benefits of $253.00/week for 5.143 weeks, commencing March 8, 2018 through April 12, 2018, as provided in Section 8(b) of the Act. Respondent is entitled to a credit of $0 in 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.

Signature of Arbitrator　　　　Date 5-31-18

MAY 31 2018

BEFORE THE ILLINOIS WORKERS COMPENSATION COMMISSION
IN THE STATE OF ILLINOIS

BERTHA QUIROZ,	)	
	)	
Petitioner,	)	
	)	Number: 17 WC 8096
vs.	)	
	)	
COMPASS GROUP	)	
	)	
	)	
Respondents.	)	

Arbitrator's Findings of Facts

As of the date of trial, Ms. Bertha Quiroz, (Petitioner) stated that she is, and has been for the past five years and six months, employed by Compass Group (Respondent). Tx7-8. She worked in food service and at times a cashier or cleaner. Tx8. Respondent is a catering company, and Petitioner's responsibilities as an employee for Respondent consists of cleaning services in offices, working as a cashier, and helping out in the kitchen. Tx8.

Petitioner was working for Respondent on September 20th 2013. Tx8. While her regular hours were 2:30 PM to 7:30 PM, she at times would stay until 9:00 P.M. depending on the workload. Tx9. Her job included cleaning 12 floors, which required that she push a big cart. On September 20, 2013 Petitioner was pushing the cart against a door to open it, when she felt a strong pain in her back. Tx9. The pain was such that it stopped her from moving, and forced her to stop at times. Tx10. She was, however, able to complete her shift. Tx10.

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Petitioner described the sensation following the twisting movement as being unable to move due to the pain in her back, hips, and legs. Tx24. Petitioner hurt herself between 12:00 and 1:00 pm that day, having started her shift at 11:00 AM. Tx24. Petitioner was taken to her manager's office, and reported her injury at that time. Tx24.

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On August 25th, 2017 Petitioner reported to Dr. Wingate, the relief from the injection having worn off. P7; Tx43. At this time Dr. Wingate recommended that Petitioner undergo an L4-S1 transforaminal lumbar interbody fusion. P7; Tx28.

Petitioner was seen by Dr. Butler for a third IME on October 18th, 2017. Tx28-29.

Petitioner underwent another MRI on March 14, 2018. P10. This was read by Dr. Sobti, who saw multilevel spondylosis throughout the lumbar spine including facet arthrosis, endplate spurring, and disc space narrowing. P10. He also saw grade 1 anterolisthesis L5 on S1. P10.

Petitioner wishes to undergo the surgery recommended by Dr. Wingate. Tx29. Petitioner was taken off work by Dr. Wingate on March 8th, 2018. P7; Tx29. Petitioner would like a different job with Respondent. Tx30.

Petitioner has never had any other accidents or injuries involving her low back. Tx31. Petitioner expressed that she is not able remain seated for a long time, and that she has to make certain movements in order to stand up or to sit down. Tx32.

Dr. Butler authored four different reports concerning Petitioner's accidents. Petitioner initially saw Dr. Butler on January 8th, 2015. Dr. Butler took a history of treatment consistent with that reported by Petitioner. R1. At this time, Dr. Butler reported that Petitioner's current

diagnosis is a lumbar disk herniation. R1. He further reported that the diagnosis is properly stated and supported by the records and objective findings, and that the medical documentation supported the causal relationship between the accident and injury. R1.

Dr. Butler found that the Petitioner required further diagnostic testing because he reported that her symptoms have become much more prominent and warrant a new MRI scan of the lumbar spine, and should receive medication to help control her subjective complaints. R1.

Dr. Butler reported that Petitioner had not reached MMI at that time.

Petitioner received the lumbar spine MRI recommended by Dr. Butler on March 11, 2015. Seven months later Dr. Butler gave his second opinion regarding Petitioner's condition, in an IME addendum dated October 16, 2015. R2. In this report, Dr. Butler stated that the MRI of her lumbar spine showed disc degeneration at the L5-S1 level with modic changes on the left side. He also noticed a left sided posterolateral herniation combined with facet hypertrophy creating severe lateral recess stenosis on the left. R2. He noted that Petitioner at this time had not reached pre-accident status nor a medical endpoint of treatment. But, because he had not seen the Petitioner in 10 months, and the MRI was 6 months old, Dr. Butler opined that Petitioner needed to be reassessed.

Dr. Butler saw Petitioner for the second time, and gave his third opinion on her status, on February 3, 2016. Again, Dr. Butler opined that Petitioner's diagnosis was a lumbar disc degeneration and left-sided disc herniation at L5-S1, and that Petitioner's work injury was likely the cause of the underlying disc herniation at L5-S1. However, at this time Dr. Butler opined that Petitioner's complaints were no longer causally related to the reported injury on September 20,

2013. Because, at this time, Petitioner was manifesting lower back pain and right lower extremity complaints as well as left lower extremity pain.

Finally, Dr. Butler opined Petitioner was at maximum medical improvement and that he would not recommend additional treatment because Petitioner did not want to pursue surgical treatment.

Dr. Butler saw Petitioner for a third, and final, time on October 18, 2017. As he had in the past, Dr. Butler took a treatment history of Petitioner. However, in this case his medical history began April 13, 2017.

In his report, Dr. Butler opined that Petitioner's current condition of ill-being was not related to her complaints of pain at work on March 13, 2017 because the mechanism of injury described to him may have, in his approximation, only resulted in a minor muscle strain, but was not sufficient to cause a permanent aggravation of her underlying degenerative condition.

Dr. Butler opined that Petitioner's current complaints do not related to an action on September 20, 2013 or March 13, 2017. His opinion was, rather, that her current pain complaints stem from an unrelated degenerative issue present at the L5-S1 level. Dr. Butler further opined that Petitioner's MRI scans from April 4, 2015 was virtually identical to the MRI scans from April 24, 2017 that do not show structural change.

Finally, Dr. Butler opined that Petitioner did not require any further medical treatment based on her workplace injuries.

Arbitrator's Conclusions of Law

C. Accident

The Arbitrator finds that the Petitioner suffered an accident on March 13, 2017 arising out of and in the course of employment for Respondent. In so finding the Arbitrator relies on the credible testimony of Petitioner, as well as the treating records of her doctors. The Arbitrator had a chance to personally observe the testimony and demeanor of the Petitioner at trial and found her testimony to be credible and consistent with the records of her treating doctors.

Petitioner testified that her job duties for the Respondent included cleaning, working as a cashier, and helping out in the kitchen. Tx8. Petitioner testified that on March 13, 2017 she was working in the kitchen making salads. Tx21. Petitioner testified that she was working her normal shift at that time, and had been there approximately 1-2 hours. Tx24. At the time of accident, she was facing forward towards a bar with vegetables, and the lettuce was behind her. Petitioner moved her body to the left to try and grab the lettuce, and felt pain in her back. Tx21. The Arbitrator observed Petitioner making the motion she described, and saw the Petitioner twisted her body to the left, 180 degrees in what was not a subtle twisting motion. Tx22.

Petitioner's account of her accident as documented in her medical histories and that of the incident report filed with her employer on the date of her accident have been consistent with her testimony at trial. P14.

Based on Petitioner's credible testimony, and that of her treating doctors, the Arbitrator finds that Petitioner suffered an accident at work on March 13, 2017, arising out of and in the course of her employment with Respondent.

F. Causal Connection

The Arbitrator finds that Petitioner's condition of ill-being to be causally connected to her workplace accident on March 13, 2017. This is based on the consistent credible testimony of Petitioner and that of her treating doctors. Specifically, the Arbitrator finds that this accident aggravated her still symptomatic condition arising out of her 2013 accident at work with Respondent. The Arbitrator finds that the Petitioner's symptoms increased in severity and frequency as a result of this injury, while noting that surgery and additional injections had been discussed, though not pursued at the time, in connection with her underlying condition from the 2013 accident. Per Dr. Wingate, the current condition of ill being is causally connected to both accidents, one being the cause and this accident being an aggravation thereof. The Arbitrator does not find Dr. Butler's opinions on this issue to be persuasive or credible.

J. Reasonableness and Necessity of Medical Treatment

Having found that Petitioner suffered a workplace accident, and the Petitioner's current condition of ill being is causally related to that accident, The Arbitrator finds that Petitioner's medical services were reasonable and necessary. Specifically, the treatment at Concentra immediately following the accident to address the aggravation of her 2013 injury, the bills for which have been submitted for payment at trial. The Arbitrator orders the Respondent to pay these bills in connection with her March 13, 2017 accident at work with Respondent.

K. Temporary Total Disability

Having determined that the Petitioner suffered an exacerbation of her accident on March 13, 2017, the Arbitrator also finds that the Petitioner is entitled to 5 and 1/7 weeks of Temporary Total Disability to be paid by Respondent. On March 8, 2018 Petitioner's treating doctor, Dr.

Wingate, took her off of work. P7. It is Dr. Wingate's intention that Petitioner be out of work while she pursues continued stabilization and strengthening with physical therapy, but that she will return to work afterwards. P7. This does not negate Dr. Wingate's recommendation for Petitioner's surgical fusion surgery. P7. This order has been in effect until the day of trial, April 12, 2018, amounting to 5 1/7 weeks.

O. Prospective Medical

Having found that the Petitioner's current condition of ill being is related to her accident at work on March 13, 2017, as an aggravation of her spinal injuries related to her 2013 accident at work, the Arbitrator further finds that the L4-S1 fusion as recommended by Dr. Wingate is reasonable and necessary to address her ongoing condition and complaints. The Arbitrator bases his finding on the credible opinions of Dr. Wingate contained in Petitioner's medical records. It is Dr. Wingate's opinion that surgical management of Petitioner's pain is significantly more likely to improve her quality of life, lessen her impairment, and lessen any ultimate disability as a result of this work-related injury. P7. To this end, Dr. Wingate is recommending L4-S1 transforaminal lumbar interbody fusion.

The Arbitrator finds that Dr. Wingate's proposed surgery is reasonable and necessary. The Respondent is ordered to authorize and pay for the above.

Arbitrator Kurt Carlson

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

BERTHA QUIROZ,

Petitioner,

19IWCC0280

vs.

NO: 16 WC 6068

COMPASS GROUP,

Respondent.

DECISION AND OPINION ON REVIEW

Initially, the Commission notes that neither the decision nor the mainframe specifically indicate that the matter was arbitrated under Section 8(a) & 19(b) of the Act, and the decision does not include the *Thomas* remand language. Nevertheless, a petition for hearing under those sections was filed by Petitioner, the Arbitrator ordered prospective treatment, and the Arbitrator did not award any permanency. Therefore, the Commission shall treat the decision as being adjudicated under those sections.

Timely Petition for Review under §§19(b) and 8(a) of the Act having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of causal connection and medical expenses both current and prospective, and being advised of the facts and law, changes the Decision of the Arbitrator as stated below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof. The Commission further remands this case to the Arbitrator for further proceedings for a determination of an 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 Respondent pay the following medical bills: $5,958.10 from Illinois Orthopedic Network; $23,897.50 from Fullerton Drake; $6,300.00 from Advanced Ambulatory SC; $5,736.34 from G&U Orthopedics; $2,416.09 from Metro Anesthesia; $3,250.00 from Spine MD; $1,590.89 from MedFirst Imaging; $6,660.71 from Prescription Partners; and $200.00 from Archer MRI under §8(a) of the Act, subject to the applicable medical fee schedule.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent authorize and pay for prospective medical treatment recommended by Dr. Wingate to treat Petitioner current condition of ill-being of his lumbar spine.

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

DATED: JUN 6 - 2019

Deborah L. Simpson

Barbara N. Flores

Marc Parker

DLS/dw
O-5/23/19
46

ILLINOIS WORKERS' COMPENSATION COMMISSION

NOTICE OF ARBITRATOR DECISION

19IWCC0280

QUIROZ, BERTHA
Employee/Petitioner

Case# **16WC006068**

COMPASS GROUP
Employer/Respondent

On 5/31/2018, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 2.03% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

2553 McHARGUE & JONES LLC
MATTHEW C JONES
123 W MADISON ST 18TH FL
CHICAGO, IL 60602

1120 BRADY CONNOLLY & MASUDA PC
MARK VIZZA
10 S LASALLE ST SUITE 900
CHICAGO, IL 60603

19IWCC0280

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

BERTHA QUIROZ
Employee/Petitioner

v.

COMPASS GROUP.
Employer/Respondent

Case # 16 WC 006068

Consolidated cases:

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Kurt Carlson** Arbitrator of the Commission, in the city of **Chicago**, on **April 12, 2018.** After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **September 20, 2013**, Respondent was operating under and subject to the provisions of the Act.

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

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

Timely notice of this accident was given to Respondent.

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

In the year preceding the injury, Petitioner earned **$15,541.76**; the average weekly wage was **$298.88**.

On September 20, 2013, Petitioner was **53** 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 $0 under Section 8(j) of the Act.

ORDER

Prospective Medical

Respondent shall authorize and pay for the L4-S1 Transforaminal Lumbar Interbody Fusion as recommended by Dr. Wingate. Respondent is ordered to authorize and pay for the above.

Medical Benefits

Respondent shall pay reasonable and necessary medical services, pursuant to the medical fee schedule, of Illinois Orthopedic Network $5,958.10; Fullerton Drake $23,897.50; Advanced Ambulatory SC $6,300.00; G&U Orthopedics $5,736.34; Metro Anesthesia $2,416.09; Spine MD $3,250.00; MedFirst Imaging $1,590.89; Prescription Partners $6,660.71; Archer MRI $200.00 as provided in Sections 8(a) and 8.2 of the Act.

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

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

[signature]
Signature of Arbitrator

Date 5.31.18

MAY 31 2018

BEFORE THE ILLINOIS WORKERS COMPENSATION COMMISSION IN THE STATE OF ILLINOIS

BERTHA QUIROZ,	)	
	)	
Petitioner,	)	
	)	Number: 16 WC 6068
vs.	)	
	)	
COMPASS GROUP	)	
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On August 25th, 2017 Petitioner reported to Dr. Wingate, the relief from the injection having worn off. P7; Tx43. At this time Dr. Wingate recommended that Petitioner undergo an L4-S1 transforaminal lumbar interbody fusion. P7; Tx28.

Petitioner was seen by Dr. Butler for a third IME on October 18th, 2017. Tx28-29.

Petitioner underwent another MRI on March 14, 2018. P10. This was read by Dr. Sobti, who saw multilevel spondylosis throughout the lumbar spine including facet arthrosis, endplate spurring, and disc space narrowing. P10. He also saw grade 1 anterolisthesis L5 on S1. P10.

Petitioner wishes to undergo the surgery recommended by Dr. Wingate. Tx29. Petitioner was taken off work by Dr. Wingate on March 8th, 2018. P7; Tx29. Petitioner would like a different job with Respondent. Tx30.

Petitioner has never had any other accidents or injuries involving her low back. Tx31. Petitioner expressed that she is not able remain seated for a long time, and that she has to make certain movements in order to stand up or to sit down. Tx32.

Dr. Butler authored four different reports concerning Petitioner's accidents. Petitioner initially saw Dr. Butler on January 8th, 2015. Dr. Butler took a history of treatment consistent with that reported by Petitioner. R1. At this time, Dr. Butler reported that Petitioner's current

diagnosis is a lumbar disk herniation. R1. He further reported that the diagnosis is properly stated and supported by the records and objective findings, and that the medical documentation supported the causal relationship between the accident and injury. R1.

Dr. Butler found that the Petitioner required further diagnostic testing because he reported that her symptoms have become much more prominent and warrant a new MRI scan of the lumbar spine, and should receive medication to help control her subjective complaints. R1.

Dr. Butler reported that Petitioner had not reached MMI at that time.

Petitioner received the lumbar spine MRI recommended by Dr. Butler on March 11, 2015. Seven months later Dr. Butler gave his second opinion regarding Petitioner's condition, in an IME addendum dated October 16, 2015. R2. In this report, Dr. Butler stated that the MRI of her lumbar spine showed disc degeneration at the L5-S1 level with modic changes on the left side. He also noticed a left sided posterolateral herniation combined with facet hypertrophy creating severe lateral recess stenosis on the left. R2. He noted that Petitioner at this time had not reached pre-accident status nor a medical endpoint of treatment. But, because he had not seen the Petitioner in 10 months, and the MRI was 6 months old, Dr. Butler opined that Petitioner needed to be reassessed.

Dr. Butler saw Petitioner for the second time, and gave his third opinion on her status, on February 3, 2016. Again, Dr. Butler opined that Petitioner's diagnosis was a lumbar disc degeneration and left-sided disc herniation at L5-S1, and that Petitioner's work injury was likely the cause of the underlying disc herniation at L5-S1. However, at this time Dr. Butler opined that Petitioner's complaints were no longer causally related to the reported injury on September 20,

2013. Because, at this time, Petitioner was manifesting lower back pain and right lower extremity complaints as well as left lower extremity pain.

Finally, Dr. Butler opined Petitioner was at maximum medical improvement and that he would not recommend additional treatment because Petitioner did not want to pursue surgical treatment.

Dr. Butler saw Petitioner for a third, and final, time on October 18, 2017. As he had in the past, Dr. Butler took a treatment history of Petitioner. However, in this case his medical history began April 13, 2017.

In his report, Dr. Butler opined that Petitioner's current condition of ill-being was not related to her complaints of pain at work on March 13, 2017 because the mechanism of injury described to him may have, in his approximation, only resulted in a minor muscle strain, but was not sufficient to cause a permanent aggravation of her underlying degenerative condition.

Dr. Butler opined that Petitioner's current complaints do not related to an action on September 20, 2013 or March 13, 2017. His opinion was, rather, that her current pain complaints stem from an unrelated degenerative issue present at the L5-S1 level. Dr. Butler further opined that Petitioner's MRI scans from April 4, 2015 was virtually identical to the MRI scans from April 24, 2017 that do not show structural change.

Finally, Dr. Butler opined that Petitioner did not require any further medical treatment based on her workplace injuries.

Arbitrator's Conclusions of Law

F. Causal Connection

The Arbitrator finds that Petitioner's condition of ill-being to be causally connected to her workplace accident on September 20th, 2013. This is based on the consistent credible testimony of Petitioner and the opinions of her treating doctors.

Petitioner credibly testified that prior to her accident on September 20th, 2013 she had never had any other treatment of accident or injuries involving her low back. Tx31. Initial imaging of her low back showed a moderate sized central left disc herniation at L5-S1. P1. Based on this MRI and Petitioner's continued complaints of pain in her low back and radiating down her left extremity, Petitioner was given an epidural steroid injection by Dr. Mercier on December 19th, 2013. The injection gave temporary relief, but not permanent. P1.

After the first injection, Petitioner did not receive any treatment as she waited for approval for further care. Tx18. Dr. Butler authored three reports between January 8th, 2015 and February 3, 2016, during which the Petitioner continued to be symptomatic, but no further treatment was authorized. Tx18, 20.

On March 3, 2016 Petitioner was seen by Dr. Gerber at Fullerton Drake for a second opinion. P6. Dr. Gerber agreed with Dr. Butler that Petitioner's left sided radicular symptoms from her lumbar spine were caused by Petitioner's work-related injury. P6. Her symptoms remained consistent with her prior records and her testimony at trial. On April 14, 2016 Petitioner underwent an EMG, which was performed by Dr. Kiang of Spine MD Limited. P8. This EMG showed "chronic mild left L5 and S1 radiculopathy likely due to her central and left

paracentral foraminal disc herniation at L5-S1." P8. Petitioner continued to treat with Dr. Gerber until July 18, 2016.

Petitioner was referred by Dr. Gerber to Dr. Wingate, who she saw on June 8th, 2016. At this time Dr. Wingate reviewed Petitioner's radiographs and EMG and, based on Petitioner's continued complaints of pain, causally related her injury to her workplace accident on September 20, 2013. P7. Dr. Wingate further opined that Petitioner's treatment thus far had not been sufficient. P7. Dr. Wingate recommended that Petitioner undergo another epidural steroid injection at the L4-L5 and L5-S1 levels. P7.

Petitioner elected to not undergo Dr. Wingate's recommended injection at that time, or to pursue surgical treatment. Tx19-20. Petitioner attempted to continue working for Respondent, while experiencing significant ongoing pain and symptomology as she had since the date of the accident. Tx19. She continued to work for Respondent without cessation of her low back and lower extremity symptoms through her second accident of March 13, 2017. As a result of this accident, Petitioner felt increased pain in her legs, hips, and lower back, worse than the pain she had previously been experiencing, however her symptoms themselves did not change. Tx25.

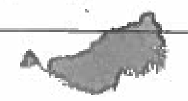
After this second accident, Petitioner initially treated at Concentra on March 14th, 2017 for. P2; Tx26. Petitioner complained of pain in her lower back and radiating pain down her left extremity. P2. Petitioner saw Dr. Chunduri at Illinois Orthopedic Network on April 13th, 2017 and related that the accident on March 14th, 2017 the pain, which had consistently been in her low back and radiating down her left leg had become more severe. P7.

Petitioner underwent the new MRI on April 24th, 2017. P9. This MRI was read by Dr. Wingate on June 15th, 2017, where he saw that the L5-S1 disc was bone on bone and had a grade

1 retrolisthesis with a large central and left disk herniation, and the left L5 neural foramen was severely narrowed. P7. Furthermore, Dr. Wingate read the scan to show that at the L3-4 level the disc had a 40% loss in disc height and that there was a moderate level of annular tearing and disk bulging. P7. At this time, Dr. Wingate recommended another injection. P7; Tx27. Petitioner underwent this injection with Dr. Chunduri on June 29th, 2017. P7; Tx27. Petitioner experienced temporary relief following the second injection. P7. Ultimately, on August 25th, 2017 Dr. Wingate recommended that Petitioner undergo an L4-S1 spinal fusion because conservative treatment had not resolved Petitioner's pain. P7.

On June 15th, 2017, Dr. Wingate opined "It does represent my belief that the ongoing complaints today are causally derived from the disk herniation that Dr. Butler states was causally related to her initial work-related injury in 2013. " P7. Dr. Wingate further expressed his opinion of Petitioner's condition of ill-being's relationship to her September 20, 2013 injury saying, "It represents my opinion and ongoing belief from a clinical standpoint that her continued and/or residual symptoms are still causally related. I have seen no evidence that she ever centralized her radicular leg pain. I see no evidence that she ever stabilized her back pain to a degree that she was able to return to work." P7. Petitioner remained symptomatic after her accident on September 20, 2013, and was never placed at MMI by her treating physicians, with her second accident being responsible for an increase in symptoms, without change in the nature and location of the symptoms themselves.

Respondent relies on the opinions of Dr. Butler in disputing the issue of causation in this matter. On January 8th, 2015 Dr. Butler diagnosed Petitioner with a lumbar disc herniation. R1. This is consistent with Petitioner's multiple diagnostic studies, and the opinions of Petitioner's treating doctors. The Arbitrator specifically notes that at the time of this earliest report, there is



no dispute about causal connection of Petitioner's condition of ill-being to her workplace accident. Dr. Butler opines, "The medical documentation supports the causal relationship between the accident and the injury." R1. After the first report, Dr. Butler requested an additional MRI. R1. Petitioner had this MRI on April 4, 2015, which again showed a disc protrusion at L5-S1. P4.

The Arbitrator finds that Dr. Butler attempts to walk back his opinion on January 8th, 2015 in his report on February 3, 2016. Here, Dr. Butler reiterates that, "the previous work injury is likely the cause of the underlying disc herniation at L5-S1." R3. Dr. Butler, however, opines that Petitioner's current complaints are no longer related to the reported injury on September 20, 2013, because Petitioner was now complaining of right lower extremity pain as well as left lower extremity pain and lower back pain. The Arbitrator finds that Dr. Butler's report on February 3, 2016 to be arbitrarily contradictory to his earlier report on January 8th, 2015, and therefore unpersuasive and not credible.

Dr. Butler saw Petitioner one last time on October 18th, 2017. This last opinion was the most divergent from his previous reports on Petitioner's condition, and inherently contradictory in nature. Specifically, Dr. Butler reviews the MRI from April 24, 2017 which he says is "virtually identical" to the MRI from April 4, 2015. R4. And that, "there is no acute herniation." R4. This is a remarkable departure from his February 3, 2016 and October 16, 2015 reports where he noted that the MRI from April 4, 2015 showed, a "mild diffuse disc bulge with a superimposed small broad based central/left paracentral disc protrusion at L5-S1." R2, R3. Furthermore, on February 3, 2016 Dr. Butler used this MRI to opine that, "The previous work injury is the likely cause of the underlying disc herniation at L5-S1." Dr. Butler's contradictory

statements are noted by the Arbitrator, and his attempts to change his opinion regarding the nature of Petitioner's injury to the L5-S1 level of her spine are not persuasive.

Therefore, having reviewed and weighed all of the evidence presented in this matter, the Arbitrator finds that the Petitioner's current condition of ill being is related to her accident on September 20th, 2013. The Arbitrator finds Dr. Wingate to be credible in his opinions on this issue, and finds the Petitioner to have been credible and reliable in her testimony at trial regarding her consistent symptoms and complaints since the date of accident.

J. Reasonableness and Necessity of Medical Treatment

Having found for the Petitioner on the issue of causation relative to Petitioner's 2013 accident at work, the Arbitrator finds that the medical care rendered to the Petitioner has been reasonable and necessary to address her lumbar spinal condition. The Arbitrator finds the Petitioner's treating physicians to have been reliable and credible in their recommendations for treatment.

O. Prospective Medical

Having found that the Petitioner's current condition of ill being is related to her accident at work on September 20, 2013, the Arbitrator further finds that the L4-S1 fusion as recommended by Dr. Wingate is reasonable and necessary to address her ongoing condition and complaints. The Arbitrator bases his finding on the credible opinions of Dr. Wingate contained in Petitioner's medical records. It is Dr. Wingate's opinion that surgical management of Petitioner's pain is significantly more likely to improve her quality of life, lessen her impairment, and lessen any ultimate disability as a result of this work-related injury. P7. To this end, Dr. Wingate is recommending L4-S1 transforaminal lumbar interbody fusion.

The Arbitrator finds that Dr. Wingate's proposed surgery is reasonable and necessary.

The Respondent is ordered to authorize and pay for the above.

Arbitrator Kurt Carlson

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

Shawn Williams,

Petitioner,

19IWCC0281

vs.

NO: 17 WC 30998

Machinery and Conveyor Services Inc.,

Respondent.

DECISION AND OPINION ON REVIEW

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

As indicated above, this matter was arbitrated under §§19(b) and 8(a) of the Act. The Arbitrator found that Petitioner failed to meet his burden of proving a compensable accident. The Commission affirms that finding. However, in the "ORDER" section of the decision, the Arbitrator included the language that "in no instance shall this award be a bar to subsequent hearing and determination of any additional amount of medical benefits or compensation for a temporary or permanent disability, if any." Because the claim was denied in its entirety, the matter will not be remanded for determination of any additional benefits and therefore the decision does bar subsequent awards. Therefore, the Commission strikes the above quoted language from the "ORDER" section of the Decision of the Arbitrator.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed September 11, 2018, is hereby affirmed and adopted with the changes noted above.

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: JUN 6 - 2019
o5/23/19
DLS/rm
46

Deborah L. Simpson

Maria E. Portela

Marc Parker

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF 19(b)/8(a) ARBITRATOR DECISION

19IWCC0281

WILLIAMS, SHAWN
Employee/Petitioner

Case# **17WC030998**

MACHINERY AND CONVEYOR SERVICES INC
Employer/Respondent

On 9/11/2018, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 2.26% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

2553 MC HARGUE & JONES LLC
BRENTON M SCHMITZ
123 W MADISON ST 18TH FL
CHICAGO, IL 60602

4412 ACCIDENT FUND HOLDINGS
GRACE DiGERLANDO
200 W MADISON ST SUITE 3850
CHICAGO, IL 60606

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

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b) & 8(a)

Shawn Williams
Employee/Petitioner

Case # **17** WC **30998**

v.

Consolidated cases: **N/A**

Machinery and Conveyor Services, Inc.
Employer/Respondent

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable Barbara N. Flores, Arbitrator of the Commission, in the city of New Lenox, on July 12, 2018. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On the date of accident, August 10, 2017, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $94,328.00; the average weekly wage was $1,814.00.

On the date of accident, Petitioner was 36 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 $0 for TTD, $0 for TPD, $0 for maintenance, and $0 for other benefits, for a total credit of $0. *See* AX1.

Respondent is entitled to a credit of as agreed by the parties under Section 8(j) of the Act. *See* AX1.

ORDER

As explained in the Arbitration Decision Addendum, the Arbitrator finds that Petitioner has failed to establish by a preponderance of credible evidence that he sustained a compensable accident at work on August 10, 2017 as claimed. By extension, all other issues are rendered moot and all requested compensation and benefits are denied.

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

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

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

Signature of Arbitrator

September 7, 2018
Date

SEP 1 1 2018

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION *ADDENDUM*
19(b) & 8(a)

Shawn Williams
Employee/Petitioner

v.

Machinery and Conveyor Services, Inc.
Employer/Respondent

Case # **17** WC **30998**

Consolidated cases: **N/A**

FINDINGS OF FACT

A consolidated hearing was held in the above-captioned case. Arbitrator's Exhibit[1] ("AX") 1. The issues in dispute in this case include whether Petitioner sustained a compensable accident on August 10, 2017, whether Petitioner gave notice of such an accident, whether there is a causal connection between Petitioner's condition of ill-being and such an accident, Respondent's liability for certain unpaid medical bills, Petitioner's entitlement to temporary total disability benefits from September 27, 2017 through July 11, 2018, and whether Petitioner is entitled to prospective medical care in the form of a consultation with a neurosurgeon, Dr. Amin, as ordered by Dr. Okpareke. AX2. The parties have stipulated to all other issues. *Id.*

Background

Shawn Williams (Petitioner) testified that, as of August 10, 2017, he had been employed by Machinery and Conveyor Services, Inc. (Respondent) for approximately 10 days. Petitioner was a Union Millwright and testified that his job with Respondent was supposed to end in mid-November. Tr. at 5. Petitioner testified that his job duties entailed demolition of old equipment that was no longer in use. He testified that the job he was hired to perform for Respondent was located at the UPS in Willow Springs. Petitioner testified that he was basically performing demolitions everyday (i.e. using scissor lifts, bringing machinery into the building, taking it out, etc.) at that job. Tr. at 6.

On cross examination, Petitioner testified that prior to his accident of August 10, 2017, he underwent a lumbar fusion and that he had continued to treat for said condition up until the date of this injury. He testified that he was also treating for rheumatoid arthritis. At the time of his injury, Petitioner testified that he had active prescriptions for Percocet, Oxycontin, Lidoderm patches, Gabapentin, and Robaxin related to his back condition and for Humera for his rheumatoid arthritis. He testified that he underwent a L4-5 fusion on May 4, 2015. Tr. at 27-31.

On cross examination, Petitioner testified that he had sought treatment for his cervical spine with Dr. Piska in 2008 at which time he underwent a couple of injections and radiofrequency. He testified that he believed he had last seen Dr. Piska in 2010. Tr. at 32-34.

On re-direct examination, Petitioner testified that he had not sought treatment for his cervical spine from 2011 through August of 2017. Tr. at 39-40.

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[1] The Arbitrator similarly references the parties' exhibits herein. Petitioner's exhibits are denominated "PX" and Respondent's exhibits are denominated "RX" with a corresponding number as identified by each party. The Arbitration Hearing Transcript is denominated "Tr. at [page number(s)]."

Accident

On Thursday, August 10, 2017, Petitioner testified that he began working at 7:00 a.m. scheduled to work a full eight-hour shift. He testified that, on that date, he was in a scissor lift to demo part of a structural steel out and that another crew had already demoed a platform, etc. As he was going up in the lift, Petitioner testified that he was looking up and did not see an approximately one-foot piece of steel tubing and he "slammed" his head into it. Tr. at 7.

Petitioner testified that the scissor lift had three-to-four steps to get to the lift. Once in the lift, he testified that there was a protective full cage around him. On the date of accident, Petitioner testified that he surveyed the area where he was going to take the rest of the structural steel out and decided where exactly to position the lift: a "[s]afe spot to go straight up into the air." He testified that he was wearing his hard that had a two-inch bill on it, which left a "tiny blind spot." As he attempted to go higher, Petitioner explained that a piece of steel was overhanging and he "nailed it." He testified that he was approximately 12 to 15 feet up when he struck the piece of steel. Tr. at 8-9.

Petitioner testified that he saw a "flash of white light" when he hit his head and went back down on the lift. While he was climbing out of the lift, he testified that his foot slipped on one of the rungs and he hit his knee on the step. He testified that he was confused, foggy and dizzy and felt pain in his entire spine and head. Tr. at 10-11.

Petitioner testified that he threw his hard hat when he got out of the lift as he was very aggravated. He testified that "one of the supervisors was around" and he informed the supervisor that he had just hit his head on a beam. Petitioner testified that he believed the supervisor was Tim McManigal, but he was not 100% and it was "possibly" Mr. McManigal's son. Petitioner testified that the incident occurred at approximately 2:30 or 2:45 p.m. He testified that he did not continue working, but cleaned up a little bit. Tr. at 12.

Petitioner testified that he did not fill out an accident report nor did anyone offer him an accident report. He testified that there were other workers demoing some of the conveyer catwalk approximately 10 to 15 feet away, but they would not have been able to see him. He testified that he was working alone on the date in question and that he was not scheduled to work on Friday, August 11, 2017, as he had previously taken the day off for his daughter's birthday. On August 11th, Petitioner testified that he was "still pretty sore" and was "kind of starting to get a little worse…" He testified that he was next scheduled to work on Saturday. Tr. at 13-15.

Petitioner testified that on August 12, 2017, he spoke with "Tim" and expressed his concerns about his lower back fusion as he was "definitely afraid that something got knocked loose because it was not feeling right." He testified that "Tim" suggested that he get it checked out, so he went to the Riverside Medical Center. Petitioner testified that he provided the Riverside Medical Center with a medical history and that he advised them about the incident at work. He testified that if the records from Riverside reflected that he fell down 3 or 4 stairs, the same would be accurate if they indicated "coming out of the lift." If said records reflected that he struck his head in his attic, he testified that the same would be inaccurate. He testified that his home had an attic, but he had not been in it since approximately 2007 or 2008. Tr. at 16-18.

On cross examination, Petitioner testified that "up until yesterday" it was his belief that he had informed Mr. Tim McManigal of his alleged injury on August 10, 2017. He testified that Tom Morgan was his direct supervisor in August of 2017 and that, to the best of his knowledge, Mr. Morgan was not at work on August 10,

2017. Petitioner testified that he did not fall down on the scissor lift nor did he stumble on August 10, 2017, his "foot just slipped off" and he hit his knee. He testified that he had no partner at work at that time and he did not know at what speed the scissor lift was traveling. Tr. at 34-37.

On re-direct examination, Petitioner testified that Tom Morgan was his direct supervisor at the time of his injury and he did not believe that Mr. Morgan was on sight on that date. He testified that Mr. Morgan's son was graduating and Mr. Morgan was out of state for the graduation. Petitioner believed Mr. Morgan was out of town for four to five days. Tr. at 39-40.

Medical Treatment

Petitioner testified that he continued to treat at the Pain Centers of Chicago from August of 2017 through the date of trial. He testified that he had received multiple injections into his neck, which only provided a small amount of relieve. Petitioner testified that he had also received a cervical blood patch for headaches, which was not helpful at all. He testified that his pain management physician was currently recommending that he see a neurosurgeon for his neck. Tr. at 21-22.

On August 12, 2017, Petitioner was evaluated at the Riverside Medical Center Emergency Room. During triage, the examining nurse noted the following history in pertinent part:

> Pt present to ER with back and neck pain. Pt states he was in the attic and hit his head and fell down the attic stairs on Wednesday. Pt states he didn't come in on Wednesday because he was hoping it would go away. Pt has extensive history of back injury.

PX1 at 10. The medical records also reflect the following history from the examining physician at the emergency room in pertinent part:

> 36 year old man with PMH RA, chronic back pain, Hx lumbar surgery/instrumentation. Comes to ER c/o back and neck pain after falling 3-4 stairs # days ago. States he bumped his head but had no LOC. Denies any dizziness, h/a. "I just want to make sure i can work and i didn't mess up my back again". States that he did not come to ER over the last three days because yesterday was hi[s] daughter's birthday.

PX1 at 7-9.

The emergency room records reveal that Petitioner reported that he was in the attic and hit his head and fell down the attic stairs on Wednesday. Reportedly, he did not come in on Wednesday because he was "hoping it would go away." Petitioner was noted to have an extensive history of back injury. PX1 at 10. X-rays of the cervical and lumbar spine taken at that time revealed no acute abnormality. PX1. Petitioner testified that it was not accurate that he hit his head in his attic as reflected in the Riverside medical records. He explained that the last time that he was in his attic was approximately 1½ years after buying his home in 2006. Tr. at 17-19.

After he was discharged from Riverside Medical Center, Petitioner testified that he went to the Pain Centers of Chicago. Petitioner testified that he was already a patient at the Pain Centers of Chicago relative to his lumbar fusion. He acknowledged that his appointment of August 15, 2017 was scheduled prior to his emergency room visit. Petitioner testified that additional imaging of his neck and lower back was recommended as well as injections for his lower back; however, the lumbar injections had already been discussed prior to his alleged work accident of August 10, 2017. Tr. at 19-21.

The medical records reflect that, on August 15, 2017, Petitioner was evaluated by Dr. Panjwani. He had a history of lumbar laminectomy performed in May of 2015 and a history of a "shattered right knee" with surgery in 2009. Petitioner also suffered from rheumatoid arthritis for which he took Humira and Celebrex. He presented at this time for a medication refill and it was noted that he was supposed to undergo a lumbar epidural steroid injection at L4-5, but did not proceed with the same as he was out of town for work. Petitioner reported that, on August 10, 2017, he was going up in an open lift at work when he hit his head on a piece of steel and developed lumbar and neck pain. Reportedly, he was off work on August 11, 2017 as it was his daughter's birthday. It was noted that Petitioner wanted a prescription for Norflex as it helped him a lot via IV in the emergency room. Petitioner also requested lumbar and cervical imaging. Reportedly, Petitioner had an appointment on this date "pertaining to his chronic lower back and neck pain." After evaluating Petitioner, Dr. Panjwani diagnosed him with degeneration of the lumbar spine, lumbar radiculoapthy, lumbar spondylosis with myelopathy, post laminectomy syndrome of the lumbar spine, cervical spondylosis, cervicalgia, degeneration of the cervical intervertebral disc, brachial neuritis or radiculitis, etc. CTs of the lumbar and cervical spines were ordered. Petitioner was tentatively scheduled for a lumbar ESI at L4-5 versus caudal ESI. Petitioner's medications were refilled and Orphenadrine was added to his prescriptions. His medications were noted to be Percocet, Oxycontin, Lidoderm and Gabapentin. PX2.

On August 29, 2017, Petitioner underwent a lumbar MRI, which exhibited mild to moderate degenerative disc disease and facet disease at L3-4 with mild central canal narrowing unchanged since 2014 and posterior fusion and discectomy at L4-5 with no evidence of recurrent stenosis. PX1 at 55.

On August 29, 2017, Petitioner underwent a cervical MRI, which revealed worsening degenerative disc disease from C4 through C6 with posterior central disc herniations and partial extrusion resulting in mild central canal narrowing and minimal contact with the cord. PX1 at 74.

On September 13, 2017, Petitioner underwent a L2-3 epidural steroid injection. PX2.

On September 27, 2017, Petitioner returned to Dr. Okpareke and reported "at most" a 50% improvement from his lumbar injection two weeks prior. Reportedly, his most "pressing pain complaint" was his neck, which radiated into his hands with bilateral upper extremity numbness. Following his evaluation, Petitioner was diagnosed with "new cervical disc disease as a result of injury." His Norflex was increased and he was advised to continue Percocet, Gabapentin and Lidocaine. A series of three cervical epidural steroid injections was recommended, which Petitioner underwent on October 11, 2017, October 26, 2017 and November 8, 2017. PX2.

On November 21, 2017, Petitioner returned to Dr. Okpareke. Reportedly, he had new cervical disc herniations at C4-5 and C5-6 with bilateral cervical radiculitis. It was noted that his neck pain had improved, but he continued with bilateral hand numbness and he was now complaining of occipital headaches and mild photophobia. After evaluating Petitioner, Dr. Okparke noted that he likely suffered from a post-dural puncture headache. He was advised to take Fioricet for breakthrough pain and, if no improvement, an epidural blood patch would be performed in one week, which Petitioner later underwent on November 30, 2017. Petitioner's medications were refilled at that time. PX2.

On January 16, 2018, Petitioner returned Dr. Panjwani. It was noted that he had undergone cervical and brain MRIs at the Riverside Hospital on January 11, 2018. Reportedly, all treatment for the head and neck had not provided much relief. It was noted that on the date of this evaluation, Petitioner had findings consistent with

bilateral occipital neuralgia. Bilateral occipitalis muscle trigger point injections were recommended. If the aforementioned provided relief, it was noted that "RFTC" could be offered as a longer lasting option. Petitioner's Oxycontin was switched to MSContin and Oxycodone was switched to Percocet. His Robaxin was increased and he was advised to continue with Gabapentin, Topamax, and Lidoderm patches. Norflex was stopped. PX2.

On March 1, 2018, Petitioner underwent a bilateral greater occipital nerve block. His Robaxin, Percocet, MS Contin and Gabapentin were refilled. PX2.

On March 21, 2018, Dr. Panjwani authored a narrative. Reportedly, Petitioner had been a patient since September 1, 2015 and Dr. Panjwani noted that he was usually treated for his chronic pain related to his lumbar laminectomy in 2015 and pain from his knee injury in 2008. However, on August 15, 2017, Dr. Panjwani noted that Petitioner reported that he was injured at work on August 10, 2017 and that he informed his boss of the injury on that day. Reportedly, Petitioner's cervical MRI of August 29, 2017 exhibited some significant changes at C4-5 and C5-6 from his prior MRI of February of 2016. Reportedly, Petitioner's cervical range of motion was "very restricted due to pain" and he was unable to perform his required functions at work. As such, Dr. Panjwani noted that Petitioner was advised to be off work until he was able to get his cervical spine evaluated and treated appropriately. It was noted that he was attempting to see a neurosurgeon for the same. Reportedly, Petitioner had also developed debilitating headaches. It was noted that Petitioner was currently in physical therapy and that he had been treated with the following medications: MSContin 30mg BID; Percocet 10/325 PO 5/day prn pain; Robaxin 750 mg to ii PO QID prn spasm (8/day.; Gabapentin 300 mg BID; and, Lidoderm patches for lower back pain. PX2.

Subsequently, Petitioner continued to follow up with Dr. Parnjwani and Dr. Okparke and, on May 14, 2018, he underwent bilateral greater occipital nerve radiofrequency ablations. PX2.

On June 20, 2018, Petitioner returned to Dr. Panjwani and reported a 30% improvement following his radiofrequency ablation. He continued to complain of headaches, neck pain radiating to the bilateral arms with numbness/tingling, bilateral hand numbness, and low back pain radiating to the left leg and thigh. Reportedly, Petitioner was "beside himself with worry and frustration" and he realized the he could "no longer go back to the work he has done all his life." It was noted that he reported that he may go back to college to qualify for a career change. Petitioner's medications were refilled at that time and he was referred to Dr. Beejal Amin, a neurosurgeon, for his neck pain with headaches. PX2.

Timothy McManigal

Respondent called Timothy McManigal (Mr. McManigal) as a witness. Mr. McManigal testified that he has been employed by Respondent for approximately 11 years as a Project Manager. He explained that his wife is the owner of the company. As the Project Manager, Mr. McManigal testified that he estimated jobs, made sure they had all necessary materials, worked on the job, and, in this case, ran the job. He testified that he was on site daily, managing the whole UPS project. Mr. McManigal testified that said project ran from June of 2017 through April of 2018 and that they had 50 to 60 employees on the job. Tr. at 41-43.

Mr. McManigal testified that on the job in question, Respondent was removing old conveyor equipment and installing new sorting equipment. He testified that he was familiar with Petitioner as he was an employee of Respondent. Mr. McManigal testified that Petitioner was hired as a Millwright on August 5, 2017 and his job

duties in August of 2017 were to remove old equipment and help install new equipment. He testified that Mr. Tom Morgan was Petitioner's direct supervisor. Tr. at 43-44.

Mr. McManigal testified that he was aware of Petitioner's present workers' compensation claim against Respondent because Petitioner informed him of the same "sometime in August" of 2017. He testified that Petitioner informed him that he would have to "take it to workers' compensation" as he had injured his neck. Mr. McManigal testified that Petitioner informed him that he hit his head going up on a scissor lift. He testified that he was on the job site on August 10, 2017, but that Petitioner did not inform him of his alleged injury on that date. Mr. McManigal testified that he saw Petitioner on August 10, 2017, but he did not recall during what part of the day. Tr. at 45-46.

Mr. McManigal testified that if any employees were injured on the job, they were to report the same to their direct supervisor per company protocol. He testified that Petitioner was aware of that protocol. Mr. McManigal testified that he believed Petitioner finished his entire shift on August 10, 2017 and, to his knowledge, Petitioner did not inform anyone that he was allegedly injured on that day. He testified that Petitioner did not work on August 11, 2017 as he had scheduled the day off for his daughter's birthday. Tr. at 46-47.

Mr. McManigal testified that Petitioner returned to work on August 12, 2017 and, at that time, he reported that he injured his neck on Thursday, the 10th. He testified that he questioned Petitioner as to why he did not advise anyone of the alleged incident and Petitioner replied that he had one year to report an injury. After that, Petitioner informed Mr. McManigal that he was going to seek treatment. Mr. McManigal testified that Petitioner did not work on August 12, 2017, but he returned to work after that and continued to work until August 23, 2017. He testified that from August 14th through August 23rd, Petitioner was performing lighter work as they had light capacity work that needed to be done on that job. Mr. McManigal testified that Petitioner went home on August 23, 2017 because he was not feeling well and he never returned to work. Tr. at 47-49.

Mr. McManigal testified that his son was likely on the job on August 10, 2017; however, his son was not anyone's supervisor at that time. Had Petitioner reported an injury to Mr. McManigal's son, Mr. McManigal testified that his son would have informed him. He testified that if anyone was injured, he would have been informed of the same by their supervisor. Mr. McManigal testified that company protocol was for an injury to be reported to the supervisor who would have then reported it to Mr. McManigal. Tr. at 49-50.

On cross examination, Mr. McManigal testified that he believed Petitioner finished his shift on August 10, 2017 because he was paid for 8 hours that day. He testified that Respondent did not have a formal light duty policy. Mr. McManigal testified that Petitioner's light duty was accommodated because, on that particular job, they had duties that were less than what was normally required, so he thought that would be a good job for Petitioner. He testified that Petitioner was making $46.35 per hour at the time of his alleged injury and that individuals performing "these lighter tasks" would also be paid that much per hour. Tr. at 53-55.

Tom Morgan

Respondent called Tom Joseph Morgan (Mr. Morgan) as a witness. Mr. Morgan testified that he was currently employed by State Group out of Michigan and that prior to said employment he was employed by Respondent at a UPS job in Willow Springs. He testified that he was on the UPS job from approximately May of 2017 until about November of 2017. Mr. Morgan testified that he was hired by Respondent for that specific job and that he was the foreman on the job. As foreman for Respondent, Mr. Morgan testified that his job was to supervise the

removal of old equipment and the installation of new equipment. He testified that he was supervising approximately 12 employees in August of 2017. Tr. at 56-58.

In his capacity as foreman for Respondent, Mr. Morgan testified that he was familiar with Petitioner and that he had hired Petitioner to work on his crew as a Millwright. He testified that he was aware of Petitioner's pending workers' compensation claim and that he became aware of the same when Petitioner approached him with the union steward. Mr. Morgan testified that he could not recall the specific date that Petitioner and the union steward approached him, but he testified that it was after the alleged incident. Tr. at 58-59.

Mr. Morgan testified that he was working with Petitioner at the UPS job site on August 10, 2017 and that he was Petitioner's supervisor at that time. On that date, Mr. Morgan testified that they were completing the removal of overhead structural steel and putting safety handrails back on platforms where the platforms had been removed. Mr. Morgan testified that Petitioner did not inform him of any injuries he might have sustained on August 10, 2017. Tr. at 59-60.

Mr. Morgan testified that on August 10, 2017, Petitioner was welding a handrail on a platform that they had cut off. He testified that the demolition process in that area of the facility was completed in the later morning of August 10, 2017. Mr. Morgan testified that Petitioner's task on that date was to go up on the scissors lift and put a handrail and toe plate on the platform that they had cut off because the platform was going to stay, so they had to make it permanently safe by welding a hand railing. Tr. at 60-62.

Mr. Morgan testified that the scissor lift would not have been underneath the platform because you could not reach the platform that way. He testified that when Petitioner went up in the scissor lift on the date in question, there was nothing above his head except "the ceiling, the roof." Mr. Morgan testified that there was no tubing or steel above Petitioner's head at that time because it was all gone. He testified that in order for Petitioner to have placed the handrail, all of the existing steel would have had to have been removed because that steel had been at the platform level. So, when Petitioner went up, the only thing above his head was the ceiling, which Mr. Morgan testified was approximately 10 feet above his head. He testified that the scissor lift only went to 19 feet and the ceiling was approximately 30 feet. Tr. at 62-63.

Mr. Morgan testified that Petitioner "was in the basket by himself at that time because there wasn't room for two people," but there were two guys on the ground to watch underneath Petitioner and to watch Petitioner. He testified that those two individuals would have been on the ground watching Petitioner because "whenever you're working up in the air…there's always somebody on the ground to make sure that nobody would walk underneath when pieces of steel or anything would come down," etc. Mr. Morgan testified that the aforementioned was a standard safety practice. Tr. at 64-65.

Mr. Morgan testified that he saw Petitioner on August 10, 2017. He testified that he made it a point to see everybody in the morning, so he could make sure they were there at starting time, and at the end of the day. Mr. Morgan testified that everybody that works for him knows that he has to see them at least twice a day and then, throughout the day, he conversed with everybody relative to their specific jobs. He testified that at no point during the day on August 10, 2017 did Petitioner inform him that he was injured. Mr. Morgan testified that at no point during that day did his ground crew inform him that Petitioner was injured. He testified that Petitioner did not appear injured on August 10, 2017. Mr. Morgan testified that he did not work on August 11th, 12th or 13th of 2017 because he was gone for parents' weekend at the Naval Academy. Tr. at 65-66.

On cross examination, Mr. Morgan testified that he hired Petitioner and at least eight other individuals. When asked if the people he hired were meant to be long term hires, he testified that their "entire craft" was short term hire. Between approximately 2:30 and 3:00 in the afternoon on August 10, 2017, Mr. Morgan testified that he was in the general area where they were doing the demolition/upgrade, which was an area measuring approximately 50 feet by 100 feet, and he could see all 12 or so individuals that he was supervising. Tr. at 67-68.

Additional Information

Petitioner testified that after August 10, 2017, he continued to work light duty for Respondent company until August 27, 2017. He testified that he ceased working due to his headaches and because he was concerned that he was a possible danger to himself and others. Petitioner testified that his head and neck still hurt. He testified that when Tom Morgan, his foreman, returned to work, he advised him and his union steward of his accident. Petitioner testified that people were questioning why he was not performing his full job and he "explained to everybody" that he got hurt. Tr. at 22-26.

Regarding his current condition of ill-being, Petitioner testified that the back of his head, neck, his head hurts. Petitioner testified that he experiences pain every day and it generally progresses as the day proceeds. Constant head turning hurts his head. Petitioner testified that he can no longer weed his yard with a weedwhacker or mow his lawn.

Petitioner testified that he wishes to undergo the recommended prospective medical treatment. He explained that he has not sustained any other injuries after his alleged accident at work.

On cross-examination, Petitioner testified that he was previously involved in a car accident in 2008 and sought treatment with Dr. Piska for his neck, knee, and lower back. Petitioner last saw her in approximately in 2010. He then switched treatment to another physician.

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 the hearing as follows:

In support of the Arbitrator's decision relating to Issues (C) and (D), whether an accident occurred that arose out of and in the course of Petitioner's employment by Respondent and the date of the accident, the Arbitrator finds the following:

Considering the record as a whole, the Arbitrator finds that Petitioner has failed to establish that he sustained a compensable injury while working for Respondent on August 10, 2017 as claimed. In so concluding, the Arbitrator finds the testimony of Mr. McManigal and Mr. Morgan to be credible and does not find Petitioner's testimony to be credible.

An employee's injury is compensable under the Act only if it arises out of and in the course of the employment. 820 ILCS 305/2 (LEXIS 2003). The "in the course of employment" element refers to "[i]njuries sustained on an employer's premises, or at a place where the claimant might reasonably have been while performing his duties, and while a claimant is at work…." *Metropolitan Water Reclamation District of Greater Chicago v. IWCC*, 407 Ill. App. 3d 1010, 1013-14 (1st Dist. 2011). The "'arising out of' component refers to the origin or cause of the claimant's injury and requires that the risk be connected with, or incidental to, the employment so as to create a causal connection between the employment and the accidental injury." *Metropolitan Water Reclamation District*, 407 Ill. App. 3d at 1013-14 (*citing Caterpillar Tractor Co. v. Industrial Comm'n*, 129 Ill. 2d 52, 58 (1989)). A claimant must prove both elements were present (i.e., that an injury arose out of and occurred in the course of his employment) to establish that his injury is compensable. *University of Illinois v. Industrial Comm'n*, 365 Ill. App. 3d 906, 910 (1st Dist. 2006).

It is undisputed that Petitioner was at work on Thursday, August 10, 2017. According to Petitioner, he was going up in a scissor lift alone at some unknown speed when he "slammed" his head into a steel beam above him located approximately 12 to 15 feet in the air. He explained that he was looking up, but did not see the beam due to a "tiny blind spot" caused by the two-inch brim of his hard hat. Petitioner described the incident rather violently and testified that he saw a "flash of white light" after he hit his head causing pain throughout his entire spine, but after which he remained upright, did not lose consciousness, and was nonetheless able to operate the lift to bring himself back down to ground level. At this point, Petitioner testified that he climbed out of the lift and his foot slipped on one of the ladder rungs such that he hit his knee after which he was very aggravated and he threw his hat on the ground.

Petitioner, Mr. McManigal and Mr. Morgan all agree that the alleged injury was unwitnessed. According to Petitioner no one was around that could have seen the accident. In contrast, Petitioner's supervisor, Mr. Morgan, explained that two ground crew members would have been watching Petitioner, or anyone going up in a lift, from ground level to maintain safety in the area below. Petitioner also testified that he immediately reported the injury on August 10, 2017 to "one of the supervisors was around" and informed him that he had just hit his head on a beam, whether it was Mr. McManigal or his son, he was unsure. In contrast, Mr. McManigal and Mr. Morgan deny Petitioner's assertion that he was injured at all and further deny that he reported any injury on August 10, 2017 to them, or their subordinates in accordance with company policy. Mr. McManigal testified that it was not until Saturday that he learned of Petitioner's alleged neck injury at work on Thursday, and he was on the job site on August 10, 2017 such that anyone to whom Petitioner reported the

injury would have reported it to him. Mr. Morgan testified that Petitioner was assigned to perform welding work on a handrail and all of the steel had already been removed from the platform above such that he could not have hit his head as alleged. Mr. Morgan testified that at no point during the day on August 10, 2017 did Petitioner, or any of his ground crew, inform him that Petitioner was injured and that Petitioner did not appear injured on that date. Thus, according to Mr. McManigal and Mr. Morgan, no accident was witnessed because no accident occurred. The emergency room records shed further light on the circumstances of Petitioner's symptomatology shortly after his alleged accident at work and the credibility of all three witnesses.

The emergency room records controvert Petitioner's version of events as he described them at the hearing and buttress the testimony of Mr. McManigal and Mr. Morgan that no injury occurred at work on August 10, 2017 as claimed. Indeed, less than 48 hours after his alleged accident at work, an emergency room triage nurse and physician note histories given by Petitioner that controvert his testimony at the hearing regarding the mechanism of injury, date of accident, and the location of accident.

On Saturday, August 12, 2017, a triage nurse noted Petitioner's report that he felt neck and back pain subsequent to an incident when "*he was in the attic* and hit his head *and fell down the attic stairs on Wednesday*." PX1 (*emphasis* added). In addition to the repeated reference to a fall down stairs in an attic, there is no reference to being at work, a lift of any kind, or a steel beam. The triage nurse also noted Petitioner's report that he "didn't come in on *Wednesday* because he was hoping it would go away." *Id.* (*emphasis* added). This notation contrasts with Petitioner's testimony that he was injured on August 10, 2017, a Thursday. The emergency room physician also took a history from Petitioner noting his report of "falling 3-4 stairs # days ago. States he bumped his head but had no LOC. Denies any dizziness, h/a. 'I just want to make sure i can work and i didn't mess up my back again'. States that he did not come to ER *over the last three days* because yesterday was hi[s] daughter's birthday." *Id.* (*emphasis* added). As with the triage nurse's note, there is no reference by the emergency room physician to Petitioner being at work at the time of the alleged injury, a lift of any kind, or a steel beam, and the physician's understanding of the mechanism of injury also involved falling down stairs three days earlier, which would have been Wednesday, August 9, 2017. Petitioner's accident as he described it at the hearing is directly contradicted by his own reports to emergency room personnel.

Based on the totality of the evidence, the Arbitrator finds that Petitioner has failed to establish by a preponderance of credible evidence that he sustained a compensable accident at work on August 10, 2017 as claimed. By extension, all other issues are rendered moot and all requested compensation and benefits are 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 WILLIAMSON)	☐ Reverse	☐ Second Injury Fund (§8(e)18)
		☐ PTD/Fatal denied
	☐ Modify	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Terri Newkirk,
Petitioner,

vs. No. 16 WC 09440,
16 WC 09441

19IWCC0282

State of Illinois,
Centralia Correctional Center,
Respondent.

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed November 27, 2017, is hereby affirmed and adopted.

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

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

Pursuant to §19(f)(1) of the Act, claims against the State of Illinois are not subject to judicial review.

DATED: JUN - 7 2019

SJM/wj
04-08-19
44

Stephen J. Mathis

D. Douglas McCarthy

DISSENT

I concur with all aspects of the majority's opinion other than its award of benefits as it relates to Petitioner's diagnosis of cubital tunnel syndrome. As to this part of the award, I respectfully dissent.

The majority in affirming and adopting the decision of the arbitrator finds the swelling due to Petitioner's lateral epicondylitis which was "in the same area could have contributed to a cubital tunnel condition." *Arbitration Decision*, p. 12. Yet, in the very next paragraph, the majority states "[w]hile there are records which reflect the Petitioner having some complaints of numbness and tingling, Dr. Stewart's argument that the anatomic locations of those complaints don't support cubital or carpal tunnel syndrome is persuasive." *Id.* The majority goes on to note "Dr. Stewart credibly testified that carpal and cubital tunnel syndrome can be caused or aggravated by traumatic injury; however, it was his opinion that such conditions were not causally related to the 9/5/14 work accident." *Id.* The majority in purportedly affording greater weight to Dr. Stewart's opinion notes the basis of this opinion as well as the corresponding medical records stating "if carpal or cubital tunnel was caused traumatically you would expect it to develop almost immediately or within a day or two due to the swelling. Based on a review of the records, this was pretty clearly not the case given what was documented." *Id.* Despite this detailed explanation of the basis of Dr. Stewart's opinion as well the supporting medical documentation, the majority finds Petitioner's cubital tunnel syndrome related. The majority's contradicting positions cannot be reconciled.

I would afford greater weight to Dr. Stewart's opinion in actuality and find Petitioner failed to prove a causal relationship between his accident and his diagnosis of cubital tunnel syndrome. As such, I would decrease the amount of permanent partial disability to 15% loss use of the left arm pursuant to Section 8(e) of the Act. Therefore, I dissent.

L. Elizabeth Coppoletti

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

NEWKIRK, TERRI
Employee/Petitioner

Case# **16WC009440**
16WC009441

CENTRALIA CORRECTIONAL CENTER
Employer/Respondent

19IWCC0282

On 11/27/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.41% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0969 RICH RICH & COOKSEY PC
THOMAS C RICH
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0502 STATE EMPLOYEES RETIREMENT
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SPRINGFIELD, IL 62794-9255

0558 ASSISTANT ATTORNEY GENERAL
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0498 STATE OF ILLINOIS
ATTORNEY GENERAL
100 W RANDOLPH ST 13TH FL
CHICAGO, IL 60601-3227

1350 CENTRAL MANAGEMENT SERVICES
BUREAU OF RISK MANAGEMENT
PO BOX 19208
SPRINGFIELD, IL 62794-9208

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

NOV 27 2017

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

STATE OF ILLINOIS)
)SS.
COUNTY OF WILLIAMSON)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

TERRI NEWKIRK
Employee/Petitioner

v.

CENTRALIA CORRECTIONAL CENTER
Employer/Respondent

Case # **16** WC **09440**

Consolidated cases: **16 WC 09441**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Paul Cellini**, Arbitrator of the Commission, in the city of **Mt. Vernon**, on **November 3, 2016**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

B. ☐ Was there an employee-employer relationship?

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

D. ☐ What was the date of the accident?

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

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

G. ☐ What were Petitioner's earnings?

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

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

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

K. ☐ What temporary benefits are in dispute?
☐ TPD ☐ Maintenance ☐ TTD

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

M. ☐ Should penalties or fees be imposed upon Respondent?

N. ☐ Is Respondent due any credit?

O. ☐ Other ______

FINDINGS

On **September 5, 2014**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$66,096.05**; the average weekly wage was **$1,271.08**.

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.

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 for any medical expenses paid prior to trial via the group health insurer pursuant to Section 8(j) of the Act.

ORDER

The Arbitrator finds that the Petitioner has proven that her left lateral epicondylitis and left cubital tunnel syndrome conditions are causally related to the September 5, 2014 accident. The Petitioner has failed to prove that any left carpal tunnel condition is causally related to the September 5, 2014 accident.

Respondent shall pay Petitioner temporary total disability benefits of **$847.39 per week** for **6 weeks**, commencing **May 26, 2016 through July 6, 2016**, as provided in Section 8(b) of the Act.

Respondent shall be given a credit for any of the awarded temporary total disability benefits that have been paid by Respondent.

Respondent shall pay reasonable and necessary medical services contained in Petitioner's Medical Expense Exhibit, with the exception of any bills related to left carpal tunnel syndrome, as provided in Sections 8(a) and 8.2 of the Act.

Respondent shall be given a credit for any awarded medical benefits that have been paid prior to hearing, 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 **$735.37 per week**, the maximum allowable statutory rate, for **50.6 weeks**, because the injuries sustained caused the **20% loss of use of the left arm**, as provided in Section 8(e) of the Act.

Respondent shall pay Petitioner compensation that has accrued from **August 3, 2016** through **November 3, 2016**, 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

November 14, 2017
Date

NOV 2 7 2017

STATEMENT OF FACTS

The Petitioner has worked for the Respondent as a correctional officer (CO) for 16 years. On 9/5/14, she testified that she was injured when, during a level 4 lockdown, the COs had to serve food to the inmates. She was working as a day room officer. She and another CO went to the dietary area to get their cart of 200 food trays for the South cluster, which she estimated weighed 200 to 250 pounds. She testified the wheels of the cart were not functioning properly and kept turning in towards each other, making it very difficult to move. While trying to force it to move towards the south cluster, the Petitioner testified that she injured her left arm. The Petitioner denied any prior injuries or treatment involving the left arm. She testified she is right hand dominant, and her right arm does not have symptoms.

After the injury, Petitioner testified she had excruciating pain throughout her left arm and hand with tingling and numbness, which would awaken her from sleep, and that she "knew I had tore something up." Accident/incident reports prepared for Respondent indicate consistent histories of the 9/5/14 activities and symptoms, which include only the left elbow. The documents indicate she reported the incident to her supervisor John Grisham, and that co-workers Steve Brough and Alan Varel were witnesses to the cart problems. Brough reported that Petitioner and Varel appeared to be having a hard time steering and moving the food cart down "the walk" and into the cell house, and that Petitioner said she had injured her elbow and arm while trying to get maneuver the cart. Varel reported he and Petitioner were feeding during lockdown "when (Petitioner) banged her elbows. Then she proceeded in telling me they were hurting. I also had a hard time be [sic] able to move the food cart." (Px13; Rx1 through 5).

On 9/9/14, Petitioner presented to her primary care provider, Dr. Butalid, with complaints of left arm and elbow pain since 9/5/14: "(Petitioner) was moving carts at work for the inmates and the cart was not cooperating while she was trying to move it." Due to the difficulty moving the cart, she reported having to push and pull it to do so. Petitioner advised that the following day she felt pain on the outside of her elbow which radiated to her forearm, a numbness and tingling sensation on the left lateral forearm and dorsum of the left thumb base, and a burning sensation on the lateral forearm. The symptoms awakened her from sleep. On physical examination Dr.

Butalid noted that Petitioner was tender at the left lateral epicondyle. He diagnosed left lateral epicondylitis but wanted to rule out carpal and cubital tunnel syndrome of the left arm. Medication and an elbow sleeve were prescribed. (Px3).

At her 9/19/14 follow up, the Petitioner reported that she had more of a burning sensation on the posterior aspect of her arm radiating down to her elbow and forearm. Dr. Butalid injected the left elbow and ordered an EMG/NCV and consultation with Dr. Burger. (Px3).

On 9/29/14, Petitioner presented to neurologist Dr. Burger. Petitioner reported the injection did not help. Examination was essentially normal with some lateral epicondylar tenderness. Dr. Burger's impression was possible lateral epicondylitis, although Petitioner's symptoms went beyond that local region. Dr. Burger recommended a trial of Nabumetone and obtained 10/17/14 left elbow x-rays (Px5), which were normal. 10/17/14 EMG/NCV testing reflected sensory peripheral neuropathy of the left upper extremity and was otherwise normal. At Petitioner's 11/13/14 follow up, Dr. Burger noted the EMG/NCV demonstrated sensory peripheral neuropathy evidenced by borderline slowing of the left ulnar and median sensory nerves, with no evidence of cubital tunnel or radiculopathy. Medication hadn't helped, and Dr. Burger advised that he did not think Petitioner's borderline sensory neuropathy accounted for her elbow pain, which sounded more mechanical in nature. Dr. Burger stated he would check lab testing to exclude medically addressable causes of her condition, and otherwise recommended an elbow MRI and referral to orthopedics. (Px4).

Petitioner reported ongoing elbow pain and burning that was making activity difficult when she followed up with Dr. Butalid on 11/18/14. He assessed Petitioner with left lateral epicondylitis and a "peripheral autonomic neuropathy due to other disorder." He prescribed the left elbow MRI and referred Petitioner to Dr. Bassman. (Px3). According to the radiologist, the 12/3/14 MRI showed no evidence of internal derangement. (Px5).

On 1/8/15, Petitioner presented to Dr. Bassman with complaints of left elbow pain. He noted Petitioner injured herself pushing a cart at work five months prior, had a normal elbow MRI and EMG/NCV, and had no complaints of numbness. Physical examination was essentially normal. Dr. Bassman diagnosed lateral epicondylitis and recommended physical therapy. (Px6).

The initial 1/21/15 intake for physical therapy noted Petitioner had a history of hunting and bowhunting prior to the injury. (Px7). Petitioner followed up with Dr. Bassman on 2/5/15, reporting no improvement with therapy. She had lateral and medial elbow soreness. A diagnosis of medial epicondylitis was added, and the elbow was drained and injected. Petitioner was advised to use a brace and was held to light duty. (Px6). At 3/5/15 follow up, Dr. Bassman noted Petitioner reported improvement with aspiration and injection, and that her pain was almost gone. He requested a copy of the EMG/NCV report, advised continued therapy and released Petitioner back to regular duty. (Px6). On that same date at therapy, the therapist reported: "(Petitioner) states that her MD was pleased with progress, told her that she is to continue therapy if doesn't completely get better, she may have surgery." (Px7).

The physical therapy notes after 3/5/15 and through the last visit of 3/18/15 appear to show a level of worsening, and at the last visit Petitioner reported she was improved but still had some ongoing symptoms that were worse with repetitive gripping activities. (Px7). At her 4/2/15 follow up with Dr. Bassman, Petitioner reported that her pain was gone, with just a "strained sensation" at times with overuse. Petitioner advised that she did not have any numbness or radiating pain. Dr. Bassman recommended a home exercise program and advised Petitioner to follow up as needed. (Px6).

The Petitioner completed an injury report with the Respondent on 8/26/15, indicating an inflamed left elbow "due to re use from previous injury." A Tristar Notice if Injury does not specify an injury or occurrence, but states "pulled left elbow." A third "Incident Report" that appears to have been prepared by Petitioner on the same date indicates: "This was due to an ongoing injury sustained on 9/5/14 of the left elbow and was given a shot of cortisone that worked until approx. 1 week prior to this report." She indicated workers' compensation said she would have to start the process again. (Px13; Rx6 & 7).

Petitioner didn't return to Dr. Bassman until 9/3/15, when she reported increased left elbow pain following several months of relief with the injection. Dr. Bassman noted that there was no numbness or swelling, but that Petitioner reported pain with gripping. Dr. Bassman again injected the elbow, but advised she would "probably need surgery in the future." (Px6).

On 1/14/16, Petitioner returned to Dr. Bassman and reported another exacerbation of lateral epicondylar pain. Lateral epicondylar release surgery was discussed. Petitioner advised she wished to proceed, so Dr. Bassman prescribed surgery and restricted Petitioner to no lifting over 10 pounds. (Px6).

On 3/30/16, Petitioner first presented to orthopedic surgeon Dr. Mall with left elbow complaints. (Px8). Dr. Mall's understanding was that he had been recommended by her attorney. (Px12). Petitioner reported injuring her left elbow on 9/8/14 after having difficulty with a broken food cart during a lockdown, when "she was having to jerk the cart back and forth to try to keep it stable and had to pull this" and "felt something give" in the left elbow. Dr. Mall's exam noted pain to palpation over the lateral epicondyle and pain with resisted wrist extension localized to the lateral epicondyle. Dr. Mall also noted pain over the radiocapitellar joint, and some pain to palpation over the ulnar nerve medially. Dr. Mall reported that Petitioner had a positive flexion compression test and Tinel's at the left elbow. Petitioner's right elbow exam was normal, as were left elbow x-rays. Based on Dr. Mall's review of Petitioner's prior left elbow MRI, he opined that it showed edema/joint effusion, indicating inflammation, as well as mild edema around the lateral epicondyle and wrist extensor tendons with partial tearing of the lateral extensor tendons. He stated: "this was not interpreted by the radiologist. However, this is clearly evident on MRI." Dr. Mall diagnosed left lateral epicondylitis, left ulnar neuritis/possible cubital tunnel syndrome, and possible intraarticular pathology. Based on a chain of events analysis, Dr. Mall opined that Petitioner's symptoms were causally related to the 9/8/14 accident with the cart. He indicated aggressively pulling a heavy cart is a mechanism of injury consistent with lateral epicondylitis, and the associated inflammation can also produce ulnar nerve symptoms and potentially "flare up or aggravate some underlying condition in the elbow joint or potentially even cause a mild cartilage injury in the elbow joint if enough force is generated through the elbow to do this." He agreed she'd had appropriate treatment for lateral epicondylitis, but wanted to verify all of Petitioner's pain generators. He injected the elbow joint to determine if it was causing pain, and if so this would impact the type of procedure he would ultimately perform for lateral epicondylitis. Dr. Mall recommended a new EMG/NCV, if the prior study did not show cubital tunnel and was more than 6 months old, and restricted Petitioner's work duties. (Px8).

At 4/13/16 follow up with Dr. Mall, Petitioner reported no relief of her symptoms following the cortisone injection. Therefore, Dr. Mall advised that he believed most of Petitioner's symptoms were related to lateral epicondylitis rather than any underlying osteoarthritis in the elbow joint itself. He prescribed left lateral epicondylar debridement and repair of the extensor carpi radialis brevis tendon. Petitioner had still not provided her prior EMG/NCV study, and Dr. Mall again recommended an updated study. Despite this, he was recommending ulnar nerve transposition surgery along with lateral epicondylitis surgery based on findings of clinical ulnar nerve symptoms. He also diagnosed left carpal tunnel syndrome (CTS), noting occasional symptoms in a median nerve distribution. Light duty was continued. (Px8).

On 5/4/16, Petitioner presented to Dr. Phillips for EMG/NCV studies. She reported a sudden onset of sharp dull aching left elbow pain with global numbness since 2014. Petitioner gave a history of undergoing C5/6 and C6/7 cervical fusion in February 2016, which helped her neck pain and headaches, but not her extremity symptoms. Petitioner denied right upper extremity symptoms. Dr. Phillips' review of the prior October 2014 EMG/NCV report notes the prolonged median and ulnar latencies had raised the issue of a sensory neuropathy, but he stated that no temperature measurement was indicated, and that a cool extremity study is the most common case of prolonged median and ulnar distal latencies. As such, he did not rely on this data. The new study, in his opinion, reflected moderate sensory motor median neuropathy across the right carpal tunnel and mild demyelinative ulnar neuropathy across the right cubital tunnel, despite the fact that Petitioner's right side was reported to be asymptomatic. On the left, Dr. Phillips noted a milder median sensory neuropathy across the left carpal tunnel, and mild-moderate demyelinative ulnar neuropathy across the left cubital tunnel. Dr. Phillips found that ulnar motor studies showed "only a couple of m/sec difference between the right and left sides." Noting his exam of Petitioner found absent pinprick sensation throughout the left arm to the shoulder, Dr. Phillips also stated: "As you know, the denial of pinprick sensation in the context of maintained digital sensory responses is considered generally inconsistent with a postganglionic peripheral nerve etiology." (Px10).

On 5/11/16, Petitioner followed up with Dr. Mall, who at that point noted that Petitioner's arm complaints were bilateral, "mostly left-sided greater than right-sided." Referencing Dr. Phillips' EMG/NCV findings, Dr. Mall assessed Petitioner with bilateral carpal tunnel syndrome, bilateral cubital tunnel syndrome, and left elbow lateral epicondylitis. Dr. Mall stated "[a]t this point the majority of the patient's symptoms are on the left side," and he recommended debridement of the left lateral epicondyle and ECRB tendon, repair of the ECRL tendon, left ulnar nerve transposition and left carpal tunnel release. Dr. Mall advised: "At this point, we will continue to monitor her symptoms on the right side and now believe that she will require surgery at this point for the right side currently." (Px8).

On 5/26/16, Petitioner underwent left carpal tunnel release, cubital tunnel decompression and nerve transposition, lateral epicondyle debridement, partial lateral epicondylectomy, microfracture of the lateral epicondyle and repair of the ECRL tendon. Dr. Mall's report notes the ECRL tendon was partially torn, and there was a "spike of bone" on the lateral epicondyle. He found the ulnar nerve to be severely compressed at the proximal entrance to the cubital tunnel, with swelling, irregularity of the nerve and hypervascularity. Because he found subluxing of the ulnar nerve, he performed the nerve transposition. Petitioner was held off work. (Px11).

On 6/8/16, Dr. Mall noted Petitioner had minimal complaints, and her numbness and tingling had resolved. Physical therapy and medication were prescribed. (Px8).

On 6/27/16, Petitioner underwent a Section 12 examination with Dr. Stewart at Respondent's request. (RX9) Dr. Stewart opined that a causal relationship existed between Petitioner's accident at work and her diagnosis of lateral epicondylitis. However, Dr. Stewart did not feel that a causal relationship existed between Petitioner's accident and the diagnoses of carpal and cubital tunnel syndrome. Dr. Stewart reported that the first indication he saw in the medical records regarding complaints of numbness and tingling was when she was first seen and evaluated by Dr. Mall approximately 18 months post injury. (Rx9).

On 7/6/16, Dr. Mall advised that Petitioner was doing well and was making significant improvements with physical therapy. Petitioner reported that she felt somewhat stronger and that her pain was improving. Therapy was continued and Petitioner was released to return to light duty as of 7/10/16. (Px8).

On 8/3/16, Dr. Stewart drafted an addendum to his prior report, reiterating his causation opinions. (Rx10).

Physical therapy records from 6/10/16 to 8/2/16 were reviewed. At the initial visit. Petitioner reported that her elbow, wrist and hand had bothered her since her 2014 incident. Her complaints appear to wax and wane in these records. On 7/1/16 Petitioner noted she felt work out, and had been raking and lifting "a bunch of wood." On 7/5/16, Petitioner reported she was now having the same symptoms in her right hand. By 7/26/16, Petitioner was complaining of pain in the elbow with even touching it. At the last visit. Petitioner noted improved strength and range of motion, but still had ongoing symptoms if she does too much. (Px7).

Dr. Mall was deposed by the parties on 8/1/16. He testified that while carpal and cubital tunnel syndromes are often thought of as repetitive-type conditions, they can also occur through trauma. Dr. Mall testified he typically gets "almost 100% improvement almost immediately" when he performs carpal and cubital tunnel surgeries, and that this is what happened with the Petitioner, with substantial improvement in her hand. Although the NCV performed by Dr. Phillips showed abnormal findings bilaterally at the elbows and wrists/hands, only Petitioner's left, injured upper extremity was symptomatic. He agreed the initial EMG/NCV was only performed on the left side, testifying "I guess, based on her symptoms of left sided problems." He testified that Petitioner never complained of any right upper extremity symptoms, and that regardless of EMG/NCV findings of CTS and/or cubital tunnel, he wouldn't necessarily diagnose these conditions on the right if she had no symptoms. (Px12).

Dr. Mall testified that he had no knowledge of Petitioner having any comorbidities or outside activities that would be considered contributory to carpal or cubital tunnel, though he agreed being female involves a greater risk of such conditions. He testified that Petitioner probably had some underlying peripheral neuropathy, but that it's hard to know if the conditions were preexisting, as she hadn't been diagnosed with the conditions prior to the accident date. Dr. Mall believed Petitioner's carpal and cubital tunnel symptoms were traumatically induced by her work-related injury. He testified that a traumatic event can precipitate swelling in the carpal and cubital tunnels, resulting in symptoms and the need for treatment. He noted that shoulder surgery, for example, can sometimes cause swelling in the arm and result in cubital tunnel syndrome. Dr. Mall testified that Petitioner has done very well post-surgically, her numbness is completely gone, and he planned to release her to full duty a few weeks after the deposition. (Px12).

On 8/3/16, Dr. Mall noted that Petitioner was making significant progress with physical therapy, and she felt like she was regaining much of her strength. He did note significant atrophy in the left forearm muscle compared to the right, but Petitioner felt that this was improving. She still had pain in the left elbow in terms of pain in the forearm muscles, but the lateral epicondylar pain was improved. On physical examination Petitioner had no significant pain to palpation over the lateral epicondyle itself. She had some mild soreness with resisted wrist extension maneuvers, and he advised it sometimes takes several months for the soreness to completely resolve. She had no numbness or tingling. Dr. Mall released Petitioner to full duty and placed her at maximum medical improvement. (Px8).

On cross-examination, Dr. Mall testified that he had no knowledge of a history of an 8/26/15 accident. He was asked to describe the symptoms that would lead him to various diagnoses. With lateral epicondylitis, it would be lateral elbow pain, difficulty with gripping and potentially significant pain. With cubital tunnel, "they can have just pain, some pain at the medial side of the elbow, so the inside part of the elbow. They could have numbness into the ring and pinky fingers, but some people don't readily describe this without the doctor probing for it. With CTS, they can complain of their hands going to sleep while driving, wrist pain that can radiate up the arm a bit, grip problems. Dr. Mall agreed that "pain" is a similar theme among all of these. (Px12).

Dr. Mall testified that when Petitioner initially presented to him she complained of numbness, and had undergone EMG/NCV testing, which led him to suspect she might have a neurologic condition beyond lateral epicondylitis. Asked to point out where in his 3/30/16 note he referenced complaints of numbness. Dr. Mall

testified: "...I don't have there that she described numbness, but I have that she – that I did a test for cubital tunnel syndrome, which makes me think that she was having symptoms related to numbness." He agreed Dr. Bassman's only diagnosis was lateral epicondylitis, and that he "did not describe any symptoms of numbness or tingling necessarily." Dr. Mall testified Dr. Burger, per the EMG/NCV findings, was "basically saying that there is swelling of the left ulnar and median nerves, so exactly what we're describing with median – with carpal and cubital tunnel." Dr. Mall again testified that Petitioner was asymptomatic in the right upper extremity, and that he was not recommending any right arm treatment. However, he testified that his examination indicated positive provocative findings at the right wrist and elbow. As to his 5/11/16 note indicating her right sided symptoms would be monitored but now believed that she would need surgery on the right, Dr. Mall testified this was probably a typographical error and should say surgery on the left. He agreed that based on Petitioner's injury being left-sided, any right sided treatment would not be related to the 9/5/14 accident. (Px12).

Dr. Mall testified that lateral epicondylitis involves only elbow pain, so it would be difficult for CTS or cubital tunnel to be mimicked by a lateral epicondylitis condition. Asked about the fact that he diagnosed Petitioner with lateral epicondylitis and cubital tunnel syndrome on 3/30/16, but he did not mention carpal tunnel syndrome, Dr. Mall testified: "It may be a dictation error or we may not have fully examined the carpal tunnel. Again, that's a while ago. I don't remember specifically what happened on that occasion. I'm just going by my notes here." As to whether the lack of an indication of carpal tunnel examination would indicate Petitioner didn't present with symptoms that would lead to such diagnosis, Dr. Mall indicated he did not know and that the elbow may have been the major focus at the 4/13/16 visit. (Px12).

On further cross-examination Dr. Mall was asked about Dr. Butalid's 11/18/14 note in which he assessed left lateral epicondylitis and "peripheral autonomic neuropathy due to other disorder". As to what the diagnosis of "peripheral autonomic neuropathy due to other disorder" could mean following an order for blood work, he replied "I guess it could mean that there's some sort of medical reason for the nerve issues..." However, Dr. Mall thought such diagnosis was simply a "coding" issue. (Px12).

As to the Petitioner's indication to Dr. Bassman on 4/2/15 that she'd had complete symptom relief, Dr. Mall testified this was after an injection, and that it's not uncommon for lateral epicondylitis symptoms to resolve with injection and then return when the injection wears off. Dr. Mall assumed that Dr. Butalid must have had some neurologic concern beyond lateral epicondylitis to send Petitioner for EMG/NCV, as this would not be prescribed for epicondylitis. Dr. Bassman didn't appear to have performed any specific peripheral nerve testing, but did mention medial elbow pain on several occasions. As to the radiologist's normal findings on left elbow MRI, Dr. Mall testified his review of the films indicated she had some partial tearing of the lateral epicondyle and some edema within the joint and around the lateral epicondyle that was not reported by the radiologist, and that his findings differ from the radiologist ". . . very frequently. That's why I require all patients to bring their disks with them because oftentimes radiologists miss things." (Px12).

Dr. Mall agreed that Petitioner had undergone cervical disc surgery at C5/6 and C6/7 in February 2016, prior to the EMG/NCV testing with Dr. Phillips. Dr. Mall testified that cervical radiculopathy can cause numbness and tingling into the upper extremities, but that the EMG/NCV testing indicated no cervical radiculopathy. He had not reviewed any of Petitioner's records of cervical treatment, or if she had radicular complaints that could mimic cubital or carpal tunnel. Dr. Mall reiterated Petitioner is doing well post-surgery, with relieved numbness and tingling, with some ongoing but dramatically improved epicondylar pain, which usually goes away with time. (Px12).

On 9/13/16, Section 12 examiner Dr. Stewart testified via evidence deposition. He is board certified in general surgery with an added qualification in hand surgery. Dr. Stewart testified that his practice is limited to the hand

and upper extremity, up to and including the elbow. He testified that lateral epicondylitis mainly involves pain with pronation, i.e. using the arm/hand with the palm turned downwards. He testified that 85% of such epicondylitis patients do not require surgery, and should have at least 9 to 12 months of conservative treatment before surgery is considered. However, he noted that the condition tends to recur. (Rx11).

Dr. Stewart testified that common CTS symptoms are numbness and tingling in an appropriate distribution, i.e. into the thumb, index and ring fingers, and the radial ring finger. It can involve nocturnal awakening with numbness and tingling, and it can worsen with prolonged activities. Cubital tunnel typically occurs with people who perform prolonged elbow flexion, and generally involves numbness and tingling that radiates into the ring and small fingers. He testified that both conditions can potentially be caused or aggravated by trauma. (Rx11).

Dr. Stewart testified his review of the history of injury for accuracy with the Petitioner indicated she was pulling a difficult-to-move cart and feeling a pulling sensation with burning and lateral left elbow pain. The Petitioner did not provide any history of an 8/26/15 injury. (Rx11).

Dr. Stewart, given no other information, would interpret a finding of "sensory peripheral neuropathy" via an EMG to indicate the electromyographer had "discovered alterations in multiple sensory nerves that he felt was not necessarily consistent with multiple compression neuropathies, but was consistent with an overall neuropathy such as those that are seen with diabetes or vitamin deficiencies, things of that nature." Dr. Stewart reviewed the report and data from Dr. Phillips' EMG/NCV, and noted that there were bilateral findings of cubital and carpal tunnel, right worse than left, while the EMG portion was within normal limits, meaning the tested muscles did not show any abnormalities. Dr. Stewart's review of Petitioner's records indicated that at no time had the Petitioner made symptomatic complaints consistent with cubital or carpal tunnel, and that she did not undergo any conservative treatment for these conditions prior to seeing Dr. Mall. Petitioner reported her elbow pain had completely resolved with surgery, other than what she described as post-surgical discomfort. (Rx11).

Dr. Stewart opined that the only condition Petitioner had that was causally related to the accident involving the cart is lateral epicondylitis, including the recurrence that resulted in surgery. He testified that Petitioner had a classic presentation of lateral epicondylitis, with symptoms of the condition, typical treatment, a period of improvement and then a subsequent recurrence. Dr. Stewart testified that Petitioner's carpal tunnel diagnosis was based purely on EMG/NCV, as she was completely asymptomatic for it when the test was taken. He testified that such a diagnosis wouldn't be related to the work accident anyway, as a jerking activity like Petitioner performed with the food cart without a bony injury in and around the carpal tunnel or ulnar nerve, such as a dislocation or fracture, would not have enough traction force to cause such condition. As to cubital tunnel, he opined that it would also not be related to the accident, as tugging on a heavy cart would only cause it if there was enough traction force to dislocate or separate the elbow joint. Dr. Stewart explained that if carpal or cubital tunnel was caused traumatically you would expect the symptoms to develop almost immediately or within a day or two due to the swelling. Dr. Stewart testified that Petitioner did have certain risk factors that could predispose her to the development of carpal and cubital tunnel syndrome, including her age, peri- or postmenopausal state, and history as a smoker. (Rx11). Petitioner had not yet reached MMI post-surgery when Dr. Stewart examined her, but he expected that she would be able to return to her regular work duties. (Rx11).

On cross examination, Dr. Stewart acknowledged he did not have the initial 9/9/14 report of Dr. Butalid, nor any of the records from Dr. Burger. He agreed that he would like to see these records if there were complaints of numbness and tingling in them. He testified that the records of Dr. Bassman note he specifically asked Petitioner about numbness and tingling and she denied it. Thus, even if there had initially been such symptoms, they had completely resolved by the time she saw Dr. Bassman or Dr. Mall. While Dr. Mall's report referenced numbness

and tingling findings during provocative testing, such symptoms were not noted in his reporting of Petitioner's stated symptomatic complaints. Dr. Stewart also testified that even if complaints of numbness and tingling are referenced by Dr. Butalid and Dr. Burger, none of the records he reviewed ever indicated any complaints of numbness and tingling in an ulnar or median distribution. Such symptomatic complaints would have more consistently been indicated. He agreed if there were such references, it potentially could alter his opinion. (Rx11).

On redirect, Dr. Stewart testified that complaints of burning in the lateral elbow, dorsal forearm and dorsal base of the thumb would not be in a median or ulnar nerve distribution. Petitioner's complaint to Dr. Butalid on 9/19/14 of numbness of the dorsum of the wrist and elbow would not be indicative of carpal or cubital tunnel. (Rx11).

The Petitioner testified that the surgeries helped with her symptoms, and that post-surgical physical therapy also provided relief. Petitioner testified she still has some ongoing arm/elbow soreness, which seems to be brought on by most activities: "Most everything I do will inflame my elbow, and there's - - its always there." She testified her grip strength is weaker than it used to be, and she still feels muscle soreness with gripping. She also reported her range of motion is "not well," but the Arbitrator notes her demonstration of this at the hearing did not indicate a significant reduction. She tries to avoid using her left arm as much as possible, especially at work. She takes over-the-counter medications, probably one Aleve or two ibuprofen daily, but takes no prescription medications for her left arm.

Petitioner acknowledged that she has been a bow hunter for over 25 years. Post-surgery, she testified she was unable to pull the string back when she tried to do so. She did, however, apply for her bow hunting license this year. She has been released from care by Dr. Mall without restrictions, and has returned to her regular job as a CO with no reduction of wages. She agreed that Dr. Mall indicated she should continue to improve. She has been able to perform her full work duties, and has had no complaints from supervisors regarding her job performance. She continues to perform a home exercise program.

Respondent's representative, Gina Feazel, was present for the hearing but did not testify.

CONCLUSIONS OF LAW

WITH RESPECT TO ISSUE (C), DID AN ACCIDENT OCCUR THAT AROSE OUT OF AND IN THE COURSE OF THE PETITIONER'S EMPLOYMENT BY THE RESPONDENT, THE ARBITRATOR FINDS AS FOLLOWS:

The Arbitrator notes that this case involves somewhat of a hybrid specific / repetitive trauma claim, and is based on activities performed by the Petitioner on one date, 9/5/14.

On that date, the Petitioner testified that the prison facility was on lockdown, which required COs to participate in the feeding of the prisoners. The Petitioner credibly testified that, in doing so, she had to operate a food cart, which she estimated to weigh upwards of 200 pounds, that was difficult to move due to a problem with the wheels. She testified that this required her to have to tug the cart repeatedly to get it to move, and in doing so felt pain in the left elbow. Other than one witness statement which indicates Petitioner "banged" her elbows on that date, the accident reports and medical histories are generally consistent with the Petitioner's testimony that the cart was problematic to move. There is no evidence which rebuts the Petitioner's stated histories and testimony regarding her use of the malfunctioning cart.

The Arbitrator finds that the Petitioner sustained accidental injury which arose out of and in the course of her employment over the course of the day on 9/5/14 when she was pulling and tugging on the heavy cart to perform the work activity of feeding inmates which was made necessary by the lockdown conditions. It is quite clear to the Arbitrator that a worker having to move a heavy cart that does not operate properly, requiring the worker to push, pull and tug on that cart, involves an increased risk of injury which arises out of the work duties. The Petitioner was in the course of her work duties when she was attempting o move the cart through the facility.

WITH RESPECT TO ISSUE (F), IS THE PETITIONER'S PRESENT CONDITION OF ILL-BEING CAUSALLY RELATED TO THE INJURY, THE ARBITRATOR FINDS AS FOLLOWS:

With regard to causation, the Arbitrator notes that the Respondent has accepted the causal relationship of Petitioner's left lateral epicondylitis condition, based in significant part on the opinion of Section 12 examiner Dr. Stewart. The main issue in this case is whether any left carpal and/or cubital tunnel conditions, and the resultant surgeries for same with Dr. Mall, are causally related to the 9/5/14 accident. For the reasons indicated below, the Arbitrator finds that the left cubital tunnel condition is causally related to the 9/5/14 accident, but that the Petitioner has failed to prove that any left carpal tunnel condition is related to the 9/5/14 accident.

The Petitioner's left lateral epicondylitis condition was centered at the elbow. It appears that both Dr. Stewart and Dr. Mall essentially agree that this condition mainly produces localized pain at the elbow at the lateral epicondyle.

The records do reflect initial complaints of numbness and tingling to Dr. Butalid on 9/9/14. However, these complaints were in the left lateral forearm and dorsal thumb base. There was no indication of numbness and tingling into the fingers at any point in the records in evidence. There was no indication of palmar side numbness or tingling. There was no indication from Petitioner of any symptoms one would typically associate with carpal tunnel syndrome. Dr. Butalid did then order EMG/NCV testing to rule out cubital and or carpal tunnel syndromes. Based on the results of the testing, no diagnosis was made for either condition by Dr. Butalid or Dr. Burger. Both doctors appear to indicate that whatever findings were made through EMG/NCV testing should be further investigated via lab testing. Petitioner then saw Dr. Bassman for multiple visits, and over the course of his treatment there were no indications of complaints of numbness or tingling. He did at one point add a diagnosis of medial epicondylitis. Based on the treatment he directed to the elbow, the Petitioner's symptoms resolved to where she indicated her pain was gone and she was released back to regular duties.

When the Petitioner returned to Dr. Bassman with recurrent symptoms on 9/3/15, it was again noted that she reported no numbness. She did report pain with gripping, but this was elbow pain, not hand or forearm pain.

Petitioner saw Dr. Mall on 3/30/16. This appeared to be a second opinion in that Dr. Bassman had already prescribed and planned to perform lateral epicondylitis surgery. There were findings by Dr. Mall indicating he had some concern for cubital tunnel on the left, and wanted to review either the prior or a new EMG/NCV based on same, but he made no indication of carpal tunnel concern. Dr. Mall's subsequent records reflect no evidence any typical carpal tunnel symptoms in the hand or wrist, but instead reflect the Petitioner's focus of elbow and forearm symptoms. In fact, it appears that it was only after EMG/NCV testing, which reflected bilateral carpal tunnel syndrome (CTS) findings, that Dr. Mall referenced CTS and/or right upper extremity symptoms. There is no evidence of any right upper extremity symptoms or complaints in the records until the 5/11/16 visit. Despite Dr. Mall's explanations via deposition that he does not treat EMG/NCV findings, the Arbitrator's review of the records appear to indicate he did just that, as it was only after the testing that there were indications of right-sided complaints of the Petitioner. While Dr. Mall testified that there may have been typographical errors in his

records, and the one regarding right-sided surgery may well have been such a typo, overall it appears to the Arbitrator that no concern was given for CTS until after the EMG/NCV testing and, as noted by the Arbitrator, not only were the CTS findings bilateral, but the findings were worse on the right.

With regard to left cubital tunnel syndrome, the Arbitrator notes Dr. Mall's surgical findings of a severe condition. This is in the elbow, in the same vicinity as lateral epicondylitis, so swelling in the same area could have contributed to a cubital tunnel condition. Petitioner did at one point have complaints about the medial elbow along with the lateral. Thus, there is evidence to support the diagnosis, and it makes sense to the Arbitrator that lateral epicondylitis in the elbow could have contributed to the onset of cubital tunnel symptoms from the elbow, particularly given the surgical findings confirmed the presence of the condition. The Arbitrator notes with interest that Dr. Mall made no such specific findings regarding what he visualized in the left carpal tunnel.

The Petitioner's support for a causal relationship of carpal tunnel, on the other hand, is weak. While there are records which reflect the Petitioner having some complaints of numbness and tingling, Dr. Stewart's argument that the anatomic locations of those complaints don't support cubital or carpal tunnel is persuasive. His testimony regarding the typical symptoms which lead to a carpal tunnel diagnosis is consistent with the Arbitrator's understanding of same, and the medical evidence at no time indicates Petitioner having complaints of hand or finger numbness in either a median distribution. Dr. Mall's records are not clear with regard to what exactly triggered his CTS diagnosis other than a positive EMG/NCV test.

Dr. Stewart credibly testified that carpal and cubital tunnel syndrome can be caused or aggravated by traumatic injury; however, it was his opinion that such conditions were not causally related to the 9/5/14 work accident. Dr. Stewart testified that Petitioner's described mechanism of injury is not one that would cause carpal or cubital tunnel syndrome. Dr. Stewart explained that a jerking sensation without a bony injury in and around the carpal tunnel or ulnar nerve, such as a dislocation or fracture, would not have enough traction force to cause the injury. Dr. Stewart explained that if carpal or cubital tunnel was caused traumatically you would expect it to develop almost immediately or within a day or two due to the swelling. Based on a review of the records, this was pretty clearly not the case given what was documented. The Arbitrator notes that Dr. Stewart's testimony that Petitioner "never once throughout her entire treatment course ever complained of symptoms consistent with carpal or cubital tunnel" is not quite clear, as he also testified that Dr. Mall was the first to note any numbness complaints while Dr. Butalid's initial record does record some. However, as noted, whether the complaints to Butalid relate to these conditions or not is questionable, and they do not appear to relate to carpal tunnel regardless. Dr. Stewart explained that the symptoms of burning sensation and numbness on the dorsum side of the wrist and elbow that Petitioner reported were not indicative of carpal or cubital tunnel syndrome. Dr. Stewart testified that Petitioner would have had to have reported isolated numbness and tingling in the palm side of the thumb, index, and middle fingers and usually the radial half of the ring finger to be carpal tunnel syndrome. Dr. Stewart testified that Petitioner would have had to report numbness and tingling in the ulnar side of the ring finger, small finger, or the top of the ulnar side of the hand to be indicative of cubital tunnel syndrome.

Based on the preponderance of the evidence, the Arbitrator finds that the Petitioner's left cubital tunnel condition was caused or aggravated by the sequelae of the left lateral epicondylitis condition which was due to the 9/5/14 accident. The Arbitrator finds that the left lateral epicondylitis and cubital tunnel surgeries are causally related to the 9/5/14 accident. However, the Arbitrator finds no support that the Petitioner had left carpal tunnel beyond an EMG/NCV test, which also reflected the condition was bilateral. There is no solid evidence that the Petitioner complained of carpal tunnel symptoms on either side. The Petitioner has failed to prove that any left carpal tunnel condition is causally related to the 9/5/14 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:

Based on the Arbitrator's findings with regard to causation, the Arbitrator finds that the Petitioner is entitled to the medical expenses in Petitioner's group exhibit which relate to left lateral epicondylitis and cubital tunnel syndrome. The Arbitrator further finds that, based on the causation findings noted above, that the Petitioner is not entitled to the medical expenses related to left carpal tunnel syndrome.

The Arbitrator finds that the Petitioner's causally related medical care has been reasonable and necessary pursuant to Section 8(a) of the Act. The Respondent is therefore ordered to pay the medical expenses contained in Petitioner's group exhibit which are causally related to left lateral epicondylitis and left cubital tunnel.

The parties have stipulated that the Respondent is entitled to credit for any bills paid pursuant to Section 8(j), as well as that the Respondent may pay any outstanding awarded medical expenses directly to the providers. The parties have stipulated that the Respondent is entitled to credit for any bills paid pursuant to Section 8(j), as well as that the Respondent may pay any outstanding awarded medical expenses directly to the providers. Respondent shall indemnify and hold Petitioner harmless from any claims from these medical providers arising out of the expenses for which it claims credit. Respondent shall pay temporary total disability benefits as stipulated.

WITH RESPECT TO ISSUE (K), WHAT AMOUNT OF COMPENSATION IS DUE FOR TEMPORARY TOTAL DISABILITY, TEMPORARY PARTIAL DISABILITY AND/OR MAINTENANCE, THE ARBITRATOR FINDS AS FOLLOWS:

The parties stipulated that the Petitioner was temporarily totally disabled from 5/26/16 through 7/6/16. The Petitioner testified that she did not receive TTD benefits during this period. The Respondent has indicated that, based on Dr. Stewart's opinion that the Petitioner's lateral epicondylitis is causally related to the accident, the Respondent is responsible for this agreed period of TTD. The Arbitrator notes that this TTD period is consistent with the records in evidence. Therefore, the Arbitrator finds that the Petitioner is entitled to TTD benefits from 5/26/16 through 7/6/16. The Petitioner agreed that if any of the awarded TTD benefits have been paid prior to the issuance of this decision, Respondent would be entitled to credit for such payments.

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

Pursuant to §8.1b of the Act, the following criteria and factors must be weighed in determining the level of permanent partial disability for accidental injuries occurring on or after September 1, 2011:

(a) A physician licensed to practice medicine in all of its branches preparing a permanent partial disability impairment report shall report the level of impairment in writing. The report shall include an evaluation of medically defined and professionally appropriate measurements of impairment that include, but are not limited to: loss of range of motion; loss of strength; measured atrophy of tissue mass consistent with the injury; and any other measurements that establish the nature and extent of the impairment. The most current edition of the American Medical Association's (AMA) "Guides to the Evaluation of Permanent Impairment" shall be used by the physician in determining the level of impairment.

(b) In determining the level of permanent partial disability, the Commission shall base its determination on the following factors;

(i) the reported level of impairment pursuant to subsection (a);
(ii) the occupation of the injured employee;
(iii) the age of the employee at the time of the injury;
(iv) the employee's future earning capacity; and
(v) evidence of disability corroborated by the treating medical records. No single enumerated factor shall be the sole determinant of disability. In determining the level of disability, the relevance and weight of any factors used in addition to the level of impairment as reported by the physician must be explained in a written order.

With regard to subsection (i) of §8.1b(b), the Arbitrator notes that neither party submitted an AMA permanent partial impairment report or opinion into evidence. As such, the Arbitrator gives this factor no weight in the permanency determination.

With regard to subsection (ii) of §8.1b(b), the occupation of the employee, the Arbitrator notes that the record reveals that Petitioner was employed as a correctional officer at the time of the accident and has been able to return to work in her prior capacity as a result of said injury. This factor tends to show a lesser degree of permanency.

With regard to subsection (iii) of §8.1b(b), the Arbitrator notes that Petitioner was 51 years old at the time of the accident. Neither party has produced evidence with regard to how the Petitioner's age may impact her permanent partial disability with regard to the causally related conditions. As such, this factor carries no weight.

With regard to subsection (iv) of §8.1b(b), Petitioner's future earnings capacity, the Arbitrator notes that no evidence was presented which indicates that the Petitioner's future earning capacity has been impacted by the accident. As such, this factor tends to show a lesser degree of permanency.

With regard to subsection (v) of §8.1b(b), evidence of disability corroborated by the treating medical records, the Arbitrator notes that Petitioner last saw Dr. Mall on 8/3/16. Dr. Mall noted that in the history of present illness that Petitioner had atrophy in the left forearm muscle compared with the right, as well as continued symptoms of pain in the left forearm muscles. She continued to have soreness with resisted wrist extension maneuvers. Dr. Mall advised Petitioner that she would likely have to wear her tennis elbow strap while doing any kind of heavy lifting activities. Despite the improvement resulting from surgery, Petitioner still had soreness in her arm and elbow with activity, though Dr. Mall indicated this would resolve over time. Petitioner testified to an ongoing lack of grip strength and soreness, and that she avoids doing things with her left arm at work and does not attempt to use her left hand. This factor carries the most weight in the permanency determination.

Based on the above factors, the record taken as a whole and a review of prior Commission awards with similar injuries similar outcomes, the Arbitrator finds that Petitioner sustained permanent partial disability to the extent of 20% loss of use of the left arm pursuant to §8(e) of the Act.

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

NEWKIRK, TERRI
Employee/Petitioner

Case# **16WC009441**

16WC009440

CENTRALIA CORRECTIONAL CENTER
Employer/Respondent

19IWCC0282

On 11/27/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.41% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

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

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

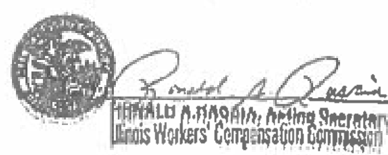
0558 ASSISTANT ATTORNEY GENERAL
AARON L WRIGHT
601 S UNIVERSITY AVE SUITE 102
CARBONDALE, IL 62901

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

1350 CENTRAL MANAGEMENT SERVICES
BUREAU OF RISK MANAGEMENT
PO BOX 19208
SPRINGFIELD, IL 62794-9208

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

NOV 27 2017



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

19IWCC0282

STATE OF ILLINOIS)

)SS.

COUNTY OF WILLIAMSON)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

TERRI NEWKIRK
Employee/Petitioner

v.

CENTRALIA CORRECTIONAL CENTER
Employer/Respondent

Case # **16** WC **09441**

Consolidated cases: **16 WC 09440**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Paul Cellini**, Arbitrator of the Commission, in the city of **Mt. Vernon**, on **November 3, 2016**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. [ ] Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?

B. [ ] Was there an employee-employer relationship?

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

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

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

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

G. [ ] What were Petitioner's earnings?

H. [ ] What was Petitioner's age at the time of the accident?

I. [ ] What was Petitioner's marital status at the time of the accident?

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

K. [ ] What temporary benefits are in dispute?
[ ] TPD [ ] Maintenance [ ] TTD

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

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

N. [ ] Is Respondent due any credit?

O. [ ] Other ______

Newkirk v. Centralia Corr. Center, 16 WC 09441

FINDINGS

On **August 26, 2015**, Respondent *was* operating under and subject to the provisions of the Act.

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

On this date, 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 $**66,096.05**; the average weekly wage was $**1,271.08**.

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

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

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

Respondent shall be given a credit of $**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 for all awarded medical expenses paid by Respondent prior to hearing via group health coverage under Section 8(j) of the Act.

ORDER

The Arbitrator finds that the Petitioner failed to prove that she sustained accidental injuries arising out of and in the course of her employment with the Respondent on August 26, 2015.

No benefits are awarded.

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

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

Signature of Arbitrator

November 14, 2017
Date

NOV 27 2017

STATEMENT OF FACTS

The Petitioner has worked for the Respondent as a correctional officer (CO) for 16 years. On 9/5/14, she testified that she was injured when, during a level 4 lockdown, the COs had to serve food to the inmates. She was working as a day room officer. She and another CO went to the dietary area to get their cart of 200 food trays for the South cluster, which she estimated weighed 200 to 250 pounds. She testified the wheels of the cart were not functioning properly and kept turning in towards each other, making it very difficult to move. While trying to force it to move towards the south cluster, the Petitioner testified that she injured her left arm. The Petitioner denied any prior injuries or treatment involving the left arm. She testified she is right hand dominant, and her right arm does not have symptoms.

After the injury, Petitioner testified she had excruciating pain throughout her left arm and hand with tingling and numbness, which would awaken her from sleep, and that she "knew I had tore something up." Accident/incident reports prepared for Respondent indicate consistent histories of the 9/5/14 activities and symptoms, which include only the left elbow. The documents indicate she reported the incident to her supervisor John Grisham, and that co-workers Steve Brough and Alan Varel were witnesses to the cart problems. Brough reported that Petitioner and Varel appeared to be having a hard time steering and moving the food cart down "the walk" and into the cell house, and that Petitioner said she had injured her elbow and arm while trying to get maneuver the cart. Varel reported he and Petitioner were feeding during lockdown "when (Petitioner) banged her elbows. Then she proceeded in telling me they were hurting. I also had a hard time be [sic] able to move the food cart." (Px13; Rx1 through 5).

On 9/9/14, Petitioner presented to her primary care provider, Dr. Butalid, with complaints of left arm and elbow pain since 9/5/14: "(Petitioner) was moving carts at work for the inmates and the cart was not cooperating while she was trying to move it." Due to the difficulty moving the cart, she reported having to push and pull it to do so. Petitioner advised that the following day she felt pain on the outside of her elbow which radiated to her forearm, a numbness and tingling sensation on the left lateral forearm and dorsum of the left thumb base, and a burning sensation on the lateral forearm. The symptoms awakened her from sleep. On physical examination Dr. Butalid noted that Petitioner was tender at the left lateral epicondyle. He diagnosed left lateral epicondylitis but wanted to rule out carpal and cubital tunnel syndrome of the left arm. Medication and an elbow sleeve were prescribed. (Px3).

At her 9/19/14 follow up, the Petitioner reported that she had more of a burning sensation on the posterior aspect of her arm radiating down to her elbow and forearm. Dr. Butalid injected the left elbow and ordered an EMG/NCV and consultation with Dr. Burger. (Px3).

On 9/29/14, Petitioner presented to neurologist Dr. Burger. Petitioner reported the injection did not help. Examination was essentially normal with some lateral epicondylar tenderness. Dr. Burger's impression was possible lateral epicondylitis, although Petitioner's symptoms went beyond that local region. Dr. Burger recommended a trial of Nabumetone and obtained 10/17/14 left elbow x-rays (Px5), which were normal. 10/17/14 EMG/NCV testing reflected sensory peripheral neuropathy of the left upper extremity and was otherwise normal. At Petitioner's 11/13/14 follow up, Dr. Burger noted the EMG/NCV demonstrated sensory peripheral neuropathy evidenced by borderline slowing of the left ulnar and median sensory nerves, with no evidence of cubital tunnel or radiculopathy. Medication hadn't helped, and Dr. Burger advised that he did not think Petitioner's borderline sensory neuropathy accounted for her elbow pain, which sounded more mechanical in nature. Dr. Burger stated he would check lab testing to exclude medically addressable causes of her condition, and otherwise recommended an elbow MRI and referral to orthopedics. (Px4).

Petitioner reported ongoing elbow pain and burning that was making activity difficult when she followed up with Dr. Butalid on 11/18/14. He assessed Petitioner with left lateral epicondylitis and a "peripheral autonomic neuropathy due to other disorder." He prescribed the left elbow MRI and referred Petitioner to Dr. Bassman. (Px3). According to the radiologist. the 12/3/14 MRI showed no evidence of internal derangement. (Px5).

On 1/8/15, Petitioner presented to Dr. Bassman with complaints of left elbow pain. He noted Petitioner injured herself pushing a cart at work five months prior, had a normal elbow MRI and EMG/NCV, and had no complaints of numbness. Physical examination was essentially normal. Dr. Bassman diagnosed lateral epicondylitis and recommended physical therapy. (Px6).

The initial 1/21/15 intake for physical therapy noted Petitioner had a history of hunting and bowhunting prior to the injury. (Px7). Petitioner followed up with Dr. Bassman on 2/5/15, reporting no improvement with therapy. She had lateral and medial elbow soreness. A diagnosis of medial epicondylitis was added, and the elbow was drained and injected. Petitioner was advised to use a brace and was held to light duty. (Px6). At 3/5/15 follow up, Dr. Bassman noted Petitioner reported improvement with aspiration and injection, and that her pain was almost gone. He requested a copy of the EMG/NCV report, advised continued therapy and released Petitioner back to regular duty. (Px6). On that same date at therapy, the therapist reported: "(Petitioner) states that her MD was pleased with progress. told her that she is to continue therapy if doesn't completely get better, she may have surgery." (Px7).

The physical therapy notes after 3/5/15 and through the last visit of 3/18/15 appear to show a level of worsening, and at the last visit Petitioner reported she was improved but still had some ongoing symptoms that were worse with repetitive gripping activities. (Px7). At her 4/2/15 follow up with Dr. Bassman, Petitioner reported that her pain was gone, with just a "strained sensation" at times with overuse. Petitioner advised that she did not have any numbness or radiating pain. Dr. Bassman recommended a home exercise program and advised Petitioner to follow up as needed. (Px6).

The Petitioner completed an injury report with the Respondent on 8/26/15, indicating an inflamed left elbow "due to re use from previous injury." A Tristar Notice if Injury does not specify an injury or occurrence, but states "pulled left elbow." A third "Incident Report" that appears to have been prepared by Petitioner on the same date indicates: "This was due to an ongoing injury sustained on 9/5/14 of the left elbow and was given a shot of cortisone that worked until approx. 1 week prior to this report." She indicated workers' compensation said she would have to start the process again. (Px13; Rx6 & 7).

Petitioner didn't return to Dr. Bassman until 9/3/15, when she reported increased left elbow pain following several months of relief with the injection. Dr. Bassman noted that there was no numbness or swelling, but that Petitioner reported pain with gripping. Dr. Bassman again injected the elbow, but advised she would "probably need surgery in the future." (Px6).

On 1/14/16, Petitioner returned to Dr. Bassman and reported another exacerbation of lateral epicondylar pain. Lateral epicondylar release surgery was discussed. Petitioner advised she wished to proceed, so Dr. Bassman prescribed surgery and restricted Petitioner to no lifting over 10 pounds. (Px6).

On 3/30/16, Petitioner first presented to orthopedic surgeon Dr. Mall with left elbow complaints. (Px8). Dr. Mall's understanding was that he had been recommended by her attorney. (Px12). Petitioner reported injuring her left elbow on 9/8/14 after having difficulty with a broken food cart during a lockdown, when "she was having to jerk the cart back and forth to try to keep it stable and had to pull this" and "felt something give" in

the left elbow. Dr. Mall's exam noted pain to palpation over the lateral epicondyle and pain with resisted wrist extension localized to the lateral epicondyle. Dr. Mall also noted pain over the radiocapitellar joint, and some pain to palpation over the ulnar nerve medially. Dr. Mall reported that Petitioner had a positive flexion compression test and Tinel's at the left elbow. Petitioner's right elbow exam was normal, as were left elbow x-rays. Based on Dr. Mall's review of Petitioner's prior left elbow MRI, he opined that it showed edema/joint effusion, indicating inflammation, as well as mild edema around the lateral epicondyle and wrist extensor tendons with partial tearing of the lateral extensor tendons. He stated: "this was not interpreted by the radiologist. However, this is clearly evident on MRI." Dr. Mall diagnosed left lateral epicondylitis, left ulnar neuritis/possible cubital tunnel syndrome, and possible intraarticular pathology. Based on a chain of events analysis, Dr. Mall opined that Petitioner's symptoms were causally related to the 9/8/14 accident with the cart. He indicated aggressively pulling a heavy cart is a mechanism of injury consistent with lateral epicondylitis, and the associated inflammation can also produce ulnar nerve symptoms and potentially "flare up or aggravate some underlying condition in the elbow joint or potentially even cause a mild cartilage injury in the elbow joint if enough force is generated through the elbow to do this." He agreed she'd had appropriate treatment for lateral epicondylitis, but wanted to verify all of Petitioner's pain generators. He injected the elbow joint to determine if it was causing pain, and if so this would impact the type of procedure he would ultimately perform for lateral epicondylitis. Dr. Mall recommended a new EMG/NCV, if the prior study did not show cubital tunnel and was more than 6 months old, and restricted Petitioner's work duties. (Px8).

At 4/13/16 follow up with Dr. Mall, Petitioner reported no relief of her symptoms following the cortisone injection. Therefore, Dr. Mall advised that he believed most of Petitioner's symptoms were related to lateral epicondylitis rather than any underlying osteoarthritis in the elbow joint itself. He prescribed left lateral epicondylar debridement and repair of the extensor carpi radialis brevis tendon. Petitioner had still not provided her prior EMG/NCV study, and Dr. Mall again recommended an updated study. Despite this, he was recommending ulnar nerve transposition surgery along with lateral epicondylitis surgery based on findings of clinical ulnar nerve symptoms. He also diagnosed left carpal tunnel syndrome (CTS), noting occasional symptoms in a median nerve distribution. Light duty was continued. (Px8).

On 5/4/16, Petitioner presented to Dr. Phillips for EMG/NCV studies. She reported a sudden onset of sharp dull aching left elbow pain with global numbness since 2014. Petitioner gave a history of undergoing C5/6 and C6/7 cervical fusion in February 2016, which helped her neck pain and headaches, but not her extremity symptoms. Petitioner denied right upper extremity symptoms. Dr. Phillips' review of the prior October 2014 EMG/NCV report notes the prolonged median and ulnar latencies had raised the issue of a sensory neuropathy, but he stated that no temperature measurement was indicated, and that a cool extremity study is the most common case of prolonged median and ulnar distal latencies. As such, he did not rely on this data. The new study, in his opinion, reflected moderate sensory motor median neuropathy across the right carpal tunnel and mild demyelinative ulnar neuropathy across the right cubital tunnel, despite the fact that Petitioner's right side was reported to be asymptomatic. On the left, Dr. Phillips noted a milder median sensory neuropathy across the left carpal tunnel, and mild-moderate demyelinative ulnar neuropathy across the left cubital tunnel. Dr. Phillips found that ulnar motor studies showed "only a couple of m/sec difference between the right and left sides." Noting his exam of Petitioner found absent pinprick sensation throughout the left arm to the shoulder, Dr. Phillips also stated: "As you know, the denial of pinprick sensation in the context of maintained digital sensory responses is considered generally inconsistent with a postganglionic peripheral nerve etiology." (Px10).

On 5/11/16, Petitioner followed up with Dr. Mall, who at that point noted that Petitioner's arm complaints were bilateral, "mostly left-sided greater than right-sided." Referencing Dr. Phillips' EMG/NCV findings, Dr. Mall assessed Petitioner with bilateral carpal tunnel syndrome, bilateral cubital tunnel syndrome, and left elbow lateral epicondylitis. Dr. Mall stated "[a]t this point the majority of the patient's symptoms are on the left side."

and he recommended debridement of the left lateral epicondyle and ECRB tendon, repair of the ECRL tendon, left ulnar nerve transposition and left carpal tunnel release. Dr. Mall advised: "At this point, we will continue to monitor her symptoms on the right side and now believe that she will require surgery at this point for the right side currently." (Px8).

On 5/26/16, Petitioner underwent left carpal tunnel release, cubital tunnel decompression and nerve transposition, lateral epicondyle debridement, partial lateral epicondylectomy, microfracture of the lateral epicondyle and repair of the ECRL tendon. Dr. Mall's report notes the ECRL tendon was partially torn, and there was a "spike of bone" on the lateral epicondyle. He found the ulnar nerve to be severely compressed at the proximal entrance to the cubital tunnel, with swelling, irregularity of the nerve and hypervascularity. Because he found subluxing of the ulnar nerve, he performed the nerve transposition. Petitioner was held off work. (Px11).

On 6/8/16, Dr. Mall noted Petitioner had minimal complaints, and her numbness and tingling had resolved. Physical therapy and medication were prescribed. (Px8).

On 6/27/16, Petitioner underwent a Section 12 examination with Dr. Stewart at Respondent's request. (RX9) Dr. Stewart opined that a causal relationship existed between Petitioner's accident at work and her diagnosis of lateral epicondylitis. However, Dr. Stewart did not feel that a causal relationship existed between Petitioner's accident and the diagnoses of carpal and cubital tunnel syndrome. Dr. Stewart reported that the first indication he saw in the medical records regarding complaints of numbness and tingling was when she was first seen and evaluated by Dr. Mall approximately 18 months post injury. (Rx9).

On 7/6/16, Dr. Mall advised that Petitioner was doing well and was making significant improvements with physical therapy. Petitioner reported that she felt somewhat stronger and that her pain was improving. Therapy was continued and Petitioner was released to return to light duty as of 7/10/16. (Px8).

On 8/3/16, Dr. Stewart drafted an addendum to his prior report, reiterating his causation opinions. (Rx10).

Physical therapy records from 6/10/16 to 8/2/16 were reviewed. At the initial visit, Petitioner reported that her elbow, wrist and hand had bothered her since her 2014 incident. Her complaints appear to wax and wane in these records. On 7/1/16 Petitioner noted she felt work out, and had been raking and lifting "a bunch of wood." On 7/5/16, Petitioner reported she was now having the same symptoms in her right hand. By 7/26/16, Petitioner was complaining of pain in the elbow with even touching it. At the last visit, Petitioner noted improved strength and range of motion, but still had ongoing symptoms if she does too much. (Px7).

Dr. Mall was deposed by the parties on 8/1/16. He testified that while carpal and cubital tunnel syndromes are often thought of as repetitive-type conditions, they can also occur through trauma. Dr. Mall testified he typically gets "almost 100% improvement almost immediately" when he performs carpal and cubital tunnel surgeries, and that this is what happened with the Petitioner, with substantial improvement in her hand. Although the NCV performed by Dr. Phillips showed abnormal findings bilaterally at the elbows and wrists/hands, only Petitioner's left, injured upper extremity was symptomatic. He agreed the initial EMG/NCV was only performed on the left side, testifying "I guess, based on her symptoms of left sided problems." He testified that Petitioner never complained of any right upper extremity symptoms, and that regardless of EMG/NCV findings of CTS and/or cubital tunnel, he wouldn't necessarily diagnose these conditions on the right if she had no symptoms. (Px12).

Dr. Mall testified that he had no knowledge of Petitioner having any comorbidities or outside activities that would be considered contributory to carpal or cubital tunnel, though he agreed being female involves a greater risk of such conditions. He testified that Petitioner probably had some underlying peripheral neuropathy, but that

it's hard to know if the conditions were preexisting, as she hadn't been diagnosed with the conditions prior to the accident date. Dr. Mall believed Petitioner's carpal and cubital tunnel symptoms were traumatically induced by her work-related injury. He testified that a traumatic event can precipitate swelling in the carpal and cubital tunnels, resulting in symptoms and the need for treatment. He noted that shoulder surgery, for example, can sometimes cause swelling in the arm and result in cubital tunnel syndrome. Dr. Mall testified that Petitioner has done very well post-surgically, her numbness is completely gone, and he planned to release her to full duty a few weeks after the deposition. (Px12).

On 8/3/16, Dr. Mall noted that Petitioner was making significant progress with physical therapy, and she felt like she was regaining much of her strength. He did note significant atrophy in the left forearm muscle compared to the right, but Petitioner felt that this was improving. She still had pain in the left elbow in terms of pain in the forearm muscles, but the lateral epicondylar pain was improved. On physical examination Petitioner had no significant pain to palpation over the lateral epicondyle itself. She had some mild soreness with resisted wrist extension maneuvers, and he advised it sometimes takes several months for the soreness to completely resolve. She had no numbness or tingling. Dr. Mall released Petitioner to full duty and placed her at maximum medical improvement. (Px8).

On cross-examination, Dr. Mall testified that he had no knowledge of a history of an 8/26/15 accident. He was asked to describe the symptoms that would lead him to various diagnoses. With lateral epicondylitis, it would be lateral elbow pain, difficulty with gripping and potentially significant pain. With cubital tunnel, "they can have just pain, some pain at the medial side of the elbow, so the inside part of the elbow. They could have numbness into the ring and pinky fingers, but some people don't readily describe this without the doctor probing for it. With CTS, they can complain of their hands going to sleep while driving, wrist pain that can radiate up the arm a bit, grip problems. Dr. Mall agreed that "pain" is a similar theme among all of these. (Px12).

Dr. Mall testified that when Petitioner initially presented to him she complained of numbness, and had undergone EMG/NCV testing, which led him to suspect she might have a neurologic condition beyond lateral epicondylitis. Asked to point out where in his 3/30/16 note he referenced complaints of numbness, Dr. Mall testified: "…I don't have there that she described numbness, but I have that she – that I did a test for cubital tunnel syndrome, which makes me think that she was having symptoms related to numbness." He agreed Dr. Bassman's only diagnosis was lateral epicondylitis, and that he "did not describe any symptoms of numbness or tingling necessarily." Dr. Mall testified Dr. Burger, per the EMG/NCV findings, was "basically saying that there is swelling of the left ulnar and median nerves, so exactly what we're describing with median – with carpal and cubital tunnel." Dr. Mall again testified that Petitioner was asymptomatic in the right upper extremity, and that he was not recommending any right arm treatment. However, he testified that his examination indicated positive provocative findings at the right wrist and elbow. As to his 5/11/16 note indicating her right sided symptoms would be monitored but now believed that she would need surgery on the right, Dr. Mall testified this was probably a typographical error and should say surgery on the left. He agreed that based on Petitioner's injury being left-sided, any right sided treatment would not be related to the 9/5/14 accident. (Px12).

Dr. Mall testified that lateral epicondylitis involves only elbow pain, so it would be difficult for CTS or cubital tunnel to be mimicked by a lateral epicondylitis condition. Asked about the fact that he diagnosed Petitioner with lateral epicondylitis and cubital tunnel syndrome on 3/30/16, but he did not mention carpal tunnel syndrome, Dr. Mall testified: "It may be a dictation error or we may not have fully examined the carpal tunnel. Again, that's a while ago. I don't remember specifically what happened on that occasion. I'm just going by my notes here." As to whether the lack of an indication of carpal tunnel examination would indicate Petitioner didn't present with symptoms that would lead to such diagnosis, Dr. Mall indicated he did not know and that the elbow may have been the major focus at the 4/13/16 visit. (Px12).

On further cross-examination Dr. Mall was asked about Dr. Butalid's 11/18/14 note in which he assessed left lateral epicondylitis and "peripheral autonomic neuropathy due to other disorder". As to what the diagnosis of "peripheral autonomic neuropathy due to other disorder" could mean following an order for blood work, he replied "I guess it could mean that there's some sort of medical reason for the nerve issues..." However, Dr. Mall thought such diagnosis was simply a "coding" issue. (Px12).

As to the Petitioner's indication to Dr. Bassman on 4/2/15 that she'd had complete symptom relief, Dr. Mall testified this was after an injection, and that it's not uncommon for lateral epicondylitis symptoms to resolve with injection and then return when the injection wears off. Dr. Mall assumed that Dr. Butalid must have had some neurologic concern beyond lateral epicondylitis to send Petitioner for EMG/NCV, as this would not be prescribed for epicondylitis. Dr. Bassman didn't appear to have performed any specific peripheral nerve testing, but did mention medial elbow pain on several occasions. As to the radiologist's normal findings on left elbow MRI, Dr. Mall testified his review of the films indicated she had some partial tearing of the lateral epicondyle and some edema within the joint and around the lateral epicondyle that was not reported by the radiologist, and that his findings differ from the radiologist ". . . very frequently. That's why I require all patients to bring their disks with them because oftentimes radiologists miss things." (Px12).

Dr. Mall agreed that Petitioner had undergone cervical disc surgery at C5/6 and C6/7 in February 2016, prior to the EMG/NCV testing with Dr. Phillips. Dr. Mall testified that cervical radiculopathy can cause numbness and tingling into the upper extremities, but that the EMG/NCV testing indicated no cervical radiculopathy. He had not reviewed any of Petitioner's records of cervical treatment, or if she had radicular complaints that could mimic cubital or carpal tunnel. Dr. Mall reiterated Petitioner is doing well post-surgery, with relieved numbness and tingling, with some ongoing but dramatically improved epicondylar pain, which usually goes away with time. (Px12).

On 9/13/16, Section 12 examiner Dr. Stewart testified via evidence deposition. He is board certified in general surgery with an added qualification in hand surgery. Dr. Stewart testified that his practice is limited to the hand and upper extremity, up to and including the elbow. He testified that lateral epicondylitis mainly involves pain with pronation, i.e. using the arm/hand with the palm turned downwards. He testified that 85% of such epicondylitis patients do not require surgery, and should have at least 9 to 12 months of conservative treatment before surgery is considered. However, he noted that the condition tends to recur. (Rx11).

Dr. Stewart testified that common CTS symptoms are numbness and tingling in an appropriate distribution, i.e. into the thumb, index and ring fingers, and the radial ring finger. It can involve nocturnal awakening with numbness and tingling, and it can worsen with prolonged activities. Cubital tunnel typically occurs with people who perform prolonged elbow flexion, and generally involves numbness and tingling that radiates into the ring and small fingers. He testified that both conditions can potentially be caused or aggravated by trauma. (Rx11).

Dr. Stewart testified his review of the history of injury for accuracy with the Petitioner indicated she was pulling a difficult-to-move cart and feeling a pulling sensation with burning and lateral left elbow pain. The Petitioner did not provide any history of an 8/26/15 injury. (Rx11).

Dr. Stewart, given no other information, would interpret a finding of "sensory peripheral neuropathy" via an EMG to indicate the electromyographer had "discovered alterations in multiple sensory nerves that he felt was not necessarily consistent with multiple compression neuropathies, but was consistent with an overall neuropathy such as those that are seen with diabetes or vitamin deficiencies, things of that nature." Dr. Stewart reviewed the report and data from Dr. Phillips' EMG/NCV, and noted that there were bilateral findings of

cubital and carpal tunnel, right worse than left, while the EMG portion was within normal limits, meaning the tested muscles did not show any abnormalities. Dr. Stewart's review of Petitioner's records indicated that at no time had the Petitioner made symptomatic complaints consistent with cubital or carpal tunnel, and that she did not undergo any conservative treatment for these conditions prior to seeing Dr. Mall. Petitioner reported her elbow pain had completely resolved with surgery, other than what she described as post-surgical discomfort. (Rx11).

Dr. Stewart opined that the only condition Petitioner had that was causally related to the accident involving the cart is lateral epicondylitis, including the recurrence that resulted in surgery. He testified that Petitioner had a classic presentation of lateral epicondylitis, with symptoms of the condition, typical treatment, a period of improvement and then a subsequent recurrence. Dr. Stewart testified that Petitioner's carpal tunnel diagnosis was based purely on EMG/NCV, as she was completely asymptomatic for it when the test was taken. He testified that such a diagnosis wouldn't be related to the work accident anyway, as a jerking activity like Petitioner performed with the food cart without a bony injury in and around the carpal tunnel or ulnar nerve, such as a dislocation or fracture, would not have enough traction force to cause such condition. As to cubital tunnel, he opined that it would also not be related to the accident, as tugging on a heavy cart would only cause it if there was enough traction force to dislocate or separate the elbow joint. Dr. Stewart explained that if carpal or cubital tunnel was caused traumatically you would expect the symptoms to develop almost immediately or within a day or two due to the swelling. Dr. Stewart testified that Petitioner did have certain risk factors that could predispose her to the development of carpal and cubital tunnel syndrome, including her age, peri- or postmenopausal state, and history as a smoker. (Rx11). Petitioner had not yet reached MMI post-surgery when Dr. Stewart examined her, but he expected that she would be able to return to her regular work duties. (Rx11).

On cross examination, Dr. Stewart acknowledged he did not have the initial 9/9/14 report of Dr. Butalid, nor any of the records from Dr. Burger. He agreed that he would like to see these records if there were complaints of numbness and tingling in them. He testified that the records of Dr. Bassman note he specifically asked Petitioner about numbness and tingling and she denied it. Thus, even if there had initially been such symptoms, they had completely resolved by the time she saw Dr. Bassman or Dr. Mall. While Dr. Mall's report referenced numbness and tingling findings during provocative testing, such symptoms were not noted in his reporting of Petitioner's stated symptomatic complaints. Dr. Stewart also testified that even if complaints of numbness and tingling are referenced by Dr. Butalid and Dr. Burger, none of the records he reviewed ever indicated any complaints of numbness and tingling in an ulnar or median distribution. Such symptomatic complaints would have more consistently been indicated. He agreed if there were such references, it potentially could alter his opinion. (Rx11).

On redirect, Dr. Stewart testified that complaints of burning in the lateral elbow, dorsal forearm and dorsal base of the thumb would not be in a median or ulnar nerve distribution. Petitioner's complaint to Dr. Butalid on 9/19/14 of numbness of the dorsum of the wrist and elbow would not be indicative of carpal or cubital tunnel. (Rx11).

The Petitioner testified that the surgeries helped with her symptoms, and that post-surgical physical therapy also provided relief. Petitioner testified she still has some ongoing arm/elbow soreness, which seems to be brought on by most activities: "Most everything I do will inflame my elbow, and there's - - its always there." She testified her grip strength is weaker than it used to be, and she still feels muscle soreness with gripping. She also reported her range of motion is "not well," but the Arbitrator notes her demonstration of this at the hearing did not indicate a significant reduction. She tries to avoid using her left arm as much as possible, especially at work. She takes over-the-counter medications, probably one Aleve or two ibuprofen daily, but takes no prescription medications for her left arm.

Petitioner acknowledged that she has been a bow hunter for over 25 years. Post-surgery, she testified she was unable to pull the string back when she tried to do so. She did, however, apply for her bow hunting license this year. She has been released from care by Dr. Mall without restrictions, and has returned to her regular job as a CO with no reduction of wages. She agreed that Dr. Mall indicated she should continue to improve. She has been able to perform her full work duties, and has had no complaints from supervisors regarding her job performance. She continues to perform a home exercise program.

Respondent's representative, Gina Feazel, was present for the hearing but did not testify.

CONCLUSIONS OF LAW

WITH RESPECT TO ISSUE (C), DID AN ACCIDENT OCCUR THAT AROSE OUT OF AND IN THE COURSE OF THE PETITIONER'S EMPLOYMENT BY THE RESPONDENT, THE ARBITRATOR FINDS AS FOLLOWS:

The Arbitrator finds that the Petitioner failed to prove that she sustained accidental injuries arising out of and in the course of her employment on 8/26/15. The evidence presented does not identify a basis for an accidental injury occurring on this date. The Petitioner did not testify to any accident or injury occurring on this date. She did complete left elbow injury paperwork with the Respondent for this date, but the documentation all states the problem was due to an ongoing injury from 9/5/14, other than one entry stating: "due to re use from previous injury." Another stated a shot of cortisone had been working until about one week prior to the report. These statements in and of themselves do not describe an accident under the Act.

The first medical report in evidence subsequent to 8/26/15 is the 9/3/15 report of Dr. Bassman, which notes the Petitioner reported increased left elbow pain after several months of relief after an injection, with no indication of a new accident or injury. Based on this evidence, the Petitioner has failed to prove a compensable 8/26/15 accident.

Based on the Arbitrator's finding that the Petitioner failed to prove an 8/26/15 accident, all other issues are moot.

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

TAMMY WILLIAMS,

Petitioner,

vs. NO: 12 WC 041031

PEORIA PUBLIC SCHOOL DISTRICT 150,

19IWCC0283

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 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 August 27, 2018 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 county, city, town, township, incorporated village, school district, body politic or municipal corporation is required to file a bond to secure the payment of the award and the costs of the proceedings in the court to authorize the court to issue such summons. *820 ILCS 305/19(f)(2)*. Based upon the named Respondent herein, no bond is set by the Commission. The

19IWCC0283

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

DATED: JUN 1 1 2019
DLS/mav
O: 04/09/19
46

Deborah Simpson

Thomas J. Tyrrell

Maria Portela

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

WILLIAMS, TAMMY J
Employee/Petitioner

Case# **12WC041031**

19IWCC0283

PEORIA PUBLIC SCHOOL DISTRICT 150
Employer/Respondent

On 8/27/2018, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 2.18% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

1618 BENASSI & BENASSI PC
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5354 STEPHEN P KELLY
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PEORIA, IL 61604

19IWCC0283

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

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Tammy J. Williams
Employee/Petitioner

v.

Peoria Public School District 150
Employer/Respondent

Case # **12** WC **41031**

Consolidated cases: ____

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Douglas McCarthy**, Arbitrator of the Commission, in the city of **Peoria**, on **7/25/18**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. [ ] Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?

B. [ ] Was there an employee-employer relationship?

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

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

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

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

G. [ ] What were Petitioner's earnings?

H. [ ] What was Petitioner's age at the time of the accident?

I. [ ] What was Petitioner's marital status at the time of the accident?

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

K. [x] What temporary benefits are in dispute?
[ ] TPD [ ] Maintenance [x] TTD

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

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

N. [ ] Is Respondent due any credit?

O. [ ] Other ____

FINDINGS

On **10/15/12**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$64,084.04**; the average weekly wage was **$1,602.10**.

On the date of accident, Petitioner was **53** years of age, ***single*** with **0** dependent children.

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

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

Respondent is entitled to a credit of any benefits paid through group under Section 8(j) of the Act.

ORDER

The Respondent shall pay the reasonable and necessary medical services of **$826.88** pursuant to the medical fee schedule or PPO agreement, whichever is less, as provided in Sections 8(a) and 8.2 of Act and shown in Pet. Ex. 15, Bates 608.

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

Petitioner is denied temporary total disability benefits for this injury.

The arbitrator finds Petitioner sustained no permanency from this accident.

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

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

D. Douglas McCarthy

Aug. 22, 2018

AUG 2 7 2018

Findings Of Fact

On October 15, 2012, Petitioner was a 53-year-old teacher who taught learning disabled students, behavioral students, and emotionally disturbed students, and had been teaching for a period of 19 years. She had an unrelated right knee replacement in June of 2011 which was performed by Dr. Gibbons. Prior to October 2012, Petitioner had been diagnosed with pre-existing medical conditions besides her right knee. Those conditions were fibromyalgia, which she was diagnosed with in 1994, and low back pain, for which she had a spinal stimulator implanted in her back. In addition, Petitioner had suffered a previous work injury that occurred on October 12, 2011.

On October 15, 2012, Petitioner was teaching a class of special education students and next to her assigned area, she kept a crate in which she stored the books that she used for her students. On that day, she got up, turned, and fell into the crate. Petitioner testified that both legs buckled when she went into the crate, and that as she fell, she hit a bookshelf and fell into plastic tubs full of educational games (Arb. Tr. 38). She testified that she was not able to get out of the crate and a gentleman nearby had to come and help her get out of the crate (Arb. Tr. 39).

Petitioner testified that the fall into the crate irritated her right knee, but the significant issue for her was that the fall caused her fibromyalgia to flare up and she had pain from her neck all the way down along her arms and her hips, and that her whole body was in pain, including her low back (Arb. Tr. 39-40). She reported the incident to her supervisor and then went to IWIRC to be evaluated.

Petitioner testified she reported to the doctor at IWIRC about the injury and that the incident did not change the chronic pain in her right knee, but that the fibromyalgia pain increased (Arb. Tr. 40).

Petitioner testified that on the following day, she went to Proctor Hospital's emergency room because her fibromyalgia had gone out of control and she was in severe pain throughout her body (Arb. Tr. 40-41). The emergency room physician noted that Petitioner told him that she had fallen into a crate at school and that now she had severe pain throughout her body. The physician noted that she had a history of fibromyalgia and that she had low back pain. His diagnosis was acute exacerbation of chronic low back pain, and he gave her an injection of Toradol and restricted her from going back to work until the following day (Pet. Ex. 6, Bates 419-426).

Petitioner went to see her rheumatologist, Dr. Vaughn Hanna, on October 29, 2012 and described to Dr. Hanna how she had fallen into a crate at work. She noted that her fibromyalgia was significantly flared up and she had pain throughout her body. His diagnosis was fibromyalgia, degenerative lumbar disease, neck pain, osteoarthritis in her left knee, and right knee status right knee arthroplasty, with pain in her shoulder. He treated her by giving her multiple trigger point injections and released her (Pet. Ex. 4, Bates 144-147).

The Petitioner was referred to Dr. Jianxun Zhou on November 21, 2012 for pain which originated with the twisting injury she underwent on October 12, 2011, but the doctor noted that she also relayed a second injury that had occurred to her approximately a month ago which significantly increased her back pain at that time (Pet. Ex. 7, Bates 453-457).

The Petitioner was examined by Dr. O'Leary, an orthopedist specializing in back care, pursuant to Section 12 of the Act. This was done at the request of the Respondent. Dr. O'Leary's opinions, contained in his evidence deposition, are cited below in the Arbitrator's conclusions of law.

Petitioner testified the fibromyalgia pain that arose from this incident eventually began to subside (Arb. Tr. 83).

Conclusions

In support of the arbitrator's decision relating to F, "is Petitioner's current condition of ill being causally related to the injury," the arbitrator finds and concludes as follows:

> Based on the foregoing findings of fact, the arbitrator finds that the Petitioner testified that she experienced severe pain in her low back and body area that was the result of the flare-up of the fibromyalgia that occurred when she fell into the crate (Arb. Tr. 39). The Proctor Hospital emergency room records described the accident as an acute exacerbation of chronic pain. Dr. O'Leary testified that based upon his examination of September 18, 2014 and his review of all of the treatment records, the accident could have caused the Petitioner to experience temporary lumbar pain. He also noted her extensive history of chronic pain and fibromyalgia. (RX 1 at 24, 25) At arbitration, the Petitioner said that her lower back and fibromyalgia conditions are stable.
>
> Based upon the above, the Arbitrator finds that the injuries sustained to the lower back on October 15, 2012 represented temporary aggravations of her pre-existing condition. Her current complaints with respect to those areas of the body are not causally related to this accident.

In support of the arbitrator's decision relating to 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 and concludes as follows:

> Based on the foregoing findings of fact, the arbitrator finds that the medical services received by Petitioner were reasonable and necessary, and Respondent did not provide for the reasonable and necessary medical services for the Petitioner. However, the Petitioner submitted the bills for her treatment to the medical insurance provided to the Petitioner by the Respondent and the Respondent is entitled to credit for all payments made on the medical bills through the medical insurance program.
>
> The Respondent shall pay the reasonable and necessary medical services of $826.88 pursuant to the medical fee schedule or PPO agreement, whichever is less, as provided in Sections 8(a) and 8.2 of Act and shown in Pet. Ex. 15, Bates 608.

Respondent shall be given a credit of $193.76 for medical benefits that have been paid and Respondent shall hold Petitioner harmless from all claims by any providers for the services for which Respondent is receiving this credit as provided in Section 8(j) of the Act.

In support of the arbitrator's decision relating to K, "what temporary benefits are in dispute, TTD," the arbitrator finds and concludes as follows:

Based upon the foregoing findings of fact, the arbitrator finds that the Petitioner testified that she did not miss any work as a result of this injury (Arb. Tr. 81), but that the work that she missed was related to the injury of October 12, 2011.

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:

Based upon the above conclusions on causation, the Arbitrator finds that the Petitioner sustained no permanency as a result of this accident.

STATE OF ILLINOIS	)
	) SS.
COUNTY OF PEORIA	)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

TAMMY WILLIAMS,

Petitioner,

vs. NO: 16 WC 028305

PEORIA PUBLIC SCHOOL DISTRICT 150,

19IWCC0284

Respondent.

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed August 27, 2018 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 county, city, town, township, incorporated village, school district, body politic or municipal corporation is required to file a bond to secure the payment of the award and the costs of the proceedings in the court to authorize the court to issue such summons. *820 ILCS 305/19(f)(2)*. Based upon the named Respondent herein, no bond is set by the Commission. The

19IWCC0284

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

DATED: JUN 11 2019
DLS/mav
O: 04/09/19
46

Deborah Simpson

Thomas J. Tyrrell

Maria Portela

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

WILLIAMS, TAMMY J Case# **16WC028305**
Employee/Petitioner

PEORIA PUBLIC SCHOOL DISTRICT150 **19IWCC0284**
Employer/Respondent

On 8/27/2018, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 2.18% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in 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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STATE OF ILLINOIS)
)SS.
COUNTY OF **Peoria**)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Tammy J. Williams
Employee/Petitioner

Case # **16** WC **28305**

v.

Consolidated cases: ______

Peoria Public School District 150
Employer/Respondent

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Douglas McCarthy**, Arbitrator of the Commission, in the city of **Peoria**, on **7/25/18**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **9/29/15**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$68,287.00**; the average weekly wage was **$1,764.00**.

On the date of accident, Petitioner was **56** years of age, ***single*** with **0** dependent children.

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

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

Respondent is entitled to a credit of any benefits paid through group under Section 8(j) of the Act.

ORDER

The Respondent shall pay the reasonable and necessary medical services of **$6,543.00** pursuant to the medical fee schedule or PPO agreement, whichever is less, as provided in Sections 8(a) and 8.2 of Act and shown in Petitioner's Exhibit 15, Bates 569-570, 605-607, and 627-639.

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

The arbitrator finds Petitioner was partially disabled to the extent of **5% loss of use of the right leg.**

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

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

D. Dylan McCarty

Signature of Arbitrator

Aug. 22, 2018

Date

AUG 27 2018

Findings Of Fact

The Petitioner was a 56-year-old teacher who taught mentally and physically handicapped children. In June of 2011, she had undergone a right knee replacement. In May of 2014, she had undergone a complete revision of her right knee replacement, and in December of 2014, she underwent an arthroscopic surgery of her right knee. Additionally, the Petitioner had previously been diagnosed with fibromyalgia and low back pain. Earlier in the month of September, notably September 8, 2015, Petitioner had twisted her right knee and had to receive medical treatment with Dr. Piero Capecci for this injury.

On September 29, 2015, Petitioner was working as a special-ed teacher at Thomas Jefferson School. One of her students was an autistic child who was repeatedly trying to run out of the school. On this date, the child attempted to run out of the school and Petitioner and a co-worker were attempting to prevent it when the child kicked Petitioner approximately 2 inches below her right knee. Petitioner immediately experienced a sharp, burning pain where she was kicked. She noted that when she tried to put weight on it, she could tell that something wasn't right in this area. She reported the injury to her school and she was sent by the school to IWIRC on the day this occurred.

She reported to the physician's assistant at IWIRC that she and a co-worker were attempting to get a student in restraints when that student kicked her in the right knee area and bit her right forearm. Petitioner explained to the physician's assistant that she was having significant pain in her right knee area. The physician's assistant also noted in his records that Petitioner told him that she had torn her MCL at the end of July of this year and was treating with Great Plains Orthopaedics for that condition. The physician's assistant diagnosed her with acute right knee contusion, right MCL tear that was not work-related, and that her knee had been replaced twice. He directed that she return to sedentary duty, lifting no more than 10 pounds occasionally, sitting mostly, minimal weight bearing, no altercation risk, and come back to recheck in 5 to 7 days (Res. Ex. 6).

Petitioner saw Dr. Capecci on October 2, 2015 and described for him the incident that occurred on September 25, 2015 with the student kicking her below the right knee and the intense pain that it caused her. Dr. Capecci x-rayed her right knee and determined that the knee prosthesis was in the appropriate location and had not been damaged. He noted that Petitioner was suffering an exacerbation from the trauma sustained from the direct impact to the medial aspect of the right knee and recommended that she come back in 5 weeks (Pet. Ex. 5, Bates 211).

As directed by IWIRC, Petitioner returned to IWIRC on October 5, 2015. She noted to the physician that her pain was better, but her right knee was still quite swollen and that her employer was compliant with the restrictions that were set forth in her last visit at IWIRC. She was diagnosed at that time with acute right knee contusion, prior right MCL tear not work-related, and prior right knee replacement. She was directed to do minimal kneeling and squatting, wear her brace as needed, not be involved in altercation risks, sit as needed, and to return in 7 to 10 days (Res. Ex. 6).

Petitioner testified that Dr. Capecci moved his practice from the City of Peoria to the City of Springfield, Illinois (Arb. Tr. 58). Dr. Capecci last saw the Petitioner on March 7, 2016 when she noted to him that she was still having pain in her right knee. She told him that she could not walk long distances and had to be careful that she does not climb too many stairs. He found that her MCL laxity had improved. His diagnosis was status post revision right total knee arthroplasty with improved ligamentous integrity from recent trauma, and he referred Petitioner for further treatment to Dr. Richard Driessnack of Great Plains Orthopaedics (Pet. Ex. 11).

Petitioner saw Dr. Driessnack for the first time on March 22, 2016. She gave him a detailed history of her past surgeries on her right knee and told him that she had suffered an injury to that knee in September of 2015 when an unruly child somehow bashed into her right knee. Dr. Driessnack noted in his records that Petitioner could not tolerate any direct pressure with palpation to her right knee, particularly in the area of the pes anserine bursa. He found that this tenderness of the pes anserine bursa was definitely Petitioner's major problem at the time of the examination. At that time, he gave her a corticosteroid injection into her right pes anserine bursa and told her to return in 6 weeks (Pet. Ex. 5, Bates 206-207).

When Petitioner returned to see Dr. Driessnack on May 6, 2016, she told him that the injection to her right knee had given her relief. She noted to Dr. Driessnack that her right knee had been doing very well after the revision by Dr. Capecci until she was injured by a child at work which caused her right knee to become very painful (Pet. Ex. 5, Bates 204-205).

Petitioner next saw Dr. Driessnack on July 8, 2016. He noted that she had severe tenderness localized to the pes anserine bursa on the right. At that time, he injected her right pes anserine bursa and told her to come back in 3 months (Pet. Ex. 5, Bates 203).

Petitioner testified that the injections she received from Dr. Driessnack gave her great relief, and that she can receive the injections every 3 months (Arb. Tr. 59). She testified that she notes that towards the end of the 3 months, she begins to feel significant pain in the area slightly below her right knee where she was kicked by the student (Arb. Tr. 60).

Dr. Driessnack saw the Petitioner again on December 28, 2016. He noted that Petitioner was having pain in her right knee, that her right knee had been replaced once and revised once, and that she now had a lot of residual pain in the pes anserine bursa area. He injected her right knee in the pes anserine bursa area and then directed that she come back in 3 months (Pet. Ex. 5, Bates 198-201).

Petitioner next saw Dr. Driessnack on March 28, 2017 and requested that she receive another injection to her right knee pes anserine bursa, which he performed on this date (Pet. Ex. 5, Bates 194).

Petitioner saw Dr. Driessnack on August 1, 2017 when he again injected her right pes anserine bursa. He instructed her to come back in 3 months for her right knee (Pet. Ex. 5, Bates 191-193).

Dr. Driessnack next saw Petitioner on November 7, 2017. Petitioner again discussed with him the improvement in her knee pain with the injections. He noted in his records that the site that he injects is where the learning disabled student kicked Petitioner and that the student kicking Petitioner in the right knee area is what caused her knee problems to flare up and start the whole process that he was dealing with. Dr. Driessnack injected her right knee on that date (Pet. Ex. 5, Bates 186-188).

The Petitioner next saw Dr. Driessnack for her right knee on April 4, 2018. She noted to Dr. Driessnack at that time that shots are a significant help in keeping her right knee pain under control. He diagnosed her at that time with having persistent bursitis pain in the right knee, and injected her in the right pes anserine bursa (Pet. Ex., Bates 175-178).

The Petitioner testified she did not miss any work as a result of this incident, but the pain she was experiencing interfered with her daily activities and she could not walk as far as she did before this injury, she could not swim as far as she did before this injury, she could not mow her yard, she has to be careful how she has her right leg bent, and that she has to be careful going up and down stairs (Arb. Tr. 92, 95-96).

Conclusions

In support of the arbitrator's decision relating to F, "is Petitioner's current condition of ill-being causally related to the injury," the arbitrator finds and concludes as follows:

> Based upon the foregoing facts, the arbitrator finds the Petitioner sustained an injury to her right knee which necessitated the use of several_steroid injections to control her pain and that she will need steroid injections in the future to control her right knee pes anserine bursa pain which arose from being kicked by a student under her control. There is no evidence that she had prior to this time an injury to her pes anserine bursa. The arbitrator notes Dr. Driessnack states in his medical records that the need for injections in the Petitioner's right pes anserine bursa were the result of Petitioner being kicked by the autistic child.

In support of the arbitrator's decision relating to J, "were the medical services that were provided to Petitioner reasonable and necessary." the arbitrator finds and concludes as follows:

> Based upon the foregoing findings of fact, the arbitrator finds that the medical services that were provided to Petitioner were reasonable and necessary to treat Petitioner for the injury she received on September 29, 2015.

In support of the arbitrator's decision relating to J, "has Respondent paid all appropriate charges for all reasonable and necessary medical services," the arbitrator finds and concludes as follows:

> Based upon the foregoing findings of fact and the exhibits provided by Petitioner, the arbitrator finds the Respondent has not paid all appropriate charges for all reasonable and necessary medical services. The Petitioner incurred $6,543.00 in

charges for reasonable and necessary medical services. Of the $6,543.00, Petitioner has paid $824.32 herself. The Respondent shall pay all reasonable and necessary medical services of $6,543.00 pursuant to the medical fee schedule or PPO agreement, whichever is less, as provided in Sections 8(a) and 8.2 of the Act and as shown in Pet. Ex. 15, Bates 569-570, 605-607, and 627-639. Of the $6,543.00, Respondent shall pay directly to Petitioner $824.32.

Respondent should be given a credit of $3,355.36 for the medical benefits that have been paid, and Respondent shall hold Petitioner harmless from all claims by any providers of services for which Respondent is receiving this credit as provided in Section 8(j) of the Act.

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:

Based upon the evidence presented and the foregoing findings of fact, the arbitrator finds that the Petitioner received an injury to her right knee when she was kicked by an autistic student who she and another person were attempting to control, and that Petitioner required continuous treatment to the right knee and will continue to require treatment to the right knee in the future as a result of this injury.

In analyzing the injury using the factors set forth in Section 8.1b of the Act, the Arbitrator notes that there was no AMA report offered into evidence. Accordingly, no weight is attached. On the accident date, the Petitioner was a 56-year old teacher of learning disabled children. Obviously, her job requires her to be on her feet to manage these students. She also needs to handle situations such as the one she faced when she was injured. She will have to deal with the effects of her injury for the rest of her work life. She has no future wage loss. With respect to the objective medical, Dr. Driessnack's ongoing treatment notes, referenced above, provide an ample basis for permanency.

Based upon the above, the Arbitrator finds that the injuries from the accident of September 29, 2015 resulted in an additional 5 % loss of the right leg to the Petitioner, over and above the loss attributed to her accidental injuries of October 12, 2011.

STATE OF ILLINOIS	)		
	) SS.		
COUNTY OF PEORIA	)		

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

TAMMY WILLIAMS,

Petitioner,

vs. NO: 12 WC 040499

PEORIA PUBLIC SCHOOL DISTRICT 150,

19IWCC0285

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, medical expenses, and nature and extent and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed August 27, 2018 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 county, city, town, township, incorporated village, school district, body politic or municipal corporation is required to file a bond to secure the payment of the award and the costs of the proceedings in the court to authorize the court to issue such summons. *820 ILCS 305/19(f)(2)*. Based upon the named Respondent herein, no bond is set by the Commission. The

19IWCC0285

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

DATED: JUN 1 1 2019
DLS/mav
O: 04/09/19
46

Deborah Simpson

Thomas J. Tyrrell

Maria Portela

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

WILLIAMS, TAMMY — Case# **12WC040499**
Employee/Petitioner

PEORIA PUBLIC SCHOOL DISTRICT #150
Employer/Respondent

19IWCC0285

On 8/27/2018, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 2.18% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

1618 BENASSI & BENASSI PC
A LOU BENASSI
300 N E PERRY AVE
PEORIA, IL 61603

5354 STEPHEN P KELLY
ATTORNEY AT LAW
2710 N KNOXVILLE AVE
PEORIA, IL 61604

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

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Tammy Williams
Employee/Petitioner

v.

Peoria Public School District #150
Employer/Respondent

Case # **12** WC **40499**

Consolidated cases: ______

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Douglas McCarthy**, Arbitrator of the Commission, in the city of **Peoria**, on **7/25/18**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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 ______

FINDINGS

On **8/31/11**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

On this date, Petitioner ***did 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 $**62,478.00**; the average weekly wage was $**1,602.00**.

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

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

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

ORDER

- **Petitioner failed to establish an accident which arose out of, and in the course of employment, while working for the Respondent on August 31, 2011.**
- **All benefits are denied.**

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

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

Signature of Arbitrator

Aug. 22, 2018
Date

AUG 27 2018

FACTS IN CASE

The Petitioner was employed by the Respondent as a school teacher for over a 25 year time period (A.T. 16).

The Petitioner underwent a right knee replacement by Dr. Gibbons in the summer of 2011 (A.T. 16-17). The Petitioner suffers from Fibromyalgia, which she had prior to August 2011 (A.T. 17).

In August 2011, the Petitioner was assigned to Trewyn Middle School (A.T. 18). The Petitioner's assignment at Trewyn Middle School was to teach on the third floor. The Petitioner identified that she would have to go up and down stairs that would vary up to 40 stairs to be climbed (A.T. 19).

In August 2011, the Petitioner started noticing pain in her right knee. This is the knee she had a prior right knee replacement (A.T. 19). The Petitioner reported having pain to her supervisor (A.T. 20). The Petitioner sought treatment from her personal physician, Dr. Hicok (A.T. 20).

The Petitioner testified that Dr. Hicok gave her two series of shots to her right knee (A.T. 22). The Respondent also assigned the Petitioner to a job task that did not require her to climb as many stairs (A.T. 22).

The Petitioner was reassigned to teach at Thomas Jefferson, which was on the first floor (A.T. 24). While working at Thomas Jefferson, the Petitioner's right knee got better (A.T. 24).

The medical records of Dr. Hicok dated August 31, 2011 reveals the Petitioner provided a history of Fibromyalgia, chronic pain, with status post right knee replacement. The history to Dr. Hicok was Petitioner has had a hard time walking stairs (Pet Exh. 2).

The Petitioner was able to go back to work and complete the school year in 2011. The Petitioner testified later in the case that she sustained a new injury to her right leg on or about October 12, 2011, October 15, 2012, September 8, 2015, and September 29, 2015.

The Petitioner testified at trial that she believed her right knee condition was related to the alleged October 12, 2011 accident (A.T. 78-79).

C. DID AN ACCCIDENT OCCUR THAT AROSE OUT OF AND IN THE COURSE OF PETITIONER'S EMPLOYMENT BY RESPONDENT?

The Arbitrator finds that the Petitioner alleged an accident as a result of climbing stairs. The Petitioner testified that she was required to climb stairs at her school she was assigned to for a two week period. The Petitioner could not identify the exact amount of times she had to climb the stairs. In fact, testified that the use of the stairs varied in nature.

The evidence establishes that he Petitioner was recovering from a non-work related right knee replacement on 8/31/11. The Petitioner admitted that she was still in recovery from the prior surgery. There was no testimony from the Petitioner of any work injury to her knee on 8/31/11.

The Arbitrator finds that the Petitioner failed to establish an accident arouse of and in the course of Petitioner's employment by Respondent.

F. IS PETITIONER'S CURRENT CONDITION OF ILL-BEING CAUSALLY RELATED TO THE INJURY?

The Arbitrator notes that the Petitioner sought conservative care after the activities of August 31, 2011. The Petitioner testified to there never being an accident where she felt were the reason for her condition of ill-being at the time of trial. Additionally, there was no medical evidence that the Petitioner's condition of ill-being was permanently aggravated by the work activities of August 31, 2011.

Wherefore, the Arbitrator finds that the Petitioner failed to establish that her condition of ill-being was causally related to the accident that arouse out of the course of employment.

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

TAMMY WILLIAMS,

Petitioner,

vs. NO: 18 WC 012171

PEORIA PUBLIC SCHOOL DISTRICT 150, **19IWCC0286**

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 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 August 27, 2018 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 county, city, town, township, incorporated village, school district, body politic or municipal corporation is required to file a bond to secure the payment of the award and the costs of the proceedings in the court to authorize the court to issue such summons. *820 ILCS 305/19(f)(2)*. Based upon the named Respondent herein, no bond is set by the Commission. The

19IWCC0286

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

DATED: JUN 11 2019
DLS/mav
O: 04/09/19
46

Deborah Simpson

Thomas J. Tyrrell

Maria Portela

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

WILLIAMS, TAMMY J
Employee/Petitioner

Case# **18WC012171**

19IWCC0286

PEORIA PUBLIC SCHOOL DISTRICT 150
Employer/Respondent

On 8/27/2018, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 2.18% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

1618 BENASSI & BENASSI PC
A LOU BENASSI
300 N E PERRY AVE
PEORIA, IL 61603

5354 STEPHEN P KELLY
ATTORNEY AT LAW
2710 N KNOXVILLE AVE
PEORIA, IL 61604

STATE OF ILLINOIS)
)SS.
COUNTY OF Peoria)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Tammy J. Williams
Employee/Petitioner

Case # 18 WC 12171

v.

Consolidated cases: ______

Peoria Public School District 150
Employer/Respondent

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Douglas McCarthy**, Arbitrator of the Commission, in the city of **Peoria**, on **7/25/18**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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 ______

FINDINGS

On **9/8/15**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$68,287.00**; the average weekly wage was **$1,764.00**.

On the date of accident, Petitioner was **56** years of age, ***single*** with **0** dependent children.

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

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

Respondent is entitled to a credit of any benefits paid through group health under Section 8(j) of the Act.

ORDER

Respondent shall pay reasonable and necessary medical services of **$685.00** pursuant to the medical fee schedule or a PPO agreement, whichever is less, as provided in Sections 8(a) and 8.2 of the Act and shown in Petitioner's Exhibit 15, Bates 605.

Respondent shall be given credit for medical benefits that have been paid through its group carrier 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.

The arbitrator finds Petitioner suffered no permanency as a result of the accident.

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

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

D. Dylan McCarthy

Signature of Arbitrator

Aug. 22, 2018

Date

AUG 2 7 2018

Findings Of Fact

The Petitioner was a 56-year-old teacher who taught mentally and physically handicapped children. In June of 2011, she had undergone a right knee replacement. In May of 2014, she had undergone a complete revision of her right knee replacement, and in December of 2014, she underwent an arthroscopic surgery of her right knee. Additionally, the Petitioner had previously been diagnosed with fibromyalgia and low back pain.

On September 8, 2015, Petitioner was working as a special-ed teacher at Thomas Jefferson School. One of her students was an autistic child who repeatedly tried to run out of the school. On this date, the child attempted to run out of the school and Petitioner twisted to grab her to prevent her from running out of the building and ended up twisting her right knee. Petitioner testified that it caused immediate pain in her right knee (Arb. Tr. 52). Petitioner further testified that she reported the injury (Arb. Tr. 53), and Respondent has offered no evidence or testimony to refute that statement by the Petitioner.

The day after the injury, the Petitioner went to her treating physician, Dr. Piero Capecci, and noted to him that the day before, she was trying to restrain an autistic child who was trying to run out of the door and she pivoted and twisted her right knee. Dr. Capecci noted that this was the knee that was already impaired. He noted that she had swelling in the right knee, and that the knee was very painful (Pet. Ex. 5, Bates 214-215). At that meeting, Dr. Capecci provided to the Petitioner permanent work restrictions of "cannot chase or run after students" (Pet. Ex. 5, Bates 297).

Petitioner next saw Dr. Capecci on September 25, 2015 and noted to him that she was still having significant pain over the medial aspect of her right knee. Dr. Capecci noted that the Petitioner had pain to palpation over the distal insertion of the MCL with slight instability and about 30 degrees of flexion. His diagnosis was painful right total knee arthroplasty with MCL strain. He instructed her to wear her brace full time and avoid swimming unless she was going to wear the brace while she swims (Pet. Ex. 5, Bates 212-213).

On September 29, 2015, Petitioner again injured her right knee at school as discussed in the decision regarding that injury (16 WC 28305).

Petitioner next saw Dr. Capecci on November 13, 2015. She noted that she was still having significant pain over her right knee. He noted that she was having pain over the MCL insertion site and that this pain site was consistent with a strain more than a rupture and was likely the consequence of the injury sustained on September 8, 2015 when she had the incident with the autistic child at work (Pet. Ex. 5, Bates 209-210).

Petitioner saw Dr. Capecci again on November 30, 2015. She again complained of right knee pain and that she had tried swimming without her brace and it only made the right knee pain worse. His diagnosis was painful revision of the right total knee arthroplasty with likely medial collateral ligament insertion site injury more consistent with a strain than a rupture, as a result of the injury sustained on September 8, 2015 (Pet. Ex. 5, Bates 208).

The Petitioner testified she did not miss any work as a result of this incident, but the pain she was experiencing in her right knee did interfere with her sleeping at night, unless she slept in the brace (Arb. Tr. 53-54).

Conclusions

In support of the arbitrator's decision relating to C, "did an accident occur that arose out of the course of Petitioner's employment by Respondent, the arbitrator finds and concludes as follows:

> Based on the foregoing, the arbitrator finds that the Petitioner did have an accident that arose out of and in the course of Petitioner's employment as a teacher by Respondent. The arbitrator notes that when Petitioner went to see her personal physician, Dr. Capecci, she described the accident that occurred on September 8, 2015 and that she had injured and twisted her right knee trying to restrain an autistic child from running out the door.

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 testified that she notified her employer of the accident (Arb. Tr. 53) and the Respondent has presented no testimony or evidence to contradict the Petitioner.

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 had three right knee surgeries prior to the date of injury. She testified that as a result of the September 8, 2015 injury, she had significant pain in her right knee and that she was having trouble sleeping at night because the pain was affecting her (Arb. Tr. 53-54).
>
> The Petitioner was treating exclusively with Dr. Capecci for her knee. A review of his office notes from before and after the accident leads to the conclusion that the accident represented a temporary aggravation of her pre-existing condition which was a strain of the medial collateral ligament. When the doctor saw the Petitioner on July 29, 2015, she reported having significant pain with increased activities over the area of the medial collateral ligament. She had been following up with Dr. Capecci after her arthroscopic surgery in December 2014. He suspected an MCL strain. When she returned one day after her accident, on September 9, 2015, he noted that there was not a lot of swelling and continued tenderness over the MCL. His diagnosis was that of an MCL strain. Her next office visit of September 25, 2015 produced essentially the same findings. Her next visit was on October 2, 2015. On that date, which was after her next alleged accident on September 29, 2015, her complaints were different. Dr. Capecci said that she had a direct impact injury to the medial aspect of the knee. Her further treatment focused on that injury. (PX 5 at 211-217)

Accordingly, the Arbitrator finds that the accident of September 9, 2015 is not causally related to the Petitioner's present condition of ill being.

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 foregoing findings of fact, the arbitrator finds that the medical services that were provided to Petitioner were reasonable and necessary, and that the Respondent did not provide for the reasonable and necessary medical services for Petitioner. However, the Petitioner submitted the bills for her treatment to the medical insurance provided to the Petitioner by the Respondent, and the Respondent is entitled to a credit for all payments made on the medical bills through the medical insurance program. The Petitioner incurred $685.00 in charges for reasonable and necessary medical services, of which Petitioner paid $151.60 herself.

The Respondent shall pay the reasonable and necessary medical services of $685.00 pursuant to the medical fee schedule or PPO agreement, whichever is less, as provided in Sections 8(a) and 8.2 of the Act and as shown in Pet. Ex. 15, Bates 605. Of the $685.00, Respondent shall pay directly to Petitioner $151.60.

Respondent should be given a credit of $396.40 for the medical benefits that have been paid, and Respondent shall hold Petitioner harmless from all claims by any providers of services for which Respondent is receiving this credit as provided in Section 8(j) of the Act.

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:

Based upon the evidence presented and the foregoing findings of fact, the arbitrator finds that the Petitioner suffered an aggravation of her pre-existing right knee injury.

However, based upon the records of Dr. Capecci, as noted above, the Arbitrator finds no permanency attributable to the accident.

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 Down	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

TAMMY WILLIAMS,

Petitioner,

vs. NO: 12 WC 041030

PEORIA PUBLIC SCHOOL DISTRICT 150, 19IWCC0287

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petitions for Review having been filed by Respondent and Petitioner herein and notice given to all parties, the Commission, after considering the issues of temporary total disability, temporary total disability rate, 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 Decision of the Arbitrator is modified only with respect to the temporary total disability rate and to the extent Petitioner is permanently disabled. The Decision of the Arbitrator is otherwise affirmed and adopted.

The Commission finds the Arbitrator erroneously determined Petitioner's temporary total disability rate exceeded the maximum temporary total disability rate that was in force as of the date of the accident, declaring Petitioner's temporary total disability rate to be $946.06 per week.

The parties stipulated Petitioner's average weekly wage was $1,602.10. Applying the formula as stipulated in Section 8(b) of the Act, Petitioner's temporary total disability rate is two-thirds of her average weekly wage, $1,068.10 per week. The maximum temporary total disability rate, as of the date of the accident, was $1,261.41 per week. Given that Petitioner's temporary total disability rate of $1,068.10 per week was less than the maximum temporary total disability rate, the Arbitrator should have found Petitioner's temporary total disability rate to be

$1,068.10 per week, not $946.06 per week. The Commission modifies the Decision of the Arbitrator accordingly.

The Commission further modifies the Decision of the Arbitrator with respect to permanent disability. The Commission agrees with the Arbitrator's analysis under Section 8.1(b) of the Act except the Commission concludes Petitioner's permanent disability to be slightly less impairing than did the Arbitrator and, therefore, finds Petitioner sustained a 35% loss of the right leg.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $1,068.10 per week for a period of 12-1/7weeks, 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 $961.26 per week for a period of 35 weeks, as provided in §8(e) of the Act, for the reason that the injuries sustained caused the 35% loss of use of the right leg.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $168,439.75 pursuant to the medical fee schedule or a PPO agreement, whichever is less as provided in §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.

No county, city, town, township, incorporated village, school district, body politic or municipal corporation is required to file a bond to secure the payment of the award and the costs of the proceedings in the court to authorize the court to issue such summons. *820 ILCS 305/19(f)(2).* Based upon the named Respondent herein, no bond is set by the Commission. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: JUN 11 2019
DLS/mav
O:04/09/19
46

Deborah L. Simpson

Thomas J. Tyrrell

Maria E. Portela

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

WILLIAMS, TAMMY J
Employee/Petitioner

Case# **12WC041030**

PEORIA PUBLIC SCHOOL DISTRICT 150
Employer/Respondent

19IWCC0287

On 8/27/2018, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 2.18% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

1618 BENASSI & BENASSI PC
A LOU BENASSI
300 N E PERRY AVE
PEORIA, IL 61603

5354 STEPHEN P KELLY
ATTORNEY AT LAW
2710 N KNOXVILLE AVE
PEORIA, IL 61604

19IWCC0287

STATE OF ILLINOIS)
)SS.
COUNTY OF Peoria)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Tammy J. Williams
Employee/Petitioner

Case # 12 WC 41030

v.

Consolidated cases: _____

Peoria Public School District 150
Employer/Respondent

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Douglas McCarthy**, Arbitrator of the Commission, in the city of **Peoria**, on **7/25/18**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **10/12/11**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$64,084.04**; the average weekly wage was **$1,602.10**.

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

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

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

Respondent is entitled to a credit of any benefits paid through group under Section 8(j) of the Act.

ORDER

Respondent shall pay reasonable and necessary medical services of **$168,439.75** pursuant to the medical fee schedule or a PPO agreement, whichever is less, as provided in Sections 8(a) and 8.2 of the Act and shown in Petitioner's Exhibit 15, Bates 569, 588-604, 609-617, and 619-626.

Respondent shall be given credit for medical benefits that have been paid through its group carrier and Respondent shall hold Petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit as provided in Section 8(j) of the Act.

Respondent shall pay Petitioner temporary total benefits of $946.06 (SAWW) per week for 12-1/7 weeks for the period of **May 20, 2014 to August 13, 2014**, for a total of **$11,487.87** as provided in Section 8(b) of the Act.

The arbitrator finds Petitioner was partially disabled to the extent of **40% of her right leg.**

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

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

Signature of Arbitrator

Aug. 22, 2018
Date

ICArbDec p. 2

AUG 2 7 2018

Findings Of Fact

The Petitioner was a 52-year-old teacher who taught mentally and physically disabled children. In June of 2011 she had undergone a right knee replacement. She had previously been diagnosed with fibromyalgia and low back pain, for which she had undergone the implantation of a spinal stimulator.

On October 12, 2011, Petitioner was standing outside her classroom when one student pushed a second student who impacted with the left rear shoulder of the Petitioner. The Petitioner testified that the impact drove her body twisting around her right knee (Arb. Tr. 26). She heard a pop and felt instant severe pain in her right knee, which was worse in the back of her right knee. It felt like someone was stabbing her in the back of the right knee with a knife. As she started to fall to the floor, a man in the area caught her and prevented her from hitting the floor. She had such severe pain in her right knee afterwards that she could not stand on her right leg. The Petitioner testified that someone brought a chair with wheels on it and they wheeled her out to the principal's car (Arb. Tr. 27). The principal then drove her to IWIRC.

The Petitioner testified that the IWIRC doctor looked over her swollen right knee and said it looked like a sprain. He restricted Petitioner to sedentary duty and instructed her to elevate the knee, ice it up to 4 times a day, and take two different kinds of medication (Arb. Tr. 27-28).

The Petitioner testified that in addition to injuring her right knee, the twisting accident caused her fibromyalgia to flare up (Arb. Tr. 30).

The Petitioner went to see Dr. Gibbons on October 17, 2011 and explained the accident to him and told him she was having severe pain in the lateral part of her right knee. Dr. Gibbons noted the swelling in her right knee, the tenderness across her right knee, and the tenderness in the anterior portion of her right knee. He diagnosed her with having a right knee sprain and directed her to remain off work until further notice. Dr. Gibbons referred Petitioner to Midwest Orthopaedics for physical therapy, which she underwent for approximately 10 months (Pet. Ex. 3, Bates 131). In addition to sending her to physical therapy, Petitioner testified that Dr. Gibbons ordered various tests to determine the reason for her severe right knee pain (Arb. Tr. 30).

The Petitioner testified that her fibromyalgia pain did not subside and she went to see Dr. Hanna (Arb. Tr. 30). When she saw Dr. Hanna, she complained of pain in her neck, right shoulder, low back and right knee. Dr. Hanna noted that her right knee was swollen and very painful and that additionally, she was suffering from a fibromyalgia flare-up, low back pain, neck pain, and shoulder pain. He directed that she continue with physical therapy and he injected the upper cervical and right shoulder area with multiple trigger point injections (Pet. Ex. 4, Bates 166-168).

The Petitioner treated with Dr. Gibbons for the 10-month period after the accident. He prescribed and she underwent multiple conservative treatment modalities, and he kept Petitioner off work (Pet. Ex. 3).

Petitioner testified that if she was on her feet moving around, the pain in her knee would increase substantially (Arb. Tr. 31). She used a walker extensively in her home and if she had to go

outside of her home, she used a cane or a walker. To get relief from her right knee pain, she had to sit and not move; however, the more she sat, the more her fibromyalgia flared up. The fibromyalgia was helped by activity and because she couldn't walk or move to any great extent without severe right knee pain, the fibromyalgia was very active and painful.

On March 21, 2012, the Respondent sent Petitioner to Springfield to see Dr. Ronald Romanelli for an IME opinion. Dr. Romanelli opined that the twisting injury to her right knee may have torn the posterior cruciate ligament and caused some post-lateral looseness in her right knee. He found this by putting her right knee into various positions and determining that there was an instability in her right knee. He also opined that it was pertinent that she had fibromyalgia, as this was probably contributing to the level of her pain, and he further opined that the fact she had a spinal cord stimulator and history of sciatic issues were all probably related to the amount of pain she was undergoing and the persistent discomfort in her right leg. In his IME, he provided suggestions for Dr. Gibbons to follow up on [Res. Ex. 2 (Dr. Romanelli Deposition Exhibit 2)].

Petitioner testified that she personally gave Dr. Gibbons the IME report from Dr. Romanelli and that he glanced through it and said he did not agree with Dr. Romanelli's suggestions as to the looseness and instability of her right knee and treatment options he could perform (Arb. Tr. 34). He did state that he agreed with Dr. Romanelli that her fibromyalgia could be a significant contributing factor (Pet. Ex. 3, Bates 93).

On May 16, 2012, Respondent sent Petitioner for another IME with Dr. Scott Sporer at Midwest Orthopedics at Rush. Dr. Sporer, after examining the medical records, examining the Petitioner, and Petitioner explaining how she suffered a twisting injury at school when she was struck by a student, opined that in his opinion the majority of her symptoms were related to insertional hamstring tendonitis. He recommended that she undergo continuing physical therapy (Res. Ex. 7).

Petitioner testified that her knee remained painful and she sold her home because she had to go up and down stairs to do laundry and up and down stairs to take the dogs out at her home (Arb. Tr. 45).

The Petitioner testified that after months of conservative treatment, the pain in her right knee and her fibromyalgia pain were reduced but neither ever went away and each flared up with any activity (Arb. Tr. 32). She requested of Dr. Gibbons that he release her from his care and allow her to return to work because nothing was providing her with permanent relief and she needed the additional income of her full salary. Dr. Gibbons released Petitioner from his care and allowed Petitioner to return to full duties for the 2012/2013 school year beginning in August of 2012 (Pet. Ex. 3, Bates 82).

Petitioner testified that at no point during the period from October 12, 2011 until she returned to work as a teacher in August of 2012 did she ever have a period of being pain-free in her right knee and from her fibromyalgia, but that the pain would decrease depending upon her activities during that period (Arb. Tr. 31-32).

Petitioner testified that she returned to her employment as a teacher in August of 2012. She testified that when she went back to work as a teacher, she was required to be up and down and walk a great deal. This caused her right knee to begin to swell again and the pain level in her right knee to go up significantly (Arb. Tr. 35-36).

Petitioner testified that at that time she decided to seek another opinion from an orthopedic surgeon and went to see Dr. Piero Capecci at Great Plains Orthopedics (Arb. Tr. 34-35). Petitioner first saw Dr. Capecci on October 10, 2012 (Pet. Ex. 5, Bates 279-281). At the October 10, 2012 appointment, she explained to Dr. Capecci that she had had a total right knee replacement in June of 2011 but had injured her right knee and back when she was struck from behind by a student and twisted her right knee. He noted she had a fluid collection on the back side of her right knee that needed to be explored to determine its origin. In addition, he recommended that she undergo a CT scan and be referred to a spine specialist for an evaluation to first rule out a herniated disc (Pet. Ex. 5, Bates 279-281).

Shortly after Petitioner saw Dr. Capecci for her right knee, she was involved in another work incident where she fell into a crate on October 15, 2012. This incident and her injuries are described more fully in the opinion filed for that accident (12 WC 41031).

In order to find the reason for Petitioner's right knee pain, Dr. Capecci began referring Petitioner to other specialists to rule out other potential causes for the right knee pain. Dr. Capecci referred the Petitioner to Dr. Jianxun Zhou for an evaluation of her low back pain and whether or not that was contributing to her right knee pain. Dr. Zhou noted the Petitioner had increased back and right knee pain after a work-related injury where she twisted her knee one year before. Dr. Zhou recommended additional outpatient physical therapy and Petitioner was restricted to no running or jumping activities. He began a trial period of Gabapentin and told her to return if her symptoms persisted (Pet. Ex. 7, Bates 453-457).

At a later point, Dr. Zhou saw Petitioner for a follow up of her back pain and referred the Petitioner to see Dr. Daniel Fassett to see if he had any other suggestions for her back pain (Pet. Ex. 7, Bates 461-462).

On December 26, 2012, Petitioner saw Dr. Capecci and he noted that her right leg was buckling on her and she felt weak. He noted a palpable fluid collection on the back of her right knee (Pet. Ex. 5, Bates 273).

The Petitioner saw Dr. Daniel Fassett on January 17, 2013. She described the injury where she was struck by a student in October of 2011 and explained that she had injured her right knee and that she had developed severe pain in her low back and her right leg. Dr. Fassett noted that Petitioner was in obvious distress due to her pain. He further noted that she had motor deficits in her right leg in dorsiflexion, knee flexion, knee extension, and hip flexion. He recommended that she undergo an EMG study of her right leg to better differentiate the source of her right leg pain and weakness (Pet. Ex. 8, Bates 475-476).

Petitioner began physical therapy at IPMR, which continued for approximately six weeks thereafter (Pet. Ex. 9).

Dr. Capecci also referred Petitioner to the Illinois Regional Pain Institute where she saw Dr. Glen Feather and again described the accident of October 2011 where she twisted her right knee and the problems it was causing to her right knee and low back. She told him the pain was worse in the posterior of right knee and the right knee pain was present every day but it varied in intensity depending on the time of the day. Dr. Feather opined that Petitioner may have injured the tendon or some other type of ligament in the right knee. He recommended that she increase her Gabapentin and that she talk to the neurosurgeon about possible surgical options and consider turning her spinal stimulator back on to see if that helped (Pet. Ex. 10).

Petitioner testified that she continued to see Dr. Capecci for her right knee pain and Dr. Hicok for her chronic pain syndrome. Dr. Capecci referred Petitioner to Dr. Tracy at INI to have her dorsal column stimulator removed (Arb. Tr. 43).

Petitioner saw Dr. Tracy on June 13, 2013 to set up the removal of the spinal stimulator because she wanted to have an MRI done and the doctor would not do an MRI as long as she had the spinal stimulator in her back (Pet. Ex. 8, Bates 482-485). Dr. Tracy removed the spinal stimulator on June 17, 2013 (Pet. Ex. 8, Bates 482).

The Petitioner testified that the statement in the medical records of INI for June 13, 2013, that she was involved in a motor vehicle accident, was totally incorrect and she does not understand where that came from (Arb. Tr. 84). She testified she was not involved in a motor vehicle accident (Arb. Tr. 85). The arbitrator notes that this reference to a motor vehicle accident does not appear in any other medical records provided by Petitioner or Respondent. Respondent has introduced no evidence to contradict Petitioner's sworn testimony other than the reference in Dr. Tracy's notes. Petitioner was referred to Dr. Tracy for the purpose of the removal of her DCS so she could have an MRI done. The arbitrator finds the Petitioner to be creditable in her denial of being in a motor vehicle accident.

On June 28, 2013, an MRI was done of Petitioner's right knee, but the exam was limited because of the metallic artifact from the Petitioner's total knee prosthesis (Pet. Ex. 5, Bates 330).

On July 26, 2013, Dr. Capecci noted that the MRI had been of limited use because of the metal artifact in her knee and further noted that she had a soft tissue mass posterolaterally that was yet to be identified (Pet. Ex. 5, Bates 259).

Respondent sent Petitioner to Dr. Ronald Romanelli for a second IME on September 28, 2013. After examining the records and the Petitioner a second time, he opined that the incident where Petitioner fell into the crate on October 10, 2012 did not aggravate or exacerbate anything regarding her right knee (Res. Ex. 2, pp. 40-41). He further opined that she probably strained her low back when this incident occurred. Petitioner noted to Dr. Romanelli at the time of the IME that she had a giving away sensation in her right knee and that she did not feel her right knee was stable. She noted to him that she could only walk on level ground and that any type of twisting aggravated her condition with her right knee. After examining her right knee, he noted that there was instability in her right knee at complete extension as well as at 30 degrees flexion. He further noted that her lateral joint line gapped during the test and that this laxity was more than one

would expect and that it was uncommon and something he had never seen before [Res. Ex. 2 (Dr. Romanelli Deposition Exhibit 3)].

In his deposition, Dr. Romanelli opined that if the Petitioner did not miss a lot of work prior to October 12, 2011, but missed a significant amount of work after that date, then in his opinion the tearing of the ligaments in the back of her right knee had happened on October 12, 2011 (Res. Ex. 2, p. 47). Petitioner testified that she missed 2 days' work after having to climb the stairs multiple times a day when she returned to work after her first right knee replacement (Arb. Tr. 25), and 10 months' work after the October 12, 2011 twisting accident where she twisted her right knee (Arb. Tr. 29).

Dr. Romanelli opined in his deposition that if the cruciate ligament had gotten stretched or torn in the work injury where she twisted her right knee, then Petitioner would need a revision and he believes that is what happened in this case. He further opined that Petitioner had a total right knee instability that required a revision (Res. Ex. 2, pp. 25 and 29).

Dr. Capecci noted in his records that he spoke to Dr. Romanelli on September 25, 2013. At that point, according to Dr. Capecci's records, Dr. Romanelli told Dr. Capecci that there could be a posterolateral corner tear of the ligament and that this could be the result of the trauma she sustained when she was struck by the student. Dr. Capecci noted that both he and Dr. Romanelli agreed that bracing would be beneficial to the Petitioner to see how she responded to the bracing before any further surgery was considered (Pet. Ex. 5, Bates 253).

Petitioner testified that Dr. Capecci ordered a new brace for her, which was very beneficial for her, and that wearing the brace dramatically reduced the pain she was having in her right knee (Arb. Tr. 46).

Dr. Capecci noted when he saw the Petitioner on February 12, 2014, that the brace was helping but she still had knee pain that was the result of lateral ligamentous insufficiency and that this was caused by the injury she sustained at work after she had had an initial right knee replacement (Pet. Ex. 5, Bates 248-249).

On May 20, 2014, Dr. Capecci replaced the Petitioner's right artificial knee. He noted in the surgical records, "there was noted to be gross instability both anteriorly and posteriorly due to posterior cruciate insufficiency as well as mediolateral instability in flexion and extension" (Pet. Ex. 5, Bates 287). Dr. Capecci opined that Petitioner was doing very well with her original right knee replacement until she had the injury at work, which ultimately led to her right knee being revised (Pet. Ex. 5, Bates 243).

Petitioner testified that the pain level in her right knee went down dramatically after the second knee replacement (Arb. Tr. 49) and that after her right knee replacement on May 20, 2014, she was off work for part of May, June, July, and part of August. She testified she was not paid workers' compensation for this period (Arb. Tr. 47).

Dr. Capecci referred Petitioner to physical therapy which she attended from June 9, 2014 to July 3, 2014 (Pet. Ex. 5, Bates 388-406).

Dr. Capecci released Petitioner to return to work on August 13, 2014 (Pet. Ex. 5, Bates 237).

Petitioner testified that after a period of time, she developed a clicking in her right knee (Arb. Tr. 51). Dr. Capecci did a right knee arthroscopy on December 30, 2014 (Pet. Ex. 5, Bates 289 - 290). Petitioner testified that the arthroscopic surgery alleviated the clicking (Arb. Tr. 51).

Dr. Capecci released Petitioner to return to work following the arthroscopic surgery on January 12, 2015 with restrictions (Pet. Ex. 5, Bates 296).

On August 26, 2015, Dr. Romanelli wrote a report based upon a review of his previous IMEs and additional records provided to him by the Respondent. He opined that Petitioner was doing well with the June, 2011 right knee replacement done by Dr. Gibbons until the accident which aggravated the right knee replacement [Res. Ex. 2 (Romanelli Deposition Exhibit 4)].

He opined to a reasonable degree of medical certainty that the Petitioner developed right knee instability from the accident where she was struck by a student and twisted her right knee which required revision arthroplasty from Dr. Capecci on May 20, 2014. [Res. Ex. 2 (Romanelli Deposition Exhibit 4)].

He further opined that Petitioner's right knee replacement by Dr. Capecci should correct the problem that he diagnosed in Petitioner in March 2012 [Res. Ex. 2 (Romanelli Deposition Exhibit 4)]. In his March 21, 2012 IME letter, Dr. Romanelli noted Petitioner stated her right knee injury occurred when she was at school when she was bumped by a student causing her to fall and twist her right knee.

Respondent also sent the Petitioner to Dr. O'Leary, an orthopedic specialist, for a Section 12 examination on September 18, 2014. The doctor testified by way of deposition, and his opinions were limited to the Petitioner's lower back and fibromyalgia conditions. (RX 1) He opined that the accident could have aggravated her conditions. (Id at 36) He said that the injuries could have caused temporary low back pain. (Id at 24, 25)

Petitioner testified that the pain level in her knee was down, but she could not walk or swim as far as she could before the injury and had to be careful going down stairs (Arb. Tr. 61). She also said that her lower back and fibromyalgia conditions were stable.

Conclusions

In support of the arbitrator's decision relating to F, "is Petitioner's current condition of ill being causally related to the injury," the arbitrator finds and concludes as follows:

> The Petitioner testified that she had gone back to baseline with regards to the pain in her knee, the flare-up of her fibromyalgia, and her back pain and was doing well. On October 12, 2011, she was struck on the left rear by a student which caused her to twist around her right knee (Arb. Tr. 74). This caused her right knee

to become very painful, swollen, and difficult for the Petitioner to walk. She had the surgery to replace her right knee on May 20, 2014. The arbitrator finds that the Petitioner's injury sustained to her right knee necessitated the right knee replacement she underwent on May 20, 2014 and the subsequent arthroscopic repair to her right knee which was done on December 30, 2014. The Petitioner testified that even after replacement of her right knee and the arthroscopic surgery to her right knee, she still cannot walk as far as she did before the injury, she cannot swim as far as she did before the injury, and she has to be careful going up and down stairs. She testified that her knee is much better since the revision and arthroscopic surgery, but it is not the same as it was before the injury (Arb. Tr. 94-95). With respect to the lower back and fibromyalgia, the Arbitrator relies upon the opinions of Dr. O'Leary, findings the accident caused a temporary aggravation of those conditions.

In support of the arbitrator's decision relating to J, "were the medical services that were provided to Petitioner reasonable and necessary," the arbitrator finds and concludes as follows:

Based on the foregoing findings of fact, the arbitrator finds that the medical services that were provided to Petitioner were reasonable and necessary to treat Petitioner for the injuries she received on October 12, 2011 and the subsequent issues arising therefrom.

In support of the arbitrator's decision relating to J, "has Respondent paid all appropriate charges for all reasonable and necessary medical services," the arbitrator finds and concludes as follows:

Based on the foregoing findings of fact and the exhibits provided by Petitioner, the arbitrator finds that Respondent has not paid all appropriate charges for all reasonable and necessary medical services. The Petitioner incurred $168,439.75 in charges for reasonable and necessary medical services after Respondent stopped paying the charges for Petitioner in August of 2012. Of the $168,439.75, $3,192.00 remains outstanding, and Petitioner has paid $3,145.88.

The Respondent shall pay reasonable and necessary medical services of $168,439.75 pursuant to the medical fee schedule or PPO agreement, whichever is less, as provided in Sections 8(a) and 8.2 of the Act and shown in Pet. Ex. 15, Bates 569, 588-604, 609-617, and 619-626. Of the $168,439.75, Respondent shall pay directly to Petitioner $3,145.88.

Respondent should be given a credit of $86,052.38 for medical benefits that have been paid and Respondent shall hold Petitioner harmless from any claims by any providers of services for which Respondent is receiving this credit as provided in Section 8(j) of the Act.

The outstanding medical is as follows:

IPMR $2,550.00

OSFMG, INI	204.00
OSFMG, INI	124.00
OSFMG, INI	314.00
	$3,192.00

In support of the arbitrator's decision relating to K, "what temporary benefits are in dispute, TTD," the Arbitrator finds and concludes as follows:

> Based upon the evidence presented and the foregoing findings of fact, the arbitrator finds the Respondent shall pay Petitioner temporary total benefits of $946.06 (SAWW) per week for 12-1/7 weeks for the period of May 20, 2014 to August 13, 2014, for a total of $11,487.87 as provided in Section 8(b) of the Act.
>
> Based upon the evidence presented, the arbitrator finds Petitioner underwent surgery on May 20, 2014 for a total right knee replacement which the Arbitrator previously found was causally related to the October 12, 2011 accident. Petitioner was not released to return to work until August 13, 2014 for a total of 12-1/7 weeks of lost time.

Pursuant to the Rules of the Commission and the Illinois Civil Practice Act, the arbitrator amends the Arbitrator's Exhibit 2 to conform to the evidence presented. Arbitrator's Exhibit 2 shall be modified to show a lost time of 12-1/7 weeks and Arbitrator's Exhibit 2 shall further be modified to show Respondent disputes same (see *Bartosik v. Home Depot, 8 IWCC 1411).*

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:

> Based upon the evidence presented and the foregoing findings of fact, the arbitrator finds that the Petitioner underwent a total knee replacement and arthroscopic surgery to her right knee.
>
> No AMA report was offered into evidence, so the Arbitrator deems the parties to have waived consideration of that factor.
>
> The Petitioner does have a physical job in that she teaches learning and emotionally disabled students. She was 52 years old at the time of her accident, so the Arbitrator places moderate weight on those factors. There was no showing of any future wage loss.
>
> Dr. Capecci told the Petitioner on September 9, 2015 that she should permanent restrict herself from some of the offending activities that she encountered on her job. (PX 5 at 214) Dr. Romanelli testified on February 17, 2016 that she should permanent restrict herself from running, stooping or squatting, as well as limiting her lifting from 50 to 100 pounds. He said that she could do medium level but not heavy duty work. (RX 2 at 48) Both doctors based their opinions on her examination findings after her final knee surgery of December 17, 2014.

Based upon the above, the Arbitrator finds the Petitioner to have sustained permanency to the extent of 40 % of the right leg.

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

TIFFANY BOXLEY,

Petitioner,

19IWCC0288

vs.

NO: 13 WC 28217

CHICAGO TRANSIT AUTHORITY,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by Petitioner herein and notice given to all parties, the Commission, after considering the issues of causal connection, medical expenses, temporary total disability, permanent partial disability, and penalties, and being advised of the facts of 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 thereof.

Findings of Fact

Petitioner was employed by Respondent as a bus operator. On August 3, 2013, the bus Petitioner was driving was rear-ended by a car while at a stoplight. Petitioner testified her neck and low back immediately bothered her after the accident. Petitioner further testified that despite previously treating for a 2007 back injury, she had recovered and had no neck or back problems immediately before the August 3, 2013 accident.

Petitioner immediately presented to Advocate Medical Group on the accident date complaining of low back pain and a headache. Dr. John Kelly noted Petitioner had suffered a prior low back injury and had also treated for pelvic pain in March 2013 that was thought to be caused by her back. Lumbar X-rays revealed no fracture and were unchanged from her prior March 15, 2013 X-rays. Dr. Kelly diagnosed Petitioner with a low back sprain, administered a Toradol injection, and took Petitioner off work.

19IWCC0288

Petitioner returned to Advocate Medical Group on August 5, 2013 with new complaints of neck and shoulder pain. Dr. Karen Taylor diagnosed Petitioner with neck and low back sprains, provided a physical therapy referral, and kept Petitioner off work. X-rays taken the following day on August 6, 2013 revealed a normal cervical spine.

Lumbar and cervical MRIs were thereafter obtained on September 20, 2013. The lumbar MRI found mild bilateral foraminal stenosis due to a subtle disc bulge and hypertrophy of facet joints at L4-L5 as well as another subtle broad-based disc bulge at L3-L4. The cervical MRI found bilateral foraminal stenosis due to subtle disc bulges at C3 through C6 and empty sella syndrome. On September 30, 2013, Dr. Robert Strugala of Midland Orthopedic Associates interpreted the MRIs to show multilevel disc bulges without acute disc herniations. Dr. Strugala diagnosed Petitioner with neck and low back pain and was optimistic Petitioner's symptoms could be addressed through physical therapy.

Petitioner participated in physical therapy from October 1, 2013 to November 21, 2013. On October 28, 2013, Petitioner reported improvement in her low back symptoms but continued to struggle regarding her neck. Dr. Strugala recommended Petitioner meet with pain management to control the neck symptoms.

On December 20, 2013, Petitioner presented to Dr. Kenneth Holmes of the EMG Centers of Chicago/Neurology for evaluation of her empty sella syndrome. Dr. Holmes opined that Petitioner's cervical and lumbar MRIs looked good for Petitioner's age, despite showing some mild degenerative changes. Dr. Holmes indicated he did not find any spinal stenosis or significant foraminal stenosis to explain Petitioner's back pain.

Petitioner returned to Dr. Strugala multiple times from January 6, 2014 to March 20, 2015. During this period, Dr. Strugala kept Petitioner off work and persistently recommended a pain management consultation. Petitioner eventually presented to Dr. Neeraj Jain of Michigan Avenue Medical Associates on April 20, 2015. Dr. Jain diagnosed Petitioner with cervical and lumbar facet syndrome, discogenic pain, and radiculopathy. A clinical dermatomal and mixed nerve test of the lower extremities was also performed at this visit, finding a L5 right 1.1 standard deviation and lumbar radiculopathy.

Petitioner attended more physical therapy from April 21, 2015 to July 9, 2015. During this period, Petitioner also received C3 to C5 facet joint injections on June 4, 2015 and right L3 to L5 transforaminal epidural steroid injections with a selective nerve root block on July 2, 2015. Thereafter on August 24, 2015, a functional capacity evaluation placed Petitioner's capabilities at the light physical demand level. The results of the functional capacity evaluation were deemed valid by the evaluating physical therapist, and Dr. Jain put Petitioner on light duty pursuant to this functional capacity evaluation on August 27, 2015.

On September 4, 2015, Petitioner saw Dr. Robert Erickson for a neurosurgical evaluation. Dr. Erickson performed additional SSEP testing of the upper extremities, which was positive for bilateral C6 radiculopathy, worse on the right side at 1.0 standard deviations. A repeat cervical MRI was thereafter obtained on October 2, 2015 and showed a 2 mm disc bulge and mild spinal stenosis at C4-C5, a 1 to 2 mm disc bulge and mild spinal stenosis at C5-C6, small disc bulges and

congenitally short pedicles, and empty sella syndrome. Also on October 2, 2015, Dr. Erickson found Petitioner's symptoms to be consistent with mechanical low back pain syndrome and noted no worrisome findings on neurological exam.

Petitioner returned to Dr. Erickson numerous times from October 16, 2015 to October 15, 2016. Throughout this time, Dr. Erickson consistently recommended a C5-C6 anterior cervical discectomy and fusion. Additionally, at Petitioner's September 21, 2016 visit with Dr. Erickson, repeat SSEP testing showed a moderately severe delay at the C6 nerve root on the right side at 0.9 standard deviations. While Petitioner treated with Dr. Erickson for her cervical complaints, she also continued to treat for her lumbar complaints with Dr. Jain from October 5, 2015 to November 28, 2016. Throughout this period, Dr. Jain consistently recommended L3-L4 and L4-L5 epidural steroid injections with a selective nerve root block. Dr. Jain also put Petitioner on modified duty per her functional capacity evaluation on October 5, 2015 before later placing her off work completely as of February 22, 2016.

Petitioner thereafter presented to Advocate Medical Group on May 30, 2017 for several issues, including but not limited to, cervical radiculopathy and empty sella syndrome. Dr. Taylor again referred Petitioner for a pain management consultation. On August 22, 2017, Petitioner returned to Dr. Taylor to have a work capability form filled out. Dr. Taylor then indicated Petitioner's return to work was to be determined.

Petitioner later began seeing Dr. Steven Chandler of South Chicago Ortho Specialists on November 27, 2017. Dr. Chandler's diagnoses for Petitioner included cervical disc disease, de Quervain's disease, lumbar disc prolapse with radiculopathy, and unilateral right knee osteoarthritis. Dr. Chandler recommended physical and occupational therapy. Petitioner last treated with Dr. Chandler on December 12, 2017, at which time Dr. Chandler provided a referral to Dr. Donald Roland and signed a disability form indicating Petitioner's cervical stenosis entitled her to the issuance of a handicap license plate.

The December 12, 2017 visit with Dr. Chandler represents the last medical treatment Petitioner received prior to hearing. Petitioner testified that although she was continuing to seek treatment, she wanted the Arbitrator to make a final decision as to the nature and extent of her injury.

Dr. Daniel Troy, an orthopedic surgeon, authored three Section 12 reports concerning Petitioner's lumbar and cervical spine dated June 29, 2015, August 29, 2016, and March 14, 2017 at Respondent's request. As part of his June 29, 2015 examination of Petitioner, Dr. Troy took several radiographs. The lumbar X-rays demonstrated a slight curve with the apex to the right at L2-L3, well-maintained lordosis and disc space height, and no gross instability with flexion and extension. The cervical X-rays demonstrated well-maintained lordosis and disc space height, no instability with flexion or extension, and no soft tissue or bony lesions. Dr. Troy opined that Petitioner's radiographs appeared normal. He also found Petitioner's prior September 20, 2013 cervical and lumbar MRIs to be normal with age-appropriate changes.

Dr. Troy opined that Petitioner's injury was subjectively-based only with no objective pathology to her lumbar or cervical spine. Dr. Troy's diagnosis as related to the August 3, 2013

accident was a subjectively-based cervical and lumbar soft tissue strain. He found Petitioner to be at maximum medical improvement and capable of full duty work from an objective standpoint at the time of his June 29, 2015 examination.

In his subsequent August 29, 2016 report, Dr. Troy opined that Petitioner's August 24, 2015 functional capacity evaluation was not an independent examination because it was performed at the same facility Petitioner received physical therapy. Following his second examination of Petitioner, Dr. Troy again found no objective cervical or lumbar findings to explain Petitioner's subjective complaints. Dr. Troy further indicated there was no need for any fusion, injections, or physical therapy. In his later March 14, 2017 addendum, Dr. Troy indicated his opinions remained unchanged after reviewing the films of Petitioner's October 2, 2015 cervical MRI. Dr. Troy interpreted the MRI to show age-appropriate cervical changes with no induced traumatic changes.

Dr. Troy testified consistent with his three reports at his September 12, 2017 deposition. Dr. Troy further testified Petitioner had several Waddell factors present and exhibited self-limiting behaviors during her Section 12 examinations. He recommended no further treatment or surgery.

The matter proceeded to hearing on March 14, 2018. On the Request for Hearing entered into evidence as Arbitrator's Exhibit 1, Respondent indicated it only disputed benefits after September 8, 2016 per Dr. Troy's Section 12 examination. The Decision of the Arbitrator, which was thereafter issued on May 24, 2018, found Petitioner's current condition was not causally related to the August 3, 2013 accident as Petitioner had reached maximum medical improvement for her work-related injuries as of June 29, 2015. The Decision of the Arbitrator denied Petitioner's claim for medical expenses after June 29, 2015 and temporary total disability benefits after September 6, 2016.

Conclusions of Law

Following a careful review of the entire record, the Commission is persuaded by Dr. Troy's opinions and agrees with the Decision of the Arbitrator that Petitioner reached maximum medical improvement for her lumbar and cervical strains as of the June 29, 2015 Section 12 examination. Nevertheless, the Commission must honor the stipulations made by the parties on the Request for Hearing entered into evidence as Arbitrator's Exhibit 1. When asked on the Request for Hearing whether Respondent disputed Petitioner's claims for unpaid medical bills and temporary total disability benefits, Respondent wrote: "Benefits are disputed after 9/08/2016 per IME by Dr. Daniel Troy." Based on Respondent's stipulations, the parties had agreed that Petitioner was entitled to payment of the claimed medical expenses and temporary total disability benefits up to September 8, 2016.

Therefore, the Commission modifies the Decision of the Arbitrator to reflect the parties' stipulations and award Petitioner payment of medical expenses and the claimed temporary total disability benefits up until September 8, 2016. The Commission otherwise affirms and adopts the Decision of the Arbitrator.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator dated May 24, 2018 is modified as stated herein.

IT IS FURTHER ORDERED that Respondent shall pay reasonable and necessary medical services that relate only to treatment regarding Petitioner's cervical and lumbar conditions before 9/8/2016, as provided in Sections 8(a) and 8.2 of the Act. All medical treatment after 9/8/2016 is denied.

IT IS FURTHER ORDERED that Respondent shall pay temporary total disability benefits to Petitioner in the sum of $820.53 per week for 160 2/7 weeks, commencing 8/4/2013 through 1/27/2016 and 2/5/2016 through 9/8/2016, as provided in Section 8(b) of the Act.

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

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

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

DATED: JUN 12 2019

Deborah L. Simpson

Barbara N. Flores

Marc Parker

DLS/met
O: 4/18/19
46

ILLINOIS WORKERS' COMPENSATION COMMISSION

NOTICE OF ARBITRATOR DECISION

19IWCC0288

BOXLEY, TIFFANY
Employee/Petitioner

Case# **13WC028217**

CHICAGO TRANSIT AUTHORITY
Employer/Respondent

On 5/24/2018, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 2.08% 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:

0579 FRIEDMAN & SOLMOR LTD
GARY B FRIEDMAN
200 N LASALLE ST SUITE 2750
CHICAGO, IL 60601

0515 CHICAGO TRANSIT AUTHORITY
ANDREW ZASUWA
567 W LAKE ST 6TH FL
CHICAGO, IL 60661

19IWCC0288

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

Tiffany Boxley
Employee/Petitioner
v.
Chicago Transit Authority
Employer/Respondent

Case # 13 WC 028217

Consolidated cases: ____

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Kurt Carlson**, Arbitrator of the Commission, in the city of **Chicago**, on **March 14, 2018**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **08/03/2013**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**64,033.32**; the average weekly wage was $**1230.80**.

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

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

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

Respondent shall be given a credit of $**132,739.40** for TTD, $**n/a** for TPD, $**n/a** for maintenance, and $**n/a** for other benefits, for a total credit of $**132,739.40**.

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

ORDER

Because petitioner's current state of ill-being is not causally related to the August 3, 2013 work injury, Petitioner's request for further TTD benefits after September 6, 2016 is denied. Petitioner reached MMI on June 29, 2015. Respondent has paid all medical and is not liable for medical bills for dates of service after June 29, 2015, as said medical treatment was excessive. Respondent is liable for the bill for the FCE dated August 25, 2015 which was recommended by Dr. Troy.

With respect to right hand, right thumb, right wrist and right knee injuries, the Arbitrator finds that these conditions are not causally related to the August 3, 2013 work injury, which caused a cervical and lumbar strain.

The Arbitrator declines to award Section 16 and 19 penalties and fees.

The Arbitrator finds Petitioner to have incurred a loss of use of 5% person as a whole based on a subjectively-based cervical and lumbar strain as a result of the accident on August 3, 2013.

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

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

Signature of Arbitrator

05-24-18
Date

MAY 24 2018

Tiffany Boxley)
)
vs.)
)
Chicago Transit Authority) Case No. 13 WC 28217
)

FINDINGS OF FACT:

Testimony

Petitioner testified that she is a bus operator for the Respondent Chicago Transit Authority. She worked for the CTA for approximately seven years. Petitioner testified that on August 3, 2013 she was driving a bus for the CTA when it was rear ended by a car. Petitioner testified that this occurred around 4:20 pm, as she was driving northbound on Broadway. She testified that immediately after the accident her neck and lower back were bothering her. She testified that she left the scene immediately and presented to Advocate Urgent Care that day for care and treatment. X-rays were taken and she received an intramuscular injection to her gluteal region. She testified that she was taken off of work and referred to her regular family doctor, Karen Taylor. (Tr. 7-10)

Petitioner testified that she presented to Dr. Taylor and was sent for therapy at Physio-therapy Associates. Petitioner testified that the physical therapy was "excruciating", "not helping" and "getting worse". Petitioner testified that she underwent MRIs to her neck and back at Chicago Ridge Radiology on September 20, 2013. She testified that she was referred to an Orthopedic Surgeon, coming under the care of Dr. Robert Strugala at Midland Orthopedics. (Tr. 10-12)

Petitioner testified that she underwent an EMG on December 20, 2013 with Dr. Kenneth Holmes. Petitioner testified that during her care and treatment with Dr. Strugala, she noticed that her neck pain was severe and excruciating, describing instances where her neck would jerk at times on its own terms. She testified that she was having trouble getting out of bed. As to her lower back, Petitioner testified that it was deteriorating and "getting worse". (Tr. 13-15)

Petitioner testified that Dr. Strugala recommended pain management and felt that she would need surgery if the pain management did not work. She testified that she received pain management with Dr. Jain from April 20, 2015 until November 28, 2016. She testified that she underwent an injection to her cervical spine on June 4, 2015. She testified that immediately before the injection she felt "horrible" and that the injection did not help. She testified that she underwent an injection to her lower back on July 2, 2015. (Tr. 15-18)

Petitioner testified that she attended an Independent Medical Examination with Dr. Troy on June 29, 2015. She testified that Dr. Troy had recommended an FCE and she underwent the FCE on August 24, 2015. She testified that she understand the FCE to say

that she could return to work very light duty but could not drive as a CTA bus operator. She testified that she could not return to work as a CTA bus operator. (Tr. 18-19)

Petitioner testified that Dr. Jain referred her to Dr. Erickson, a neurosurgeon. She testified that she last treated with Dr. Erickson on October 5, 2016, and he had recommended surgery to her cervical spine. She testified that at the last visits with Dr. Jain, Strugala, or Erickson, she had severe pain in her lower back and neck, along with numbness in her baby finger and ring finger. She testified that she attempted to return to work in August of 2016, but was terminated. (Tr. 19-23)

Petitioner testified that she presented at the Trinity Hospital emergency room on December 19, 2016 complaining of neck and hand pain. She testified that medical care and treatment were terminated after Dr. Troy reviewed her records, and she continued to treat with Dr. Karen Taylor on three occasions in 2017. She testified that she has had no other accidents up to the present time. She was referred to Dr. Steven Chandler, an Orthopedic Surgeon and saw him on November 27, 2017 and February 12, 2018. (Tr. 23-25) She testified that Dr. Chandler referred her to pain management. (Tr. 27)

Petitioner testified that Dr. Karen Taylor has been her regular family doctor for almost 20 years. She testified that she stopped receiving treatment from Dr. Chandler because her Medicaid was cut off. (Tr. 26-27)

Petitioner testified that her neck is constantly bothering her and she cannot turn her head real quick without pain, which she described as severe in nature. She testified that her fingers were numb and she had pain in her fingernails. She testified that her lower back was severely hurting, and radiated down her buttocks to her right leg. She testified that she takes norco. She testified that she desires the case to end and wanted a final decision on the nature and extent of her injury. (Tr. 27-29)

Petitioner testified that she has been off of work at the direction of her treating physicians from August 4, 2013 through January 27, 2016 and February 5, 2016 to the present day. She was provided a cervical brace and a TENS unit. (Tr. 29-30)

On Cross-Examination, Petitioner testified that she was not taken from scene of the accident in an ambulance. (Tr. 32) She testified that when she is involved in a bus accident, she fills out forms, one in particular being the "Report to Manager". Petitioner identified Respondent's Exhibit Number 4 as one of the forms she would fill out or sign after there is an incident involving a bus. She testified that she had signed the document marked at as Respondent's Exhibit Number 4, but could not recall if she had personally filled it out. (Tr. 32)

Petitioner agreed that the form she signed contained language above the signature line specifying that the information given is thorough, accurate and factual. She agreed that a standard CTA bus is approximately 40 feet long, and she testified that she was driving a standard bus when the accident occurred. She testified that while she didn't measure the bus, she was sitting in the driver's seat at the time. (Tr. 33-34)

Petitioner testified that she had treated for a back injury in 2007 and underwent a lumbar spine MRI. She testified that she was off of work for a few months, and that at the time she was working for the CTA. She testified that she saw Dr. Troy on June 29, 2015 and August 29, 2016 and was always truthful and accurate in the statements she made to him. (Tr. 35)

On Redirect Examination, Petitioner testified that she was "wonderful" in the six years that transpired between the 2007 incident and the 2013 incident. Petitioner testified that after the 2013 incident she drove the bus to her relief point and took another bus to the garage to explain what had happened. She was then taken to Urgent Care by her daughter.

Over Respondent's objection, Petitioner further testified that there were statements in Dr. Troy's IME reports that she felt were inaccurate. She testified that Dr. Troy had mentioned in the report that she had arrived to the IME by herself, but she testified that her aunt had taken her to the IME appointment. Petitioner further testified that the report noted that Dr. Troy's assistant was in the room at the time of examination, but Petitioner recollection was that she was not present. (Tr. 46)

Deposition Transcript

Dr. Daniel Troy was present for an evidence deposition held on September 12, 2017 and attended by attorneys from both Petitioner and the Respondent. Dr. Troy testified that he is an Orthopedic Surgeon who has been practicing for 17 to 18 years and specializes in spinal surgery, with the vast majority of his practice consisting of cervical and lumbar surgeries. He testified that he performs between 150 and 200 spinal surgeries per year. (R.X. 1, 1-6)

Dr. Troy testified that he saw Tiffany Boxley for an Independent Medical Examination on June 29, 2015. He identified the report he made of the visit. He testified that at the appointment, Petitioner gave him a history of the injury, noting that she was involved in a motor vehicle accident where her bus was rear ended. (R.X. 1, 7-8)

Dr. Troy testified he that he reviewed numerous medical records from Petitioner's PCP Dr. Karen Taylor, Physical Therapy Associates, Dr. Robert Strugala, and Dr. Neeraj Jain. He testified that on the date of the appointment, Petitioner was complaining of pain in her lumbar spine radiating down her right lower extremity into her left lower extremity as well as left-sided cervical neck symptoms. Dr. Troy testified that there was not a significant degree of radiculopathy described. Dr. Troy testified that he performed a physical examination on Petitioner and documented it in his report. He noted Petitioner weighed 240 pounds and was five foot six feet tall, adding that she was about 80 to 90 pounds overweight. (R.X. 1, 9-10)

Dr. Troy testified that he felt Petitioner demonstrated self-limiting behaviors with regard to her cervical spine range of motion. He noted that her low-back pain was diffuse

in nature and the pain was vague in nature and not pinpoint, but subjective. Dr. Troy testified that he felt there were numerous Waddell factors present, as well as nondermatomal pain patterns. (R.X. 1, 12)

Dr. Troy testified that he reviewed radiographs of the pelvis, lumbar spine and cervical spine as well as films and reports of an MRI of the lumbar spine and of the cervical spine. He felt the radiographs of the pelvis demonstrated no abnormalities. The lumbar radiograph demonstrated well-maintained disc space height and well-maintained lordosis. The cervical spine radiograph was normal. He testified he reviewed the films and report of cervical spine MRI from September 20, 2013 and noted mild bilateral foraminal stenosis due to subtle broad based disc bulge at the C3-4 level. He agreed with the radiologist's opinion. He testified that he reviewed the films and report for the lumbar MRI done on September 20, 2013. His impression was a subtle disc bulge and foraminal stenosis at the L5-L5 level and a subtle based disc bulge abutting the thecal sac at L3-L4. (R.X. 1, 15-16)

Dr. Troy testified that he believed Petitioner had suffered a strain to her neck and low back as a result of the August 3, 2013 motor vehicle accident. He testified that she had noted she had previously injured her back in 2007. He testified that he felt at the time that she had over-treated for what he characterized as a subjectively-based injury. Dr. Troy believed Petitioner's injury was "subjectively-based" because there were no discreet abnormalities on the radiographs, the MRI of the lumbar spine was essentially normal and the cervical MRI was devoid of abnormalities besides some "age-appropriate" changes. He testified that although Petitioner had complained of pain, there were no objective findings to support her complaints. (R.X.1, 17-18)

Dr. Troy testified that he believed Petitioner's treatment had been excessive, and that 90 to 95 percent of individuals with a cervically based neck or lumbar strain would recover in twelve weeks. He noted that at the time he first saw her, it had been two years since the date of injury. He again mentioned the lack of objective pathology on the lumbar and cervical MRIs. (R.X. 1, 18-19)

Dr. Troy testified that he believed from an objective standpoint that Petitioner could work full duty and had reached Maximum Medical Improvement, but believed she should undergo a Functional Capacity Evaluation. (R.X.1, 21)

Dr. Troy testified that he saw Petitioner a second time on August 29, 2016. He identified a report he made describing the visit. He testified that he reviewed additional medical records of physical therapy visits, Dr. Neeraj Jain, Dr. Robert Erickson and a Functional Capacity Evaluation from August 24, 2015. Dr. Troy testified that at this visit, Petitioner complained of neck and low-back pain, diffuse in nature. He performed a physical examination and noted self-limitations. He testified that he reviewed an updated MRI of the cervical spine dated October 2, 2015. He initially reviewed the report but was provided the films at a later date, which he testified were of poor quality. Dr. Troy testified that the MRI demonstrated a two-level disc bulge at C4-5, mild stenosis at C5-6,

with a smaller disc bulge. Dr. Troy testified that he viewed no discreet changes between the October 2nd cervical MRI and the cervical MRI done previously. (R.X. 1, 27)

Dr. Troy testified that he reviewed the FCE done on August 24, 2015. He noted that it was valid and placed restrictions on lifting. He testified that he found it significant that the FCE was performed at the same facility where Petitioner was receiving physical therapy. Dr. Troy further explained that relationships can develop over time between therapists and patients, which can make it hard for people to be truly independent. Dr. Troy concluded that the FCE was not a truly independent examination. (R.X. 1, 29-30)

Dr. Troy testified that he believed Petitioner demonstrated no objective pathology to her cervical spine at the August 29, 2016 visit, and that he disagreed with the request for the Petitioner to undergo a fusion of the cervical spine. He testified that he believed Petitioner could work full duty, from an objective standpoint. He further explained that no further treatment was needed, noting that Petitioner had already received an extensive amount of treatment over the last several years. Dr. Troy again cited the lack of objective findings on both the radiographs and MRIs in support of his opinion. (R.X. 1, 30)

On cross-examination, Dr. Troy testified that he reviewed a job description from the CTA. He also testified that he was contacted about performing an IME by his assistant, who assists and organizes IME requests. He testified as to the process of setting up an IME. Dr. Troy guessed that he does between two or three IMEs per week, 100 to 125 per year. Dr. Troy testified that he takes care of trauma patients at Christ Medical Center as he is on staff there. He estimated that he does about 350 surgeries per year. (R.X. 1, 37-40)

Dr. Troy testified that dermatome patterns reference the part of skin that is innervated by a pinched nerve. Dr. Troy testified that Waddell's Test is not a definitive test but he did perform all five tests including the tenderness test, simulation test, distraction test, exaggerated body test and overreaction test. Dr. Troy testified that a positive tenderness finding would be if the patient screamed in pain when he lightly touched their skin. He testified that in his report he noted Petitioner's degree of palpation, her pain response was out of proportion. Dr. Troy testified that the simulation test involves either moving the patient's hips or having the patient move their hips, noting that the vast majority of motion when you bend or rotate comes through your hips rather than your back. Dr. Troy testified that when he performed the simulation test on Petitioner, she complained of pain. He testified that he performed the exaggeration test and that Petitioner demonstrated findings of exaggerated pain with motion. He testified that Petitioner had positive Waddell findings on 3 out of 5 factors. (R.X. 1, 49-54)

Dr. Troy testified that the FCE released Petitioner to light duty. He testified that he discounted the FCE because it was not performed at an independent facility. Noting his own physical therapy department, he explained that physical therapy regimens can be for periods between 10 and 16 weeks, and some of the patients and therapists are almost like "best friends" during that time, making it difficult to be truly independent. (R.X. 1, 54-57)

Medical Records

Petitioner had an x-ray of her lumbar spine on August 3, 2013. The impression was "no fracture" and there was no change from a prior x-ray done on March 15, 2013. An x-ray of the cervical spine was done on August 6, 2013 and was normal. Petitioner saw her Dr. John Kelsey on August 3, 2013 and it was noted she was in a motor vehicle accident while driving a bus when she was hit from behind by a small car. The assessment was low back sprain. It is noted that she was in a prior accident in 2006 and injured her lower back. (R.X.1)

Petitioner presented to Dr. Karen Taylor on August 5, 2013. It was noted that her lumbar spine exhibited no tenderness on palpation and there was paraspinal tenderness only. A straight-leg raising test was negative and a contralateral straight-leg raising test was negative. Dr. Taylor noted her neck was normal and palpation revealed no abnormalities or bony tenderness. (P.X.1)

Petitioner performed physical therapy at Novacare. She first presented on August 20, 2013 and last visited on November 18, 2013, when it was noted she would begin pain management. The physical therapist noted on October 28, 2013 that Petitioner stated she was unable to walk more than one block (P.X.2)

Petitioner presented to Dr. Robert Strugala, an Orthopedic Surgeon, on September 30, 2018. It was noted she had neck and lower back pain after a motor vehicle accident at work. Dr. Strugala reviewed the MRIs of the neck and back and noted multilevel disc bulge without acute appearing disc herniation. Dr. Strugala opined that he did not anticipate that Petitioner would need surgery and her symptoms would properly be addressed with physical therapy. It was noted at the October 28, 2013 appointment that Petitioner had a normal gait and ambulated without difficulty. (P.X.4)

Petitioner was referred for pain management. On July 22, 2014 it was noted she was still awaiting pain management approval and had recently suffered a fall. It was noted she had an abrasion to her right knee which had healed. She continued to follow up regularly with Dr. Strugala, who opined that as of March 20, 2015 she had plateaued and would require pain management. It was noted on April 16, 2015 that she had an appointment with pain management scheduled. The last visit with Dr. Strugala was on June 19, 2016, at which it was noted that the pain management doctor had administered a cervical injection. (P.X.4)

Petitioner presented to Dr. Kenneth Holmes, a Neurologist, on December 20, 2013. He reviewed the MRIs of her lumbar and cervical spines and opined that there are mild degenerative changes, but "overall looks pretty good for age to me". He did not find any spinal stenosis or significant foraminal stenosis to explain the back pain she was treating for. (P.X.6)

Petitioner first presented to Dr. Neeraj Jain for pain management on April 20, 2015. Dr. Jain recommended multilevel steroid injections and physical therapy. On

January 4, 2016. A bilateral L3-L4, L4-L5 epidural steroid injection was recommended. Petitioner last saw Dr. Jain on February 22, 2016, at which the multilevel lumbar injections were recommended again. (P.X. 7)

Dr. Jain performed a right sided C3-C4, C4-C5 facet joint injection on June 4, 2015. Dr. Jain performed a right sided multilevel epidural steroid injection and selective nerve root block on July 2, 2015. (P.X. 9)

Petitioner attended physical therapy at Premier Therapy in the spring and summer of 2015. She was discharged on July 9, 2015. This treatment was prescribed by Dr. Jain. She completed an FCE at Premier Therapy on August 24, 2015. This was considered valid and placed her in the light physical demand category. (P.X.8, 11)

Dr. Robert Erickson, a Neurosurgeon, recommended that Petitioner undergo an anterior cervical discectomy and fusion at C5-C6. (P.X. 12) He first saw her on September 4, 2015 and reviewed the MRI imaging from 2013, which he felt demonstrated small bulging discs at C3 through C6, and what he believed was a small focal disc herniation at the C5-6 level. He noted mild foraminal stenosis associated with a diffuse bulging disc at L4-L5. Dr. Erickson recommended a repeat MRI scan. Dr. Erickson believed there was a small focal disc herniation at C5-6. (P.X.7)

Reports of cervical and lumbar MRIs are in evidence. An MRI of the cervical spine was performed on September 20, 2013 and demonstrated mild foraminal stenosis due to subtle broad based disc bulge. There was minimal bilateral foraminal stenosis due to subtle disc bulge. An MRI of the lumbar spine was performed on September 2013 and demonstrated mild foraminal stenosis due to subtle disc bulge and hypertrophy of facet joints at L4-L5 and subtle broad based disc bulge abutting the thecal sac at L3-L4. An MRI of the cervical spine from October 2, 2015 demonstrated a 2 mm disc bulge and mild spinal stenosis at C4-5, a 1-2 mm disc bulge and mild spinal stenosis at C5-6. (P.X. 18-20)

Petitioner's Exhibit 28 contains records from Dr. Steven Chandler, an Orthopedic Surgeon. Dr. Chandler saw Petitioner on November 30, 2017 for right knee pain, right wrist pain, right hand pain and right thumb pain which Petitioner attributed to the August 3, 2013 work accident. It was noted that Petitioner rated her pain as 10/10. She was diagnosed with DeQuervain's tenosynovitis of the right wrist, and mild right knee arthritis. At an occupational therapy visit on December 1, 2017, it was noted that her right hand pain had started after a cooking accident a month prior. An EMG of bilateral lower extremities was performed on January 22, 2018 and was normal. (P.X.28)

An MRI of the lumbar spine was performed on February 6, 2018. The study exhibited mild degenerative changes in the mid to lower lumbar spine without significant spinal canal stenosis. An MRI of the cervical spine was performed on February 6, 2018 and demonstrated multilevel degenerative disc changes at C4-C5 and C5-C6 resulting in borderline to mild spinal canal stenosis. (P.X.28)

Injury Form

Petitioner signed a form as part of the Respondent's regular process of reporting an injury on duty. The form notes that there was minor damage to the bumper of the bus. The form gives an accident date of August 3, 2013. By signing the form, Petitioner attested that the information given in the report was through, accurate and factual (R.X.2)

CONCLUSIONS OF LAW

In regard to "F" is there a causal connection between Petitioner's work injury of August 3, 2013 and his current condition of ill-being, the Arbitrator finds as follows:

The Arbitrator finds that the Petitioner's current condition of ill-being is not causally related to the work-related injury of August 3, 2013

The Arbitrator adopts the opinion of Dr. Daniel Troy, who testified credibly that Petitioner suffered a lumbar and cervical strain as a result of the August 3, 2013 work accident, but had reached maximum medical improvement as of June 29, 2015 and was capable of returning to work full duty as a bus operator. In adopting Dr. Troy's opinion, the Arbitrator notes that the post-injury lumbar and cervical MRI results taken on September 20, 2013 were indicative of arthritic, age-related changes and without any evidence of acute herniation. The Arbitrator notes that upon reviewing both MRIs, Dr. Strugala on September 30, 2013 opined that he did not anticipate that Petitioner would be a surgical candidate. (P.X. 4) Furthermore, Neurologist Dr. Kenneth Holmes reviewed both MRIs on December 20, 2013 and opined that overall they showed degenerative changes, and looked "pretty good" for her age. (P.X. 6) He did not find any spinal stenosis or significant foraminal stenosis to explain the back pain she was complaining of. The Arbitrator notes that Dr. Troy credibly testified that at both of his IME visits on June 29, 2015 and August 29, 2016 that Petitioner's subjective pain complaints could not be supported by any objective findings (R.X.1)

The Arbitrator further takes note of the most recent MRI studies of the cervical and lumbar spines done on February 6, 2018. Both of these studies continued to exhibit degenerative findings. (P.X.28)

In adopting the findings and medical opinions of Dr. Troy, the Arbitrator finds that Petitioner is not in need of further treatment to either her cervical spine or lumbar spine, and that Petitioner is not a candidate for any cervical spine surgery proposed by Dr. Erickson. While Dr. Erickson diagnosed Petitioner with a disc herniation at C5-6, the Arbitrator notes Petitioner has seen three different Orthopedic Surgeons, one neurologist, and multiple radiologists, none whom have reviewed her MRIs and diagnosed her with a disc herniation at C5-6, or at any other level of her cervical or lumbar spine.

Furthermore, the Arbitrator notes that Petitioner's initial treating physician, Dr. Strugala, is on the same page as Dr. Troy as to her lack of surgical candidacy. Dr.

Strugala saw Petitioner nearly a month after her work injury and reviewed MRI slides taken a little more than a month after the work accident. Dr. Strugala, like Dr. Troy did not diagnose Petitioner with a disc herniation and did not find Petitioner to be a surgical candidate.

The Arbitrator finds Dr. Troy credible in regard to his observations of Petitioner's self-limiting behavior and positive Waddell factors. Despite 4 years and 7 months of treatment with numerous physicians, Petitioner's cervical and lumbar MRIs continue to demonstrate a lack of significant objective findings. The Arbitrator finds that Petitioner's subjective complaints were out of proportion to her objective findings, and notes that on October 28, 2013, Petitioner had separate appointments with her physical therapist at Novacare and Dr. Strugala. The note from Dr. Strugala states that Petitioner demonstrated a normal gait and ambulated without difficulty. However, the physical therapy note from the same date states that Petitioner had complained she was unable to walk more than one block. (P.X.2, P.X.4)

The Arbitrator adopts Dr. Troy's medical opinion that Petitioner suffered a cervical and lumbar strain as a result of the work injury. In doing so, the Arbitrator finds it significant that Petitioner reported minor damage to her bus on the date of accident. (R.X.2) The Arbitrator notes that Petitioner was able to drive a bus to a relief point from the scene of the accident. Furthermore, Petitioner testified that she was sitting in the front of the bus at the time it was rear ended by the other vehicle. Petitioner testified that a standard CTA bus is about 40 feet in length. The Arbitrator finds it is reasonable to conclude that Petitioner was sitting 40 feet away from the point of impact of a collision which only produced minor damage to the bumper of Petitioner's bus. (R.X.2) The Arbitrator finds it reasonable that a minor motor vehicle accident would result in a subjectively-based cervical and lumbar strain. The Arbitrator does observe that it is difficult to find that a minor motor vehicle accident would result in 4 years and 7 months of prolonged excessive treatment, especially where multiple imaging studies have failed to demonstrate objective findings.

The Arbitrator does not find Petitioner's reported right hand, right thumb, right wrist and right knee problems to be causally related to the August 3, 2013 work accident. Petitioner complained of lower back and neck pain as a result of the August 3, 2013 accident when she presented to Urgent Care and her PCP Dr. Karen Taylor. She continued to treat with Dr. Strugala for back and neck pain. Petitioner did not attempt to actively treat for right upper extremity and right knee pain until November 30, 2017. The Arbitrator finds it significant that once Petitioner was referred to Occupational Therapy, she explained to the therapist on December 1, 2017 that her right hand pain was caused by a cooking accident one month prior. (P.X.28) The Arbitrator finds it significant that Petitioner reported a fall to Dr. Strugala on July 22, 2014, and it was noted she had an abrasion on her right knee. (P.X.4)

In regard to issue "J', were the medical services provided to Petitioner reasonable and necessary, the Arbitrator finds as follows:

Dr. Troy's credible medical opinion found Petitioner at MMI as of June 29, 2015. Therefore, all medical incurred after June 29, 2015 is not reasonable, necessary, or related to the August 3, 2013 work accident, with exception of the FCE performed on August 25, 2015, which was recommended by Dr. Troy. Furthermore, the Arbitrator finds that Petitioner's continued medical treatment up until the present date was excessive considering the lack of objective findings on multiple imaging studies and Dr. Troy's credible testimony that Petitioner had suffered a strain to her neck and low back.

In regard to issue "K" the Arbitrator finds as follows:

As petitioner has failed to prove that her current state of ill being is causally related to the August 3, 2013 work accident, and MMI was established as of June 29, 2015., Petitioner is not owed any further TTD benefits.

In regard to issue "M" the Arbitrator finds as follows:

Petitioner seeks an award of Section 16, Section 19(l) and Section 19(k) penalties and fees based on unpaid medical bills and unpaid TTD benefits.

Respondent must show, once a demand for payment is made, that it acted in an objectively reasonable manner, under all of the existing circumstances, in denying, or delaying the payment of, benefits. Crockett v. Industrial Commission, 218 Ill.App.3d 116, 121 (1st Dist. 1991)

In this case, Respondent's denial of benefits to Petitioner is based upon Dr. Troy's credible medical opinion finding Petitioner at maximum medical improvement as of June 29, 2015 and capable of working full duty from an objective standpoint. Dr. Troy testified at deposition and also authored a report attached the deposition explaining his medical opinion.

Respondent denied benefits in reliance on Dr. Troy's June 29, 2015, August 29, 2016 and March 14, 2017 reports. Respondent was not unreasonable or vexatious in relying on the medical opinion of a qualified Orthopedic Surgeon in denying benefits. Respondent's actions, though unfavorable to Petitioner, were not without merit.

Therefore, Petitioner is not owed penalties under Section 16, Section 19(l) and Section 19(k).

In regard to issue "O" the Arbitrator finds as follows:

The Arbitrator adopted Dr. Troy's credible medical opinion that Petitioner suffered a lumbar and cervical strain as a result of the August 3, 2013 work accident. The Arbitrator finds that Petitioner is at maximum medical improvement as of June 29, 2015. The Arbitrator notes that Dr. Troy opined that a lumbar and cervical strain would generally result in a recovery period of 12 weeks from the injury date. Petitioner is awarded permanent disability of 5% loss of use of a person as a whole.

STATE OF ILLINOIS	)	
	) SS.	
COUNTY OF PEORIA	)	

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

19IWCC0289

Tangela Taylor,
Petitioner,

vs.

NO: 15WC 41372

City of Peoria ,
Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of 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 December 4, 2018, 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: JUN 12 2019
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DS/jrc
046

Deborah Simpson

Maria Portela

Thomas J. Tyrrell

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

19IWCC0289

TAYLOR, TANGELA
Employee/Petitioner

Case# **15WC041372**

CITY OF PEORIA
Employer/Respondent

On 12/4/2018, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 2.49% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

5354 STEPHEN P KELLY
ATTORNEY AT LAW LLC
2710 N KNOXVILLE AVE
PEORIA, IL 61604

0980 HASSELBERG GREBE SNODGRASS
KENNETH M SNODGRASS
401 MAIN ST SUITE 1400
PEORIA, IL 61602

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

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
NATURE AND EXTENT ONLY

Tangela Taylor
Employee/Petitioner

v.

City of Peoria
Employer/Respondent

Case # **15** WC **41372**

Consolidated cases: ______

The only disputed issue is the nature and extent of the injury. An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **McCarthy**, Arbitrator of the Commission, in the city of **Peoria**, on **10/18/18**. By stipulation, the parties agree:

On the date of accident, **12/6/15**, 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 $**87,581.00**, and the average weekly wage was $**1,684.25**.

At the time of injury, Petitioner was **43** years of age, ***single*** with **0** dependent children.

Necessary medical services and temporary compensation benefits have been provided by Respondent.

Petitioner was paid full salary pursuant to the Public Employee Disability Act from December 7, 2015 through May 26, 2017. The Petitioner was paid TTD benefits from July 27, 2017 through September 27, 2017.

ORDER

The injuries sustained caused 4**0% loss Man As A Whole, or 200 weeks times the maximum PPD rate of $755.22.**

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

Nov. 30, 2018
Date

DEC 4 - 2018

Findings of Fact

The Petitioner became employed by the Respondent in 1998 as a police officer (A.T. 17). The Petitioner has been employed as a police officer for the Respondent from 1998 up until the date of the accident (A.T. 18). The Petitioner testified the general duties of a police officer would be responding to 911 dispatch calls, talking to citizens, taking legal action when needed, requiring potential exposure to physical fights and getting into physical altercations (A.T. 19).

The parties stipulate that on December 6, 2015 the Petitioner sustained a work injury, the Petitioner was on a felony call for a suspect that had been accused of making a bomb threat (A.T. 21). The Petitioner testified that she was trying to apprehend the suspect when the suspect ran back to the van and took off. The Petitioner was caught in the car and was dragged by the fleeing vehicle and fell to the group (A.T. 22-24).

When the Petitioner tried to get up off the ground, she noticed she had extreme pain to her right leg and ankle. The Petitioner called for help and ambulance assistance was provided (A.T. 26). The Petitioner testified that she went to the emergency room as OSF St. Francis Medical Center (A.T. 27).

The Petitioner testified she became under the care of Dr. Kinzinger, who is an orthopedic specialist at Great Plains Orthopaedics (A.T. 28).

On December 6, 2015, the Petitioner underwent surgery. The surgery was done by Dr. Kinzinger. The Petitioner had three fractures to her right ankle (A.T. 29).

The Petitioner testified as to her recovery from the first surgery at the time of the trial. The recovery was uneventful. The Petitioner testified that from December 6, 2015 to August 2016 she was taken off work from Dr. Kinzinger and under his care (A.T. 31).

Payroll records entered into evidence show that from August 6, 2016 through January 14, 2017, the Petitioner performed some light duty work for the Respondent. (PX 10) The Petitioner testified that she did perform light duty at that time. Dr. Kinzinger's notes indicate that on January 9, 2017, he saw her for an examination. At that time, she was found to have limitations in motion of the ankle as well as pain to palpation. He placed her on permanent restrictions of weight bearing as tolerated for activities of daily living, no police activities such as running, jumping, being in altercations or significant lifting. He said that he would see her back in six months to discuss removal of her hardware. (PX 4; O.V. 1-9-2017) Dr. Moody, the occupational specialist who had seen her originally the day after her accident and whom referred her to orthopedics, saw her for an examination on January 11, 2017. His office note indicates that he felt it unlikely that she would be able to regain the functional capacity to return to work as a police officer. He suggested permanent restrictions of no lifting over 15 pounds, no confrontations or tactical training, no running or jumping and positional changes as needed. (PX 6)

The above referenced records show that from January 15, 2017, the Petitioner did not return to work for the Respondent. (PX 10) The evidence also shows that on May 26, 2017, the Petitioner's employment with the Respondent ended. (PX 11)

The Petitioner testified that the pain in her right ankle never went away after being released to permanent restrictions by Dr. Kinzinger. The Petitioner eventually underwent a second surgery to remove the hardware placed in the Petitioner's right ankle and foot from the first surgery by Dr. Kinzinger. The second surgery was September 15, 2017 (A.T. 36).

The Petitioner testified that the second surgery did make her ankle feel better. The Petitioner testified that she went through normal medical care and treatment after the second surgery for the hardware removal (A.T. 38).

Dr. Kinzinger saw her for the final time on November 2, 2017. His examination again showed limitation in dorsiflexion and plantar flexion of the right ankle. She reported to him that she was a lot better, with some tingling and tenderness still present. His note recommended weight bearing as tolerated. (PX 4; O.V. 11-2-2017)

The Petitioner testified at the time of trial that her right ankle still hurts. She is never completely pain free. The Petitioner's right ankle also reacts to weather. The Petitioner takes arthritis medication for her ankle pain. The Petitioner also has knee pain (A.T. 39).

The Petitioner testified that she went through a pension hearing and was awarded a pension award on September 20, 2017. The Petitioner was awarded on-line duty pension disability benefits and found she was unable to do work as a police officer (A.T. 41).

The Petitioner testified at the time of trial that the pension doctors that examined her confirmed the restrictions of no running, jumping, lifting over 15 lbs., no confrontational events, no conflicting events (A.T. 42).

The medical evidence offered at the time of the trial confirms the Petitioner's testimony as it relates to the two surgeries she received for her right ankle. The Arbitrator notes also that Dr. Kinzinger testified in this case by way of deposition on June 20, 2018. (PX 17) At that time he acknowledged that the hardware removal surgery had a positive result on the Petitioner's symptoms. (Id at 45) He also said that he still agreed with the permanent restrictions placed on the Petitioner by Dr. Moody. (Id at 40) He believed she still could not return to the demanding tasks of police work. (Id at 34) He also said that she had the potential for the development of traumatic arthritis in the foot and ankle. He said that her fractures involved the joint surface, leading to damage of the cartilage which could potentially cause incongruity of the joint surface. He said that could lead to arthritis of the tibio-talar joint. (Id at 37)

Four other orthopedic specialists examined the Petitioner in connection with her injuries. Dr. Vora performed a Section 12 examination at the Respondent's request on July 22, 2016. He found mild limitation of motion in the ankle, slight atrophy in the right calf, slight swelling in the right ankle and pain on palpation. Though he opined that her subjective complaints exceeded her objective findings, Dr. Vora concluded that at that time she was unable to perform the full duties of a police officer. He suggested that her condition could improve with further treatment. Drs. Boscardin, Anderson and Kolb all examined the Petitioner in connection with her claim for service related disability. The exams took place between July and August of 2017. All three doctors found her unable to perform the full duties of her job. They also opined that it was unlikely that she could improve enough with future treatment, including hardware removal, to be able to perform her job. (PX 14, 15, 16)

The Petitioner was no longer working as a police officer at the time of trial. The Petitioner has changed her job and now is an independent contractor selling products for Mary Kay.

WHAT IS THE NATURE AND EXTENT OF THE INJURY?

With regard to the issue of nature and extent, the Arbitrator notes that pursuant to Section 8.1b of the Act, for accidental injuries occurring after September 1, 2011, permanent partial disability shall be established using five enumerated criteria, with no single factor being the sole determinant of disability. Per 820 ILCS 305/8.1b(b), the criteria to be considered are as follows: (i) the reported level of impairment pursuant to subsection (a) [AMA "Guides to the Evaluation of Permanent Impairment"]; (ii) the occupation of the injured employee; (iii) the age of the employee at the time of the injury; (iv) the employee's future earning capacity; and (v) evidence of disability corroborated by the treating medical records. Applying this standard to this claim, the Arbitrator makes the following findings listed below.

With regard to Sec. 8.1(b) (i); the Arbitrator notes that there was no impairment rating performed on the Petitioner in this case. This factor will not be considered.

With regard to Sec. 8.1(b) (ii); the occupation of the Petitioner, the Arbitrator notes that the Petitioner was employed by the Respondent as a Patrol Police Officer. The Petitioner was unable to return to work regular work duties. The Petitioner was placed under permanent restrictions. The Petitioner's occupation did change

~~and she is unable to pursue her normal occupation as a direct result of the work injuries. The Arbitrator gives~~ considerable weight to this factor.

With regard to Sec. 8.1(b) (iii); the Arbitrator notes that the Petitioner was 43 years old at the time of the injury. The Arbitrator gives significant weight to this factor, as the Petitioner is a young individual who will be living with pain and arthritis for a long time period.

With regard to Sec. 8.1(b) (iv); the Petitioner's future earning capacity, there is evidence that the Petitioner would have loss of earning capacity as a police officer. At the time of trial, the Petitioner was receiving a pension disability. Respondent argued that her line of duty pension provided by the City of Peoria provides her guaranteed income to eliminate any loss of her future earning capacity. The Arbitrator does not find this argument to be persuasive. The evidence established that the Petitioner is permanently restricted and unable to return to her regular profession as a police officer. As such, her career choices are limited. Her occupational base has now been significantly narrowed and, at her age, will be narrowed for a long time. Her pension benefits are not earnings. According to the testimony of Mr. Nichting of the Pension Board, the Petitioner's entitlement to the benefits is subject to an annual review by a doctor of their choosing. In other words, her ability to receive those benefits is out of her control. They do not impact her future earning capacity. The Arbitrator places significant weight on this factor.

Sec 8.1(b) (v); the evidence substantiates permanent restrictions placed upon the Petitioner after two surgeries to her right ankle. The Petitioner has sustained three fractures to her right ankle. As a result of the work injury, the Petitioner has been placed on permanent restrictions. The Petitioner has altered her occupation and activities due to the work injury. In addition to the objective findings seen by Dr. Kinzinger she also has some likelihood of developing arthritis in the future. Her symptoms and exam findings do show some improvement since her hardware was removed. Dr. Kinzinger's office note of November 2, 2017 shows a slight increase in her ankle motion over previous exams. Her reported symptoms were also less than before the surgery and she expressed the same improvements when she saw Dr. San German on December 8, 2017. (PX 4,5) Based on the evidence at the time of trial, the Arbitrator gives significant weight to this factor.

As stated above, the Respondent has argued that the Petitioner has not suffered any wage loss because her entitlement to a disability pension. They go on to argue that the amount of the benefit negatively impacts the amount of compensation she should receive pursuant to Section 8 (d) 2 of the Act. The Arbitrator does not find this argument to be persuasive. First of all, the Respondent cites no authority to support its position. Secondly, as stated above, the pension benefits are not a substitute for the earning capacity she has lost because of her injuries. Finally, Section 8 (d) 2 does not even require one to show a loss of earning capacity to receive an award. In this case the Petitioner must show that her injuries partially incapacitated her from performing the duties of her usual and customary line of employment. As stated above, the evidence clearly points to such a finding.

Based on the above factors, and the record taken as a whole, The Arbitrator finds the Petitioner sustained permanent partial disability to the extent of 40% loss of use of her person as a whole pursuant to section 8(d) 2.

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

Patrick Devlin,

Petitioner,

vs. NO: 17WC 17441

Village of Ashland,

Respondent.

19IWCC0290

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, nature and extent, medical expenses, prospective medical care, surgery authorization and 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 10, 2018, is hereby affirmed and adopted.

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

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

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

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

DATED: JUN 13 2019

Elizabeth.Coppoletti

o060519
LEC/jrc
043

Stephen Mathis

Douglas McCarthy

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

DEVLIN, PATRICK
Employee/Petitioner

Case# **17WC017441**

VILLAGE OF ASHLAND
Employer/Respondent

19IWCC0290

On 8/10/2018, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 2.18% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

1824 STRONG LAW OFFICES
RYAN L MEIKAMP ESQ
3100 N KNOXVILLE AVE
PEORIA, IL 61603

2337 INMAN & FITZGIBBONS LTD
FRANK G JOHNSTON ESQ
301 N NEIL ST STE 350
CHAMPAIGN, IL 61820

STATE OF ILLINOIS)
)SS.
COUNTY OF SANGAMON)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

PATRICK DEVLIN
Employee/Petitioner

v.

VILLAGE OF ASHLAND
Employer/Respondent

Case # **17** WC **17441**

Consolidated cases: ____

19IWCC0290

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Christina Hemenway**, Arbitrator of the Commission, in the city of **Springfield**, on **June 18, 2018**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On the date of accident, **November 28, 2016**, Respondent *was* operating under and subject to the provisions of the Act.

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

On this date, 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 **$31,317.00**; the average weekly wage was **$602.25**.

On the date of accident, Petitioner was **61** years of age, ***married*** with **0** dependent children.

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

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

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

ORDER

As explained in the Arbitration Decision, Petitioner's current condition of ill-being with regard to his left hand and wrist is causally related to the accident of November 28, 2016. Petitioner has not reached maximum medical improvement.

Respondent shall pay for prospective medical treatment related to his left hand and wrist, including surgery, as recommended by Dr. Ma.

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 8, 2018
Date

ICArbDec19(b)

AUG 10 2018

STATE OF ILLINOIS)
) SS
COUNTY OF SANGAMON)

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

PATRICK DEVLIN
Employee/Petitioner

v. Case #: **17 WC 17441**

VILLAGE OF ASHLAND
Employer/Respondent

MEMORANDUM OF DECISION OF ARBITRATOR

FINDINGS OF FACT

This cause came before the Arbitrator on Petitioner's Section 19(b) Petitioner. The parties stipulated that Petitioner sustained an accident which arose out of and in the course of his employment on November 28, 2016. Issues at the time of hearing were causal connection and prospective medical, specifically the surgery recommended by Dr. Ma. The parties stipulated, however, that should the Arbitrator find in favor of Respondent on those issues, further issues of nature and extent and credit for a prior permanency settlement of 10.5% of the left hand should be also addressed by the Arbitrator.

On November 28, 2016, Petitioner was 61 years old, married, and had no dependent children. He was employed by Respondent in the Public Works department and on that day was instructed to rotate the tires on his work truck. He jacked up each end of the truck, rotated the tires, and at one point attempted to kneel down on the "creeper". He described the creeper as a piece of equipment that has wheels on it and is used to get underneath the vehicle. He testified that as he knelt down on the creeper it slid out from under him and he fell forward. The back of his left hand caught the metal frame of the creeper and he fell forward onto the creeper. He testified that his hand was flat against the metal part of the creeper and his chest was on top of it, but his wrist did not bend or flex. He had pain and noticed a "goose egg" on the back of his hand that stuck up about an inch or so. He demonstrated that the location of the bump was on the back (or dorsal side) of his hand, just up from his wrist. Petitioner testified that he had a prior problem with his left hand in 1984, but at the time of the accident he was not having any issues with his hand and was not under any work restrictions.

Petitioner testified that he reported the accident to the girls in the office, as well as to his supervisor. He was taken by one of the office employees to the emergency room at that time,

where he was treated with a brace. He followed up with his family doctor about a month later, who referred him to Dr. Ma at Springfield Clinic. At his first appointment, Dr. Ma instructed him to continue wearing the brace, and at the second visit he administered an injection into the wrist. The injection did not help his symptoms and he continued to have pain, at which point Dr. Ma recommended surgery. He has not had the surgery to date but would like to do so. He has not returned to Dr. Ma since April 2017.

Petitioner testified that he currently cannot move his hand backwards without sharp pain in the center of his wrist. He no longer works for Respondent, as he had an opportunity to work for his son-in-law in a less physical position, which he took at least in part due to his left hand.

On cross-examination, Petitioner acknowledged that he had not sought medical treatment in about 18 months and that he had seen Dr. Ma a total of three times. He acknowledged that he had seen Physician's Assistant Taylor Manning in November 2017 and January 2018 for unrelated health issues, and did not report any concerns or symptoms related to his left wrist. He acknowledged that he was not given any work restrictions by his primary physician or by Dr. Ma, except to wear the wrist brace.

Following the accident, Petitioner presented to the emergency room at Passavant Area Hospital and reported he had fallen onto his left wrist when the creeper slipped. The trauma nurse noted swelling about the left wrist and circled the entirety of the left dorsal wrist in the diagram to denote the affected area. The diagram also includes an indecipherable word and a line drawn to the ulnar side of the wrist. (PX2, page 2.) The ER physician noted swelling in the left wrist and on the diagram noted swelling in the dorsal wrist and tenderness in the ulnar area. (PX2, page 4.) X-rays showed: (1) no acute trauma or fracture; (2) widening of the scaphoid lunate distance consistent with scaphoid lunate ligament disruption, age uncertain, with likely dorsal intercalated segment instability, "age uncertain but possibly old"; and (3) likely coalition between the capitate and hamate possibly between the capitate and portions of the triquetrum and lunate, versus osteoarthritis, between the capitate and misshapen lunate. It was noted that the findings suggested possible old post-traumatic change and no acute changes. The history noted on the radiology report was, "Fell this morning. Hyperextended left wrist. Pain and swelling ulnar side." PX2.

A CT scan was also completed and revealed: (1) no definitive acute fracture; (2) findings of previous post-traumatic change involving the wrist, including dorsal intercalated segment instability associated with disruption of the scaphoid lunate ligament; (3) perilunate dislocation; (4) bony avulsion fracture fragments dorsal to the wrist, likely originating from the capitate and triquetrum; (5) coalition, likely congenital, between the capitate and hamate bone; (6) marked osteoarthritis between the capitate and lunate, associated with the perilunate dislocation and old post-traumatic change, with marked subchondral cystic change involving the capitate; (7) possible triangular fibrocartilage calcification; and (8) mild ulnar negative variance. The radiologist noted, "I do not see any definitive soft tissue swelling about the wrist to suggest that these changes are acute, likely these changes reflect chronic changes associated with old trauma, *although there is some soft tissue edema perhaps representing bruising in the dorsal soft tissues the level of the distal radius and ulna.*" The history noted on the radiology report was, "Slipped on slider board while working underneath the vehicle, *fell and banded [sic] on left wrist.*" (The history also noted, erroneously, that Petitioner had no prior surgeries to the left wrist or hand.) PX2, RX4.

Assessment by the emergency physician was left wrist contusion. Petitioner was put in a cock-up splint, instructed to ice and elevate his wrist, and was released to return to work the following day. He was to follow up with his primary care physician in two to three days. PX2.

Petitioner's next medical treatment was December 28, 2016, when he presented to Springfield Clinic and was evaluated by Physician's Assistant Taylor Manning. He reported he had hit his left wrist on the edge of the metal creeper and then fell forward onto his wrist. He noted there was no cut or bleeding, but he did have swelling. He reported he had been wearing a brace for the past month and taking anti-inflammatories, Meloxicam, and Tramadol. These treatments had been helpful, but he experienced hand and wrist swelling whenever the brace was off. He also complained of continued tenderness, and increased pain with activities such as turning the steering wheel while driving and pushing or pulling things. PA Taylor noted, "He did injure the left wrist about 30 years ago and tells me that he 'crushed all the bones' in his left wrist. He had this surgically repaired." PA Manning conducted a physical examination and noted that there was mild swelling in the left wrist and hand, without further description as to specific location. Color, range of motion, strength, and sensation were all normal. Assessment was left wrist injury. Petitioner was instructed to continue use of the brace, Meloxicam, and Tramadol and was referred to Dr. Ma in orthopedics. PX3.

On January 4, 2017, Petitioner presented to Dr. Jianjun Ma in the orthopedic department at Springfield Clinic. He completed a patient intake form and noted that a creeper slid out from under him, he fell, and "wrist caught edge of creeper". He also noted he had prior left wrist surgery in 1984 for "broken bones". Dr. Ma noted the following history:

"The patient has a significant medical history of left wrist injury. The patient had left wrist surgery in 1984. The patient stated that he had pins placed in the left wrist with some bone grafting. He stated that he has some pain in the left wrist but he has been doing well overall until recently. The patient experienced pain in the left wrist after a fall at work on 11/28/2016." PX3.

Petitioner reported to Dr. Ma that he had constant and burning pain, which he rated as 5/10, and that the pain was aggravated with daily activities. On examination, there was significant tenderness to palpation on the **dorsal aspect** of the left wrist. Pain was aggravated with wrist extension. Sensation and range of motion was normal. Dr. Ma reviewed the x-rays and CT scan taken in the ER in November and also obtained new x-rays. He noted that the studies showed severe arthritis in the left wrist, especially between the capitate and the lunate, and further showed that the capitate was dorsally subluxated. Dr. Ma talked with Petitioner about the nature of wrist arthritis and noted that he did not believe Petitioner was ready for surgical intervention such as wrist arthrodesis. He instructed Petitioner to continue with bracing, anti-inflammatories, and activity modification, and to return in six to eight weeks. PX3.

On January 23, 2017, Petitioner presented to PA Carol Harper of Springfield Clinic with complaints of low back pain. It was noted he had been through a course of physical therapy, which had helped, and that he was continuing to take Meloxicam and Tramadol. There was no mention of his left hand or wrist. RX4.

Petitioner returned to Dr. Ma on March 8, 2017, and reported continued pain mostly with activity, specifically with shoveling, which he described as intermittent and achy and 4/10 in severity. He noted the pain had not improved over time. On examination, Dr. Ma noted a well-healed surgical scar to the dorsal aspect of the hand. Petitioner had discomfort with wrist flexion. Due to ongoing complaints, Dr. Ma administered an injection into the left wrist and instructed Petitioner to return in six weeks. He noted if symptoms progressed that a repeat CT scan could be warranted. PX3.

On April 11, 2017, Petitioner presented to PA Carol Harper at Springfield Clinic for follow up on lower back and leg pain. It was noted that he had been in physical therapy from November to January. It was further noted that he was taking Meloxicam and Tramadol as needed. There was no mention of his left hand and wrist. RX4.

On April 19, 2017, Petitioner followed up with Dr. Ma and reported that his pain had not improved and that the steroid injection had provided little relief. He described his pain as intermittent, sharp, burning, and 4/10 in severity. He had been wearing a brace with some relief. On examination, there was significant tenderness of the dorsal aspect of the left wrist and pain with flexion. Dr. Ma noted, "X-ray and CT films of the left wrist were obtained today and reviewed by myself suggesting multiple cystic lesion in the capitate, lunate, and triquestral." It is not clear to the Arbitrator whether Dr. Ma is referring to the CT scan taken in the ER or whether a repeat CT was done, as the records do not contain any updated CT report. Dr. Ma noted that he discussed with Petitioner the nature of his wrist/radiocarpal joint arthritis and that he had significant bony destruction of the capitate and lunate. Given the lack of response from bracing and steroid injection, a left wrist fusion was recommended. PX3. The Arbitrator notes this is the final treatment record regarding the left hand and wrist.

On November 10, 2017, Petitioner presented to PA Manning for a medication check for his insomnia and hypertension. It was noted, "He also takes Tramadol and Meloxicam twice a day for his knee pain and his back pain." Petitioner reported that he sometimes had insomnia due the pain from his knee and back. He further reported the he planned to retire at the end of the month. There was no mention of his left hand or wrist. RX4.

On January 17, 2018, Petitioner presented to PA Manning. The record indicates, and Petitioner testified, that this was a pre-operative examination prior to a cataract surgery. There was no mention of the left hand or wrist. RX4.

Respondent's Exhibit 4 contained pre-accident medical records from Springfield Clinic covering the period of January 11, 2011, through November 14, 2016. Treatment during this period was primarily for medication checks and left hip and low back pain. There was no treatment related to the left hand or wrist. The Arbitrator notes, however, that Petitioner was consistently prescribed Meloxicam and Tramadol throughout that period of time for his low back.

On June 9, 2017, Petitioner was evaluated by Dr. Lawrence Li, Respondent's Section 12 examiner. Dr. Li testified by way of deposition on March 19, 2018, consistent with his report following the examination. He is a Board Certified Orthopedic Surgeon whose practice is focused on treatment of the shoulders, hands, and knees. RX1.

As to the mechanism of injury, Dr. Li testified that Petitioner advised that he put his knee on the creeper and it slipped, causing him to fall forward and hit the ulnar aspect of his left wrist on the side of the creeper. He noted that Petitioner hit the ground as well on the same ulnar aspect. He testified that he reviewed the medical records and other documents which were consistent with Petitioner's report to him of the fall occurring on the ulnar wrist. RX1.

Dr. Li noted that Petitioner reported a significant prior injury to his wrist which involved an intercarpal fusion. He described an intercarpal fusion as when some of the eight bones in a wrist are fused to each other as a result of an injury. He further testified that he saw evidence of this fusion when he reviewed the CT scan and x-ray of the left wrist. He opined that the images showed a previous fusion of the capitates, hamate, and possible pisiform. He also noted that the CT scan showed significant osteoarthritis at the lunocapitate articulation and mild osteoarthritis at the radiocarpal joint. He testified that none of the findings on the CT scan of November 28, 2016, could possibly have been caused by this injury. RX1.

Dr. Li testified that during his examination of Petitioner, he noted about 20 degrees less flexion of the left wrist as compared to the right wrist with no gross acute swelling of the left wrist. He noted that Petitioner was non-tender over the ulnar aspect, snuffbox, metacarpals, and CMC joint. The only place Dr. Li noted tenderness was over the capitolunate joint, which is located in the center of the back of the hand. RX1.

Dr. Li diagnosed Petitioner with left wrist injury that was resolved. He also diagnosed Petitioner with preexisting capitolunate osteoarthritis as a result of the previous intercarpal fusion. He opined that the capitolunate arthritis, which still bothered him, was not permanently aggravated, accelerated, or changed by the November 2016 work incident. Dr. Li testified that the rationale for this opinion was that Petitioner fell on the ulnar aspect of the wrist and his symptomatic area was the capitolunate joint in the middle of the back of his wrist. He also opined that Petitioner's problem was osteoarthritis of the joint, which would not occur from an acute injury. Dr. Li acknowledged that Petitioner's presentation at the IME examination and the findings of the CT scan (loss of motion, restriction bending his wrist, soreness) were all consistent with someone who suffered a significant prior wrist injury and had arthritis. RX1.

Dr. Li testified that Petitioner was at maximum medical improvement as it related to the work accident. He did not believe that any work restrictions were necessary. With regard to the surgery recommended by Dr. Ma, irrespective of causation, Dr. Li testified that he would personally try conservative treatment first but conceded that "the radiocarpal fusion would possibly be something that would be needed in the future". RX1.

On cross-examination, Dr. Li stated that he has experience doing complex wrist fusions, though these types of injuries and surgeries are not common. He was directed to page 23 of the records from Passavant Area Hospital and the drawing used to identify Petitioner's symptoms. He acknowledged that the drawing indicated an injury to the entire left wrist, with swelling noted over the ulnar aspect and tenderness over the radial aspect. RX1.

On redirect, Dr. Li testified that given the extent of his left wrist arthritic changes, he would expect Petitioner to have pain. RX1.

Dr. Ma testified by way of deposition on March 13, 2018. He is a Board Certified Orthopedic Surgeon and Board Certified Hand Surgeon. Dr. Ma testified consistent with his treating records. He began treating Petitioner on January 4, 2017, upon referral by PA Taylor Manning, for evaluation of left wrist pain. He noted that Petitioner had a prior wrist injury in 1984 which resulted in surgery with a pin and bone grafting. He further noted that Petitioner complained of worsening pain since his fall at work on November 28, 2016. Upon examination, Dr. Ma noted that he had significant tenderness to palpitation on the dorsal aspect of the wrist as well as pain aggravated with extension. PX4.

Dr. Ma testified that he reviewed Petitioner's CT scan and x-rays, which showed arthritis. He testified that the arthritis was not caused by Petitioner's work accident, but opined that the accident aggravated his condition and caused his wrist to be symptomatic with pain and limited motion. He testified that the work accident was both an aggravation of his underlying degenerative condition and accelerating factor for the need for additional treatment, noting that the pain was "significantly worse after the accident". Dr. Ma further noted that prior to his work accident, Petitioner was working full duty without complaints. PX4.

Dr. Ma testified that he saw Petitioner a total of three times, with treatment consisting of a steroid injection, anti-inflammatories, bracing, and activity modification. After Petitioner reported no improvement in symptoms, he recommended a total wrist fusion to address Petitioner's pain complaints. He did not believe that physical therapy, as recommended by Dr. Li, would benefit Petitioner. He explained that the procedure would fuse the wrist and leave him with only limited motion. Following surgery, Petitioner would be restricted from work for three to six months and thereafter may be able to return to work with restrictions, if available. PX4.

On cross examination, Dr. Ma acknowledged that Petitioner had a prior wrist surgery consisting of bone grafting and a pin, but that he had not reviewed the actual operative report. With regard to the mechanism of injury, he advised that his recollection was that Petitioner had fallen onto his wrist, but nothing more specific beyond that. Dr. Ma acknowledged that Petitioner had not returned to see him since surgery had been recommended (almost 11 months at the time of his testimony) and that he had seen him a total of three times. PX4.

CONCLUSIONS OF LAW

The Arbitrator hereby incorporates by reference the above Findings of Fact, and the Arbitrator's and parties' exhibits are made a part of the Commission's file. After review of the evidence and due deliberations, the Arbitrator finds on the issues presented at trial as follows.

<u>In support of the Arbitrator's decision relating to issue (F), whether Petitioner's current condition of ill-being is causally related to the injury, the Arbitrator finds the following:</u>

A claimant has the burden of proving by a preponderance of the credible evidence all elements of the claim, including that any alleged state of ill-being was caused by a workplace accident. *Parro v. Industrial Commission*, 260 Ill.App.3d 551, 553 (1st Dist. 1994).

The mere existence of health problems of an employee prior to a work-related injury neither deprives the employee of a right to benefits nor relieves the employee 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 courts have established that when a pre-existing condition is aggravated by employment, it may constitute a work-related accident. *Peoria Motors v. Industrial Comm'n*, 92 Ill.2d 260 (1982); *Cook Co. v. Industrial Comm'n* 68 Ill.2d 24 (1977). However, the claimant maintains the burden of showing that their ongoing condition is work related by a preponderance of the credible evidence. *Lawless v. Industrial Comm'n*, 96 Ill.2d 260 (1983); *Lyons v. Industrial Comm'n*, 96 Ill.2d 198 (1983).

The parties stipulated that Petitioner sustained an accident which arose out of and in the course of his employment on November 28, 2016. The Arbitrator finds that Petitioner's current condition of ill-being with regard to his left hand and wrist is causally related to his work accident on November 28, 2016, and finds that he has not reached maximum medical improvement. In so concluding, the Arbitrator finds significant that the record is consistent throughout with regard to Petitioner's complaints and objective findings, which started immediately after the accident.

The record establishes that Petitioner presented to the emergency room less than two hours after the accident and reported that he had *fallen onto his left wrist*. The trauma nurse and the attending physician both noted swelling in his wrist, not only on the ulnar/pinky side but also on the dorsum, or back, of the wrist. The x-ray technologist noted a history that Petitioner had fallen and *hyperextended his left wrist* with resulting pain and swelling on the ulnar side. The CT technologist noted a history that Petitioner had fallen and *landed on his left wrist*. The radiologist, Dr. Raymond Lee, reviewed the CT films and noted that there was no definitive soft tissue swelling about the wrist to suggest an acute trauma, but that there was some soft tissue edema *"perhaps representing bruising in the dorsal soft tissues the level of the distal radius and ulna."* All of these histories and objective observations are consistent with Petitioner's testimony as to how the accident occurred and his subjective complaints following the accident.

The record further establishes that Petitioner thereafter followed up with his primary care physician and reported that he hit his wrist on the edge of the creeper and "ended up falling forward *onto his wrist*". Swelling was noted on examination. Thereafter, although Dr. Ma did not elaborate on the history of the mechanism of the accident, he did note tenderness on the dorsal aspect of the left wrist and pain that was aggravated with wrist extension. Again, these histories and objective findings are consistent with Petitioner's testimony.

Although Respondent attempted to show that Petitioner simply hit the ulnar side of his wrist, without trauma to the dorsal aspect, the record does not support this position, as detailed above. It is undisputed that Petitioner sustained a previous severe injury to his left wrist in 1984, for which he underwent surgery with pinning and bone grafting, and which resulted in arthritis. The record is void, however, of any evidence of recent treatment, complaints, or restrictions with

regard to his left wrist prior to his fall at work. Petitioner's testimony went unrebutted as to the *lack of* such treatment, complaints, or restrictions prior to the fall.

The Arbitrator notes that Dr. Li opined that Petitioner's pre-existing arthritis was not permanently aggravated, accelerated, or changed by the November 2016 work incident. He testified that the rationale for this opinion was that Petitioner fell on the ulnar aspect of the wrist and his symptomatic area was the capitolunate joint in the middle of the back of his wrist. Given the foregoing discussion regarding the history of the mechanism of the fall, the Arbitrator finds that Dr. Li's opinion is not supported by the treating record.

Based upon the foregoing and the record in its entirety, the Arbitrator finds that Petitioner met his burden of proof on the issue of causation.

In support of the Arbitrator's decision relating to issue (K), Petitioner's entitlement to prospective medical care, the Arbitrator finds the following:

Upon establishing causal connection and the reasonableness and necessity of recommended medical treatment, employers are responsible for necessary medical care required by their employees. Specific medical procedures or treatment that have been prescribed by a medical service provider have been "incurred" within the meaning of the statute, even if they have not yet been paid for. *Plantation Mfg. Co. v. Industrial Comm'n*, 294 Ill.App.3d 705, 710 (2nd Dist. 1997).

Dr. Ma has recommended a total wrist fusion and Petitioner would like to undergo the procedure. Dr. Li recommended, irrespective of causation, that Petitioner exhaust conservative care prior to such surgery but did concede that "the radiocarpal fusion would possibly be something that would be needed in the future". Dr. Ma testified, and the record is clear, that Petitioner has undergone conservative treatment of bracing, activity modification, anti-inflammatories, and a steroid injection. Dr. Ma opined that physical therapy, as suggested by Dr. Li, would not be of benefit to Petitioner and would not eliminate the need for surgery.

The Arbitrator finds that Petitioner has not reached maximum medical improvement and is in need of further care. The Arbitrator further finds that Respondent is liable for prospective medical care for Petitioner's left hand and wrist, including the surgery recommended by Dr. Ma.

In light of the Arbitrator's findings, the remaining issues of nature and extent of the injury and credit for a prior permanency settlement are not ripe and are rendered moot at this time.

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Jerry Endicott,

Petitioner,

vs. NO: 18 WC 11057

Madison County Sheriff,

19IWCC0291

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by Petitioner herein and notice provided to all parties, the Commission after considering the sole issue of permanent partial disability and being advised of the facts and the 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.

Pursuant to Section 8.1b of the Act, the Commission weighs the following five factors accordingly (*820 ILCS 305/8.1b(b)* (West 2014); *Corn Belt Energy Corp. v. Illinois Workers' Compensation Commission*, 2016 IL App (3d) 150311WC, ¶ 52, 56 N.E.3d 1101):

Section 8.1b(b)(i) – level of impairment

Neither party obtained an impairment rating; as such, the Commission assigns no weight to this factor.

Section 8.1b(b)(ii) – occupation of the injured employee

At the time of the March 28, 2018 accident, Petitioner was employed as a county sheriff's deputy. Since being released from care by Dr. Paletta, Petitioner has been working his full, regular job without restrictions. T. 18-19. The Commission finds this weighs in favor of a decreased permanence.

Section 8.1b(b)(iii) – age of the employee at the time of the injury

Petitioner was 49 years-old on the date of accident. The Commission observes Petitioner has a moderate work life expectancy which will require him to manage the effects of his injury for some period of time. The Commission finds this weighs in favor of an increased permanence.

Section 8.1b(b)(iv) – employee's future earning capacity

Petitioner returned to work in the same position and earning the same or more than prior to the injury. There is no evidence that his future earning capacity was adversely impacted as a result of his injury. As such, the Commission assigns no weight to this factor.

Section 8.1b(b)(v) – evidence of disability corroborated by treating medical records

According to the medical records, Petitioner was initially evaluated at MultiCare Specialists on March 29, 2018 by Dr. Lupardus, Dr. Eavenson and physical therapist Corey Voss. Petitioner complained of severe left medial knee pain and demonstrated a significant limp. Dr. Lupardus noted digital x-rays of the left knee were obtained and revealed medial joint space narrowing. Corey Voss noted it appeared Petitioner was suffering from a left medial meniscus tear and recommended modalities including electric stimulation, ultrasound, manual mobilization, stretching and an exercise program consisting of stretching and strengthening to be included in a home exercise program. Dr. Eavenson diagnosed a tear of the left knee medial meniscus and ordered a left knee MRI. PX1.

A left knee MRI was performed on March 30, 2018. The radiologist noted the following findings: for the menisci, there was blunting of the free margin of the body of the medial meniscus which may be related to a prior partial meniscectomy. There was a complex tear of the undersurface of the posterior horn of the medial meniscus with displaced meniscal fragment within the meniscal tibial recess. The anterior horn of the medial meniscus and the lateral meniscus were intact. In the patellofemoral joint, there was fissuring of the articular cartilage of the trochlear groove. The marrow signal and articular surfaces showed a diffuse thinning of the articular cartilage throughout the medial compartment of the knee. There were areas of grade IV chondrosis throughout the medial aspect of the medial tibial plateau. There was no focal chondral defect or abnormal bone marrow signal throughout the lateral compartment of the knee. There was a small knee joint effusion and a small popliteal cyst. The soft tissues about the knee were otherwise unremarkable. PX2.

After reviewing the left knee MRI, Dr. Eavenson referred Petitioner to Dr. Paletta of The Orthopedic Center of St. Louis. PX1. On April 4, 2018 Dr. Paletta evaluated Petitioner who complained of pain localized mainly to the medial aspect of the left knee along the joint line and anteriorly. Following his examination, it was Dr. Paletta's impression Petitioner sustained a left

knee medial meniscus tear in the setting of some underlying pre-existing chondrosis and recommended Petitioner consider surgery of arthroscopy with probable partial meniscectomy versus repair. PX3.

Dr. Paletta performed left knee surgery on April 17, 2018. The operative report (PX4) noted the following pre-operative diagnoses: 1) left knee pain; 2) medial meniscus tear; 3) medial compartment degenerative joint disease; and 4) patellofemoral chondrosis. Dr. Paletta performed the following procedures: 1) left knee examination under anesthesia; 2) diagnostic arthroscopy; 3) arthroscopy with debridement and chondroplasty of patellofemoral articulation; 4) arthroscopy with debridement and chondroplasty of medial tibial femoral compartment; 5) partial medial meniscectomy; and 6) partial lateral meniscectomy. PX4.

Petitioner last saw Dr. Paletta on June 6, 2018 and reported no left knee pain and denied any recurrent swelling. Petitioner reported his left knee felt a little tight when he comes into flexion. The physical therapist previously noted Petitioner had not restored to full flexion. On examination, Dr. Paletta found the surgical incisions were well-healed; there was no effusion, no warmth or erythema, and no soft tissue swelling; he had full extension; by goniometer his flexion measured 118 degrees on the left, compared to 126 degrees on the right, and he lacked about 8 to 10 degrees, which was consistent with what the physical therapist's estimate was; there was no residual joint line tenderness; ligament examination was intact; neurovascular examination was intact. Dr. Paletta's impression was Petitioner was doing well. Dr. Paletta noted he explained to Petitioner the mild flexion loss would continue to gradually improve. Dr. Paletta noted Petitioner did not require additional formal physical therapy at this time. Dr. Paletta also noted Petitioner could begin a return to full activities as tolerated, including full recreational and vocational activities. Petitioner required no specific work restrictions. Dr. Paletta opined Petitioner was at maximum medical improvement and discharged from care. Petitioner was to return to work effective June 11, 2018. PX3.

Petitioner testified his lack of left knee range of motion had not improved since his last visit with Dr. Paletta. T. 15. He has frequent left knee aching, overall aching of his entire left knee, especially in the mornings which requires him to take Ibuprofen or anti-inflammatories. T. 16. The achiness increases throughout the day, and if he sits for an hour or two, his left knee begins to ache. *Id.* Petitioner uses a joint lubricant supplement, Glucosamine Chondroitin as well as an anti-inflammatory twice a day a couple of times a week. T. 16-17.

The Arbitrator found Petitioner's ongoing complaints noted above were not corroborated by Dr. Paletta's records. The Commission disagrees and finds the medical records do corroborate Petitioner's complaints. The Commission finds the above weighs in favor of an increased permanence.

Based on the above factors and the record in its entirety, the Commission finds Petitioner sustained a 17.5% loss of use of the left leg pursuant to Section 8(e) of the Act.

The Commission notes the Arbitrator awarded Respondent credit of $11,324.19 paid in temporary total disability benefits but did not award the corresponding benefits. The Commission finds Petitioner was temporarily totally disabled from March 29, 2018 through June 10, 2018, a period of 10-3/7 weeks.

The Commission affirms all else.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Arbitrator's December 7, 2018 decision is modified for the reasons stated herein and otherwise affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay the reasonable, necessary and related medical expenses including the treatment outlined in PX5 covering the care of Dr. Paletta and at The Orthopedic Ambulatory Surgery Center, The Orthopedic Center of St. Louis and MRI Partners of Chesterfield, as per the parties' stipulation and pursuant to §8(a) of the Act, subject to the Medical Fee Schedule pursuant to §8.2 of the Act. The parties also stipulated Respondent shall pay the medical bills submitted at trial for Petitioner's treatment with MultiCare Specialists for both chiropractic services and physical therapy services up to and including April 4, 2018 and, thereafter, only for physical therapy services at said provider between May 1, 2018 and June 7, 2018 pursuant to §8(a) of the Act, subject to the Medical Fee Schedule pursuant to §8.2 of the Act. The parties further stipulated Respondent is not responsible for any other charges at MultiCare Specialists. Respondent shall receive credit for all medical benefits that have been paid, and Respondent shall hold Petitioner harmless for any claims as provided in §8(j) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $790.64 per week for a period of 37.63 weeks, as provided in §8(e) of the Act, for the reason that the injuries sustained caused the permanent loss of use of the left leg to the extent of 17.5%.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall have credit for all amounts paid, if any, to or on behalf of Petitioner on account of said accidental injury. The Commission notes Respondent paid $11,324.19 in temporary total disability benefits for the period from March 29, 2018 through June 10, 2018.

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

There is no bond for the removal of this cause to the Circuit Court by Respondent pursuant to §19(f)(2) of the Act. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: JUN 13 2019
LEC/maw
o05/01/19
43

L. Elizabeth Coppoletti

Stephen J. Mathis

D. Douglas McCarthy

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

ENDICOTT, JERRY
Employee/Petitioner

Case# **18WC011057**

MADISON COUNTY SHERIFF
Employer/Respondent

19IWCC0291

On 12/7/2018, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 2.49% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

4463 GALANTI LAW OFFICE PC
DAVID M GALANTI
PO BOX 99
E ALTON, IL 62002

1001 SCHREMPF KELLY & NAPP
MATTHEW W KELLY
307 HENRY ST SUITE 415
ALTON, IL 62002

19IWCC0291

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
NATURE AND EXTENT ONLY

Jerry Endicott
Employee/Petitioner

v.

Madison County Sheriff
Employer/Respondent

Case # **18** WC **11057**

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 **Nancy Lindsay**, Arbitrator of the Commission, in the city of **Collinsville**, on **October 18, 2018**. By stipulation, the parties agree:

On the date of accident, **3/28/18**, 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 $**84,698.04**, and the average weekly wage was $**1,628.82**.

At the time of injury, Petitioner was **49** years of age, ***married*** with **2** dependent children.

Necessary medical services and temporary compensation benefits have been provided by Respondent.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

Petitioner sustained an undisputed accident to his left knee on March 28, 2018. The only issue in dispute is the nature and extent of Petitioner's injury.

The Arbitrator finds as follows:

Petitioner was first seen for medical care and treatment in connection with his left knee injury at MultiCare Specialists on March 29, 2018. At that time, a course of chiropractic care and physical therapy was undertaken. (PX 1)

Dr. Eavenson ordered an MRI which was completed at MRI Partners on March 30, 2018. Same revealed a complex tear of the undersurface of the posterior horn of the medial meniscus with a displaced meniscal fragment. There was no indication of an acute ligament injury. There were degenerative changes noted. (PX 1; PX 2)

Petitioner then undertook a course of care with Dr. George Paletta beginning on April 4, 2018. At that time, Dr. Paletta diagnosed a medial meniscus tear with some underlying, pre-existing chondrosis, for which Dr. Paletta recommended an arthroscopy with a probable partial meniscectomy versus a repair. (PX 3)

The surgery was completed at The Orthopedic Ambulatory Surgery Center of Chesterfield on April 17, 2018. On that date, Dr. Paletta undertook an arthroscopy with a debridement and chondroplasty, a partial medial meniscectomy and a partial lateral meniscectomy. Dr. Paletta's post-operative diagnoses were of left knee pain, a left knee medial meniscus tear, left knee degenerative joint disease, left knee patellofemoral chondrosis and a left knee lateral meniscus tear. (PX 3; PX 4)

On April 30, 2018, Petitioner followed up with Dr. Paletta at which time Dr. Paletta recommended a further four-week course of physical therapy for Petitioner.

Petitioner returned to Dr. Paletta for the last time on June 6, 2018. Petitioner denied any knee pain or recurrent swelling. Dr. Paletta noted the Petitioner's left knee lacked 8 to 10 degrees of flexion in the left knee as compared to his right knee, and that this was consistent with what the therapist's estimate of his loss of range of motion. Further, Dr. Paletta discussed with Petitioner glucosamine and chondroitin sulfate brand types to treat his on-going problems, as well as allowing him to use over the analgesics, such as Aleve or Ibuprofen as needed. Petitioner was resassured regarding the mild flexion loss which the doctor felt would gradually improve. Dr. Paletta placed Petitioner at maximum medical improvement, released Petitioner from care and concluded that Petitioner was capable of returning to full, unrestricted activities as of Monday, June 11, 2018. (PX 3)

Petitioner's case proceeded to arbitration on October 18, 2018. Petitioner was the sole witness at the hearing. Respondent tendered no exhibits.

At trial, Petitioner was asked what problems he was having, other than the range of motion noted in Dr. Paletta's medical records and he testified that he has frequent aching in his knee, in particular in the morning, that he occasionally takes over-the-counter pain medications and that he utilizes a joint lubricant supplement, which he had also taken prior to the accident. He testified that his knee range of motion has not improved since June 6, 2018 and he has ongoing pain estimated at a "3" on a scale of "1 – 10" as well as global aching.

The parties have stipulated and Respondent agrees that it shall pay, pursuant to the fee schedule or negotiated rate, whichever is less, all reasonable and related necessary medical services associated with Petitioner's claim, including the treatment outlined in Petitioner's Exhibit No. 5 covering Petitioner's treatment under the care of Dr. Paletta and at The Orthopedic Ambulatory Surgery Center, The Orthopedic Center of St. Louis and MRI Partners of Chesterfield. The parties have also stipulated and Respondent agrees that it shall pay, pursuant to the fee schedule or negotiated rate, whichever is less, the bills submitted at trial for Petitioner's treatment with MultiCare Specialists for both chiropractic services and physical therapy services up to and including April 4, 2018 and, thereafter, only for physical therapy services at said provider, for Petitioner's therapy covering between May 1, 2018 and June 7, 2018. The parties have stipulated that Respondent is not responsible for any other charges at MultiCare Specialists.

Respondent shall be given a credit of $**11,324.19** for TTD, $**0** for TPD, $**0** for maintenance, and $**0** for other benefits, for a total credit of $**11,324.19**.

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 **$790.64/week** for a further period of **32.35 weeks**, as provided in Section 8 (e) of the Act, because the injuries sustained caused **15% loss of use of the left leg.**

Respondent shall pay Petitioner compensation that has accrued from **3/28/18** through **10/18/18**, 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.

Nancy Lindsay
Signature of Arbitrator

December 4, 2018
Date

DEC 7 - 2018

Petitioner testified that he can walk, jog, and he has no pain with activities. He had not yet tried "full out" running. Petitioner has returned to his full, unrestricted employment as a Madison County Sheriff's Deputy.

The Arbitrator concludes:

Issue (L) Nature and Extent

Since this injury occurred after September 1, 2011, the Arbitrator analyzes permanent partial disability under the five factors set forth in Section 8.1(b). Pursuant to §8.1b of the Act, permanent partial disability from injuries that occur after September 1, 2011 are to be established using the following criteria: (i) the reported level of impairment pursuant to subsection (a) of the Act; (ii) the occupation of the injured employee; (iii) the age of the employee at the time of the injury; (iv) the employee's future earning capacity; and (v) evidence of disability corroborated by the treating medical records. 820 ILCS 305/8.1b. The Act provides that, "No single enumerated factor shall be the sole determinant of disability." 820 ILCS 305/8.1b(b)(v).

First, the Arbitrator observes that there has been no reported level of impairment pursuant to AMA guidelines. Therefore, the Arbitrator gives no weight to this factor.

Second, the Arbitrator considers the occupation of the injured employee. Petitioner's occupation is that of a county sheriff's deputy. He is required to engage in the full duties of a law enforcement officer and is working full duty with no indication as to any need for assistance and with no testimony as to any difficulty performing his regular job duties. The Arbitrator gives great weight to this factor.

Third, the Arbitrator considers the age of the employee at the time of the injury. Petitioner was 49 years old at the time of his accident and has a moderate number of years ahead of him to work. Petitioner can reasonably be expected to work and live with the effects of his injury for some period of time. The Arbitrator gives weight to this factor.

Fourth, regarding a loss of future earning capacity, the Arbitrator notes that no evidence was presented as to same. Therefore, the Arbitrator assigns no weight to this factor.

Fifth, evidence of disability corroborated by the medical records of Petitioner's treating physician, the Arbitrator notes that Dr. Paletta indicated that Petitioner could be subject to early arthritis as a result of his injury and surgery. Dr. Paletta also concluded that Petitioner was "doing well" at the time of his discharge from care. Petitioner's ongoing complaints as described at arbitration are not corroborated by Dr. Paletta's records. The Arbitrator gives weight to this factor.

Having considered all of the factors above, the Arbitrator concludes that Petitioner has sustained a 15% loss of his left leg 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 WINNEBAGO	)	☐ Reverse	☐ Second Injury Fund (§8(e)18)
			☐ PTD/Fatal denied
		☒ Modify Permanent Disability	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

ROBERTO RAMIREZ,

Petitioner,

vs. NO: 16 WC 32826

WALMART,

19IWCC0292

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of causation 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 Arbitrator concluded that although Petitioner sustained an injury to his right ring finger only, his resulting deficits merited an award of loss of use of the hand. Respondent takes issue with the Arbitrator's finding, first arguing the Section 8.1b(b) analysis was improper, then arguing Petitioner's injury was limited solely to a single finger and therefore his disability is a loss of a finger. While the Commission is not persuaded by Respondent's arguments regarding the Section 8.1b(b) factors, we do agree Petitioner's permanent disability is properly measured as a loss of use of a finger.

There are two avenues by which a claimant with a finger injury can establish permanent disability as loss of use of the hand: 1) statutorily under §8(e)9, or 2) the evidence establishes the disability to the finger affects the functionality of the hand. Section 8(e)9 provides as follows:

> The loss of 2 or more digits, or one or more phalanges of 2 or more digits, of a hand may be compensated on the basis of partial loss of use of a hand, provided,

> further, that the loss of 4 digits, or the loss of use of 4 digits, in the same hand shall constitute the complete loss of a hand. *820 ILCS 305/8(e)9.*

In the instant matter, Petitioner suffered an injury to only one phalange of one digit: the proximal interphalangeal ("PIP") joint of his right ring finger. As such, his injury does not come under the umbrella of §8(e)9. Therefore, to qualify for permanent disability to the hand, Petitioner's residual deficits must appreciably affect the functionality of his hand. Petitioner testified he has pain in his finger while working, specifically with the cold temperatures in the cooler, handing bags to customers, and pulling pallets of merchandise. T. 12. He also reported problems with putting his hand in his pocket, putting on his socks, tying his shoes, and typing. T. 12-14.

The Commission finds the difficulties Petitioner described are not so burdensome as to constitute a loss of use of the hand. Nonetheless, the medical records establish Petitioner has a 45-degree contracture of the PIP joint of his right ring finger. The Commission finds this is a significant deformity to Petitioner's finger. Moreover, Petitioner credibly testified he routinely experiences pain in his finger.

The Commission vacates the award of 17.5% loss of use of the hand and instead finds Petitioner sustained a 75% loss of use of the right ring finger pursuant to Section 8(e)4. It necessarily follows from our conclusion that Respondent's credit for the prior loss of use of a hand award is no longer applicable, and we vacate same.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed March 16, 2018, as modified above, is hereby affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that the award of 17.5% loss of use of the right hand, as well as the corresponding credit for the prior award of 5% loss of use of the right hand, are vacated.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $461.77 per week for a period of 20.25 weeks, as provided in §8(e)4 of the Act, for the reason that the injuries sustained caused the 75% loss of use of the right ring finger.

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.

19IWCC0292

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $9,500.00. 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: JUN 13 2019

LEC/mck

O: 5/1/19

43

L. Elizabeth Coppoletti

Stephen Mathis

D. Douglas McCarthy

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

RAMIREZ, ROBERTO
Employee/Petitioner

Case# **16WC032826**

WALMART
Employer/Respondent

19IWCC0292

On 3/16/2018, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.85% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

2489 BLACK & JONES
JASON ESMOND
308 W STATE ST SUITE 300
ROCKFORD, IL 61101

5074 QUINTAIROS PRIETO WOOD & BOYER
LEO PLUCINSKY
233 S WACKER DR 70TH FL
CHICAGO, IL 60606

STATE OF ILLINOIS)
)SS.
COUNTY OF Winnebago)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Roberto Ramirez
Employee/Petitioner

v.

Walmart
Employer/Respondent

Case # 16 WC 32826

Consolidated cases:

19IWCC0292

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Jessica Hegarty**, Arbitrator of the Commission, in the city of **Rockford**, on **January 17, 2018**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. [ ] Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?

B. [ ] Was there an employee-employer relationship?

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

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

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

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

G. [ ] What were Petitioner's earnings?

H. [ ] What was Petitioner's age at the time of the accident?

I. [ ] What was Petitioner's marital status at the time of the accident?

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

K. [ ] What temporary benefits are in dispute?
[ ] TPD [ ] Maintenance [ ] TTD

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

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

N. [ ] Is Respondent due any credit?

O. [ ] Other

FINDINGS

On the date of accident, **November 27, 2015**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner's average weekly wage was **$769.62**.

On the date of accident, Petitioner was **44** years of age, ***married*** with **2** dependent child.

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

ORDER

- The Respondent shall pay the Petitioner the sum of **$461.77** / week for a period of 25.625 weeks, as provided in Section 8(e) of the Act, representing 17.5% **loss of use of the right hand, less Respondent's credit of 5% loss of the right hand** as a result of settlement in case number 13 WC 24917.

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

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

Signature of Arbitrator

3/15/18
Date

ICArbDec

MAR 16 2018

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

ROBERTO RAMIREZ Employee/Petitioner,	))	
	)	
V.	)	Case # 16 WC 32826
	)	
WALMART Employer/Respondent.	))	19IWCC0292

ADDDENDUM TO THE DECISION OF THE ARBITRATOR

This matter proceeded to hearing on January 17, 2018 in Rockford, Illinois pursuant to Section 19(b) of the Act. (Arb. 1). The sole issue in dispute is the nature and extent of Petitioner's injury. (Id.).

FINDINGS OF FACT

Petitioner worked in Respondent's loss prevention department for 8-9 years. It is uncontested that on November 27, 2015, Petitioner was injured when a customer ran into his right hand, jamming his right ring finger, after which, he felt pain. Petitioner did not immediately seek treatment as he assumed his finger would improve within a few days.

When Petitioner's condition failed to improve, Respondent sent him to Physician's Immediate Care on January 10, 2016, at which time, Petitioner was diagnosed with a sprain to his right ring finger. (Px. 1). Petitioner then sought treatment on February 3, 2016 with Dr. Jorge Villacorta who recommended Petitioner seek an orthopedic consult. (Px. 2).

On February 25, 2016, Petitioner presented to Ortho Illinois where Dr. Brian Bear provided an injection into the Petitioner' right PIP joint and recommended a course of physical therapy. (Px. 3). Petitioner underwent approximately 2 months of physical therapy through May 3, 2016.

On May 31, 2015, Petitioner followed-up with Dr. Bear who noted, despite a course of conservative care including physical therapy, intra-articular corticosteroid injections, and static wrist splinting, Petitioner had not made significant gains in range of motion. (Id.). Dr. Bear recommended surgical intervention consisting of the placement of an external fixator (i.e. "Digit Widget") on Petitioner's right ring finger which was later performed on August 24, 2016. (Id.).

Surgery to remove the above-mentioned hardware was performed on October 18, 2016. Petitioner then underwent physical therapy through November 30, 2016 in an effort to treat the ongoing contracture.

At his last visit with Dr. Bear on December 6, 2016, Petitioner complained of mild contracture at the PIP joint of the ring finger. He denied pain with rest or activity. After exam, Dr. Bear noted that Petitioner had "developed a recurrent 45-degree PIP joint contracture". (Id.). Dr. Bear noted, "unfortunately, we were unable to maintain the extension achieved with the Digit Widget in place. This phenomenon can occur. It is reported in the literature." Dr. Bear recommended a home exercise program and splinting to prevent worsening of the contracture. The doctor released Petitioner from care at MMI, noting Petitioner can perform all activities without restrictions. (Id.).

Petitioner testified he moved to Respondent's produce department approximately 2-3 months after his injury.

At the hearing, the right-handed Petitioner demonstrated the contracture in his right ring finger.

Petitioner testified he experiences increased pain with cold and heat, has difficulty tying his shoes, typing, handling bags, pulling pallets and lifting more than 5-10 pounds with his right hand. Petitioner further testified he experiences painful cramping in that finger that necessitates extra breaks at times.

Petitioner acknowledged receipt of a prior settlement of 5% loss of use of the right hand due to an injury in April of 2012. Petitioner testified that he had recovered fully from that injury and had normal use of his right hand prior to his November 27, 2015 injury.

CONCLUSIONS OF LAW

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

In assessing the nature and extent of Petitioner's injury, the Arbitrator must consider the following five factors:

An impairment report prepared by a physician using the most current edition of the American Medical Association's "Guides to the Evaluation of Permanent Impairment."

The Arbitrator notes no impairment rating was submitted

The occupation of the injured employee.

Petitioner worked for Respondent for approximately 8-9 years in loss prevention and continues to work for Respondent. Approximately 2-3 months after his injury, Petitioner switched to the produce department. In that capacity, Petitioner testified he experiences difficulty handling baskets, carrying heavy bags, and pulling pallets with his right hand. The Arbitrator assigns greater weight to this factor as Petitioner's occupation requires frequent use of his right hand.

The age of the employee at the time of the injury.

Petitioner was 44 years old at the time of his injury. The Arbitrator assigns more weight to this factor noting Petitioner has many years left in his life with which he must deal with the consequences of his injury.

The employee's future earning capacity.

There was no specific evidence documenting Petitioner's reduced earning capacity. Petitioner testified to changing departments from loss prevention to produce, but did not experience a decrease in pay. Accordingly, the Arbitrator assigns no weight to this factor.

Evidence of disability corroborated by the treating medical records.

Petitioner testified to ongoing pain with heat and cold, difficulty tying his shoes, buttoning clothes, and typing. He described difficulty lifting heavy items or handling baskets. He testified to taking extra breaks at times due to cramping in the ring finger.

At his last appointment on December 6, 2016 with his treating surgeon, Dr. Bear, the doctor noted Petitioner had "developed a recurrent 45-degree PIP joint contracture". (Id.). Dr. Bear noted,

"unfortunately, we were unable to maintain the extension achieved with the Digit Widget in place. This phenomenon can occur. It is reported in the literature." Dr. Bear recommended a home exercise program and splinting to prevent worsening of the contracture. Dr. Bear noted at the time of Petitioner's release in December of 2016 that there was nothing more that could be done to improve the 45-degree PIP contracture.

At Petitioner's last therapy appointment on November 30, 2016, the therapist noted that Petitioner experienced difficulties putting his hands in his pocket and lifting boxes of produce at work due to pain.

The Arbitrator finds that Petitioner's testimony was credible at hearing and consistent with his medical records. The Arbitrator assigns more weight to this factor.

While Petitioner sustained injury to his right ring finger, he has lost some use of his dominant, right hand as a result of the uncontested work-related accident at issue. After a careful review of the evidence contained in the record, including the above-mentioned factors, the Arbitrator finds that Petitioner has sustained a 17.5% loss of the right hand pursuant to Section 8(e) of the Act.

As mentioned above, Petitioner had a prior Workers' Compensation settlement for 5% of his right hand which respect to case 13 WC 24917 (Rx. 2).

Accordingly, the Arbitrator finds that the Respondent shall pay the Petitioner the sum of **$461.77** / week for a period of **25.625** weeks, representing **17.5% loss of use of the right hand, less Respondent's credit of 5% loss of the right hand** as a result of settlement in case number 13 WC 24917, pursuant to Section 8(e) of the Act.

STATE OF ILLINOIS	)		
	) SS.		
COUNTY OF COOK	)		

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

William Lucio,
Petitioner,

vs. NO: 14WC 4982

M & O Environmental,
Respondent.

19IWCC0293

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 statute of limitations, medical expenses, temporary total disability, permanent partial disability, credit for group payments and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed May 23, 2018, is hereby affirmed and adopted.

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

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

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

DATED: JUN 13 2019
o042319
MP/jrc
049

Maria Portela

Deborah Simpson

DISSENT

I dissent from the majority opinion and would find that Petitioner's claim is not barred by the Statute of Limitations. More to the point, I believe that Petitioner condition of ill-being relative to his headaches subsequent to 8/2/10 continued to be causally related to the undisputed head trauma he suffered on 2/17/10, and that as a result the payment of benefits by his union's Health and Welfare Fund on 1/16/12 effectively tolled the Statute of Limitations so that the filing of his Amended Application for Adjustment of Claim on 5/1/14 was timely.

The evidence shows Petitioner suffered a serious injury on the date of accident when the man lift he was driving hit a pot hole and he was thrown out of the basket and struck his head. Petitioner testified that he does not remember much about what transpired after the incident given that he blacked out – hence the confusion in the record as to whether or not he suffered a loss of consciousness. However, he was diagnosed at the time of his initial treatment with a chest wall contusion, neck sprain, open scalp wound and headache, which he rated as 10 out of 10 on the pain scale. Petitioner continued to have headaches on and off thereafter, with differing intensities, including on the date the Arbitrator cut off causation on 8/2/10. Indeed, at that time Dr. Foreit recorded that Petitioner's recurrent headache complaints had been even more intense over the past few weeks, although Dr. Foreit felt it was more sinus-related. (PX2). Petitioner likewise complained of headaches at a subsequent visit to Dr. Foreit on 9/23/10 and eventually when he sought treatment for his chronic "on and off" headaches with Dr. Evans-Beckman on 1/9/12. (PX2, PX4). More importantly, Petitioner reported that he had no history of chronic headaches, blurring of vision or dizziness prior to the accident (T.16; PX1), and he credibly testified that he continued to have headaches and pain during the period he worked for Respondent from 3/22/10 until he sought treatment with Dr. Evans-Beckman on 1/9/12, or what the Arbitrator points out is an almost two-year gap in treatment. It is this gap and other gaps in treatment that would appear to have greatly influenced the Arbitrator's decision to cut off causation as of 8/2/10. However, as Dr. Neri pointed out, Petitioner continued to push through and do what he had to do during this period to keep living. (PX24), and I don't believe that's an unreasonable assumption given the severity of the head trauma Petitioner suffered on the date of the accident and the chronic nature of his condition.

As a result, I would find that Petitioner's condition of ill-being continued to be causally related subsequent to 8/2/10 and up through the date of arbitration, based on the credible testimony of Petitioner and the opinion of Dr. Neri. As such, his Application for Adjustment of Claim was filed within the Statute of Limitations, and I would award benefits accordingly, including a finding that Petitioner is permanently and totally disabled for life pursuant to §8(f) of the Act.

For the foregoing reasons, I dissent.

Thomas J. Tyrrell

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

LUCIO, WILLIAM
Employee/Petitioner

Case# **14WC004982**

M & O ENVIRONMENTAL
Employer/Respondent

19IWCC0293

On 5/23/2018, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 2.08% 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:

1836 RAYMOND M SIMARD PC
205 W RANDOLPH ST
SUITE 815
CHICAGO, IL 60606

2097 GRANT & FANNING
BLAKE LYNCH
300 S RIVERSIDE PLZ SUITE 2050
CHICAGO, IL 60606

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

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

WILLIAM LUCIO
Employee/Petitioner

v.

M & O ENVIRONMENTAL
Employer/Respondent

Case # **14** WC **04982**

Consolidated cases: ____

19IWCC0293

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Paul Cellini**, Arbitrator of the Commission, in the city of **Chicago**, on **March 13, 2018**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **February 17, 2010**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**64,637.20**; the average weekly wage was $**1,243.02**.

On the date of accident, Petitioner was **28** years of age, ***married*** with **7** dependent children.

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

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

Respondent shall be given a credit of $**2,907.40** for TTD, $**0** for TPD, $**0** for maintenance, and $**16,618.00** for other benefits, for a total credit of $**19,525.40**.

ORDER

The Arbitrator finds that the Petitioner has shown by the preponderance of the evidence that the State of Illinois has jurisdiction over his claim involving an accident on February 17, 2010 accident.

The Arbitrator finds that the Petitioner has failed to prove that his condition of ill-being subsequent to August 2, 2010 is causally related to the February 17, 2010 accident.

The Petitioner failed to file his claim with regard to the February 17, 2010 accident within the applicable statute of limitations period pursuant to Section 6(d) of the Act.

No benefits are awarded.

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

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

Signature of Arbitrator

May 18, 2018
Date

MAY 2 3 2018

STATEMENT OF FACTS

Petitioner denied ever having symptoms of or treating for headaches, vertigo, loss of hearing on the right, neck pain, sleeplessness or psychological issues prior to 2/17/10.

In summer of 2007, Petitioner resided in Lynwood, Illinois. He applied to join Heat and Frost Insulators union Local 17, which involved completing an application and taking a one week class for asbestos removal training at the Local 17 facility in Chicago, Illinois. Petitioner testified he was in Illinois when he received a call in the last week of August 2007 from the union business agent (BA), Brian Glenn, offering him a job. He accepted the job and reported to work the next day for Respondent M&O Insulation at a job site at Methodist Hospital in Dyer, Indiana.

At the Dyer site, Petitioner met Respondent's job foreman, Mike Campbell. Petitioner testified the union agreement specified that workers were entitled to two hours of show up time if they appeared for a work assignment. Prior to starting work that day in Dyer, Petitioner had to complete tax forms and take a urine drug test. He then began to work before the results of the drug test, and testified he worked 10 hours that day. At the end of that day, Campbell asked him to report for work at a U.S. Steel in Gary, Indiana the next day, this time for Respondent M&O Environmental, which performs asbestos abatement and removal. He did not complete separate tax documents for M&O Environmental and Insulation.

Respondent's facility was located in East Hazel Crest, Illinois. The Petitioner submitted copies of two separate paychecks from the Respondent from 8/27/07 and 9/2/07 (Px25), one from M&O Environmental and one from M&O Insulation, both of which indicated deductions for union dues. Petitioner testified he worked exclusively for M&O, either for Environmental or Insulation, until the date of accident, 2/17/10, and would receive separate checks from each company, all issued from M&O's Illinois headquarters. He estimated working about 50% of his jobs in Indiana and 50% in Illinois. The job site foreman would tell the workers where to report the next day, and the foreman would receive his instructions from M&O's superintendent at the Illinois headquarters. Petitioner would return to his Illinois home after his workdays.

On 2/17/10, Petitioner was working for M&O Environmental. While driving a manlift at U.S. Steel in Gary, Indiana, he hit a pothole while going over train tracks and: "I guess I flew out of the manlift". He testified he blacked out and didn't recall exactly what happened. The accident was caught on video, and he testified it showed the front right tire got stuck and he flew out, hitting his right side of his body, as well as his left side and head. The video was not submitted into evidence. He was taken to Methodist Hospital, and testified he was conscious when he got in the ambulance: "I felt pain everywhere".

The initial 2/17/10 records from Methodist Hospital indicate Petitioner was thrown from a man lift basket, falling approximately 4 feet and striking his head. The main report indicates he flipped over, hitting is lower right rib cage on the bar before flipping out of the machine, but that he did not hit the ground because he had a harness on. The triage note indicates there was no loss of consciousness, but a flapped head laceration on the forehead at

the hairline. Abdominal pain was also noted with positive discoloration. A pain diagram referenced mild posterior neck pain. X-rays of the nasal bone, cervical spine and chest were negative. Head, abdominal and pelvic CT scanning was unremarkable other than some subcutaneous forehead swelling. Petitioner noted a prior right knee injury and that he was taking medication for it, as his drug testing was positive for opiates. As there was nothing surgically acute regarding the abdomen, Petitioner was discharged on 2/18/10 with pain medication and he planned to follow up with his family doctor. (Px1).

On 2/22/10, Petitioner testified the Respondent had him see Dr. Foreit at Comprehensive Care. Petitioner reported falling out of his forklift while going over several tracks, and that the bouncing impacted his head and stomach. He reported some shortness of breath, head pain and that he had been somewhat forgetful since. His head pain was 10/10, and he noted no other pain other than at the base of his neck and at the cervical and thoracic areas, right greater than left. Neurologic examination was essentially normal, and Petitioner reported no change in cognition or coordination. Norco and ice were prescribed. It appears Petitioner's laceration staples were removed on 2/26/10, and on 3/2/10, Dr. Foreit noted Petitioner reported off and on headaches, but no dizziness or lightheadedness, and that neurologic exam was non-focal. Petitioner was referred to plastic surgeon Dr. Grevious for wound revision. It appears that he had been on work restrictions, but the records do not specify what they were. (Px2).

On 3/4/10, Dr. Grevious performed surgery to debride the necrotic tissue from the head laceration and close the wound. He restricted Petitioner to light duty until on 3/25/10 discharging him and releasing him to full duty as of 3/29/10, noting Petitioner wanted to get back to work as soon as possible. (Px3).

On 3/16/10, Petitioner saw Dr. Foreit and reported no headaches or other head problems, just a little thoracic pain and tightness after returning to work. Based on the TTD stipulations (see Arbx1), Petitioner returned to work on 3/22/10. On 4/5/10, Dr. Petitioner reported his headaches were "just minimal", and he reported no other issues with his head that would be related to the accident. His rib pain was reduced but he still had anterior and posterior chest/thoracic region pain. He was released from care. (Px2).

Petitioner returned to Dr. Foreit on 8/2/10 with complaints of headaches, recurrent with increased intensity over the last couple of weeks, and was concerned it could be related to the accident. He was using over the counter medication for this as well as for congestion. Petitioner also reported some cervical pain, mainly right sided. The doctor prescribed medication and nasal decongestant. Petitioner returned to Dr. Foreit for the last time on 9/23/10. Petitioner was pleased with the laceration suture. He reported he still had occasional headaches, but they were not debilitating, but the medication wasn't helping much when he had them. He continued to sound congested, and there was pressure and swelling in the turbinates. The diagnosis was headache pain most likely with congestive component with diminished effect from previous injury. Dr. Foreit released the Petitioner, noting he should seek private treatment, not workers' compensation, if he had further headache issues. (Px2).

From 3/22/10 to 1/9/12, Petitioner continued to work for the Respondent. He testified that during that time he had constant headaches, pain in his right body from the ankle to just below his neck, and that he felt really tired all the time. He did not again seek treatment until 1/9/12, this time with family physician Dr. Evans-Beckman. He reported complaints of severe headaches on and off since the accident two years prior. An intake form that appears to have been completed by Petitioner reflects he was there for his head and knee. Petitioner also reported rib pain since the accident. He noted right knee pain that was due to an old baseball injury, and was referred for a right knee MRI through insurance (BC/BS) paid for this through Petitioner's health and welfare fund. The Petitioner testified he was referred to neurologist Dr. Curtain, but the Arbitrator does not see this reflected in the records of Dr. Evans-Beckman. The record indicates he was advised to follow up in 6 months. Several subsequent notes reflect consultation with Dr. Chaudri, a DO. Petitioner saw Dr. Chaudri on 2/15/12 and

3/14/12 for orthopedic right knee evaluation, noting a 1995 date of onset. Petitioner reported feeling poorly ("malaise"). The report reflected no problems with the neck or vision, dizziness, vertigo or other sensory disturbances. He did note headache. The only findings involved the right knee. (Px4).

Petitioner saw Dr. Curtain on 4/5/12, and the Arbitrator notes that this handwritten note is difficult to decipher. Petitioner testified Dr. Curtain referred him for a sleep study and CT scan, but the Arbitrator could not read such prescriptions in the report. (Px5).

Petitioner did not then seek further treatment until a 2/4/13 visit to the Advocate Christ Hospital ER with complaints of headache and insomnia for the last 6 to 7 months, apparently more significant over the prior three days. It was a throbbing, frontal headache. He reported no similar headache problems prior to his 2010 work accident, and that since then he'd had headaches about twice a week. The diagnosis was post-concussion syndrome with headaches, and Petitioner indicated he wanted to know what was wrong and asked for an MRI. He was repeatedly offered pain medications, but declined. A brain MRI that day was unremarkable. He was advised to follow up with his family doctor and a neurologist. (Px9).

At a 2/14/13 follow up with Dr. Curtain notes Petitioner reported fear of getting an MRI due to fear of what it would show. Dr. Curtain indicated it was normal. Petitioner reported worsening headaches that had become daily secondary to analgesic rebound – Petitioner reported he had stopped taking Gabapentin because he felt it upset his stomach if he didn't eat in the morning. Dr. Curtain advised him his options were limited and to restart the medication. 2/25/13 and 6/27/13 follow up notes are very hard to read, though the former does note headache and sleep issues. (Px5).

Petitioner testified he was taken off work on 2/21/13 and sent for the sleep study, and that he returned to light duty work on 4/7/13 on light duty, involving restrictions including no work prior to 7 a.m. to allow for sleep, and that he couldn't be left by himself in the warehouse.

Petitioner saw pulmonologist Dr. Heniff on 3/6/13 for complaints of insomnia, which Petitioner indicated he had no problems with prior to the work accident in 2010. He reported this has resulted in fatigue during the day, which became a problem when he fell asleep while driving recently. Dr. Heniff ordered a sleep study and prescribed Ambien, and they discussed sleep habits. (Px7).

A 3/7/13 sleep study with Dr. Warren indicated unspecified hypersomnia, and snoring in the absence of respiratory events which did not explain Petitioner's symptoms. Petitioner had reported daytime sleepiness, "witnessed apnea", morning headaches, sleep fragmentation and nocturnal diaphoresis. It was noted that his EEG was consistent with the use of benzodiazepine (Ambien, clonazepam), and that the three long-acting sedating medications he was taking could explain Petitioner's daytime sleepiness. He was advised to undergo an ENT evaluation and to reduce or eliminate the sedating medications. (Px5).

The sleep study was discussed with Petitioner at a 3/18/13 visit with Dr. Heniff, but the report is minimal, noting only a Trazadone prescription. On 4/1/13, Petitioner reported Trazadone and Ambien weren't helping as he still could not stay asleep. Adderall was added, and on 4/11/13, Petitioner reported this medication helped, so he was taken off Klonopin and Ambien. (Px7). A 6/27/13 work slip of Dr. Heniff restricted Petitioner from ladders and climbing, as he was still having his medications adjusted and was deemed "unstable", however there was no progress or SOAP note to go with this slip (Px5).

On 7/11/13, Dr. Evans-Beckman noted complaints of lightheadedness, persistent headaches, memory loss, agitation and insomnia. Petitioner reported feeling lightheaded at work and that he fell asleep while driving. He

was taken off work, and there is a 7/24/13 note regarding a referral for a neuropsychological evaluation with Dr. Bernard. There is a separate entry from 7/11/13 indicating "Dr. Curtain consult noted", as well as other July notes regarding completion of a disability form. (Px4).

Dr. Evans-Beckman issued multiple disability statements noting diagnoses of migraine, memory loss, near-syncope and lightheadedness: "also severe insomnia Pt. became lightheaded/unable to drive/focus." The notes indicate an onset of 7/10/13, with preexisting migraines, and that the Petitioner "cannot drive, focus, concentrate due to migraine & lightheadedness." He appears to have been held off from 7/11/13 to 1/31/14. A "Head Trauma Residual Functional Capacity Questionnaire completed by Dr. Evans-Beckman notes numerous subjective cognitive problems with all of the Petitioner's mental skills being indicated as either fair to poor/none. It states that Petitioner is incapable of even low stress jobs. The note indicates additional problems of partial deafness in the right ear and blurred vision. (Px4).

On 7/15/13, Dr. Heniff noted Petitioner was seen with his wife to discuss fatigue at work and sleeping issues. Petitioner was taking Adderall and Gabapentin, noting he has tried essentially every sleeping pill and still had insomnia. The doctor noted Respondent wasn't yet covering Rozeram. Heniff noted that, with Gabapentin, Petitioner might always have some unsteadiness and fatigue, but he was continuing to take it as that was the only thing that helped his headaches. Dr. Heniff stated: "I am going to try to get him alert enough so he can return to work without restrictions, but at least at this time with what he describes, I am uncomfortable to do that as he works with heavy equipment and has to climb heavy beams and has already had a hand injury related to a work accident." He again referred Petitioner for a sleep study with Dr. Warren, so it does not appear he reviewed the prior study. (Px5).

On 7/22/13, Dr. Warren noted Petitioner began to develop severe headaches several months ago, and then severe sleeplessness. Gabapentin helped his headaches, but resulted in intermittent dizziness. Adderall was started for chronic ADD symptoms – while that condition had since improved, he still had insomnia. Dr. Warren noted the sleep study showed a complete absence of respiratory events, limb movements or sleep fragmentation. He opined that Petitioner may have an element of "sleep state misperception." While he believed Petitioner had insomnia, given his wife's report of having witnessed it, he noted this was likely multifactorial and that Petitioner could have a mood disorder (irritability) or possibly insomnia from psychophysiologic causes. He started Petitioner on Cymbalta and indicated he should reduce his Gabapentin dose given complaints of dizziness. (Px8).

7/22/13, Petitioner started losing time from work, and he testified that he hasn't worked anywhere since that date.

Petitioner initially sought treatment with ENT Dr. LoSavio on 7/25/13 at Rush. Petitioner presented with concern for hearing loss, right greater than left, over the last 16 years after getting hit in the head with a bat with possible TM perforation. He also noted the work injury, and that he lost consciousness and had worse hearing since. Petitioner also reported a 2-week history of daily vertigo, and that he had an episode of bloody drainage from the right ear a week prior. Petitioner reported increasing headaches over the past year. Dr. LoSavio had an audiogram performed that day and diagnosed sensorineural hearing loss on the right. Impacted cerumen was removed from the bilateral ears. An MRI was prescribed, as well as dyazide, noting a question of whether Petitioner had Meniere's disease given the vertigo symptoms. (Px11).

A temporal bone MRI was performed on 7/30/13 and was noted to be unremarkable. (Px11).

Petitioner sought care on 7/31/13 with neurologist Dr. Mercurio at Rush University. He testified this was on referral from Dr. LoSavio. The intake form noted Petitioner was seeking a second opinion regarding headaches

and dizziness. Petitioner reported a three-year history of frontal headaches and a 3-week history of four episodes of dizziness/lightheadedness. He reported the headaches started a month after the 2010 accident and progressively worsened. After Dr. Curtain prescribed Gabapentin, Petitioner indicated he didn't initially take it, and that he has variable success with it, noting multiple other medications haven't helped. Petitioner also complained of insomnia and irritability. Dr. Mercurio examined Petitioner and reviewed a July 2013 MRI of the temporal bones, concluding that the character of the headaches and time course made the head injury the likely source of headaches. As to the dizziness, he opined that it was "likely a self-limited, possibly viral etiology." Dr. Mercurio advised Petitioner to continue his current medications of gabapentin and Cymbalta and agreed with a neuropsychological evaluation. (Px10).

At 8/22/13 follow up with Dr. LoSavio, Petitioner reported ongoing dizziness episodes that would last about an hour, usually with movement. He also noted a bloody right ear that morning, but his wife said he was scratching it. Dyazide was not helping his symptoms. The doctor noted ongoing suspicion for Meniere's disease, which can potentially be due to post-concussive syndrome given recent history of head trauma. Videonystagmography (VNG) was obtained and was normal. (Px11). The VNG tester, Amy Winston, noted Petitioner was experiencing episodic lightheadedness and dizziness (every 2-3 days), but no true vertigo, with onset on 7/20/13, reportedly while he was driving. Petitioner described the sensation as intense lightheadedness, but no spinning feeling. Petitioner reported episodes had been triggered by bending over, turning the head quickly and rolling over. Vestibular therapy was continued by Dr. LoSavio, noting if Petitioner did not improve a migraine diagnosis would be considered. (Px11). It appears that the Petitioner underwent therapy for vertigo from 9/12/13 to 2/1/17.

A neuropsychological evaluation took place with clinical neuropsychologist Dr. Bernard on 9/23/13 at Rush. Petitioner reported he had been off work since February, and that he had a 2010 head injury when he hit a steel beam and that he had a brief loss of consciousness. He noted 10 years of formal education, and being diagnosed with a behavioral disorder in 4th grade, ADHD. He reported a brief loss of consciousness with the work accident. He reported development of headaches, dizziness and forgetfulness. Dr. Bernard indicated Petitioner had likely depression, which Petitioner reported started when he had to stop working. Dr. Bernard stated: "In summary, test results reveal borderline verbal intellectual abilities and average nonverbal intellectual skills. There are mild difficulties with executive functions, and visual naming is impaired. However, other cognitive functions are within normal limits. The diagnostic significance of these findings is unclear. It is possible that some of his cognitive difficulties may be attributed to a post-concussive syndrome. However, his headaches more than likely result in distractibility. Additionally, at least some of his low test scores are related to his low educational attainment. The patient appears mildly depressed, and adjustment of his anti-depressant medication appears indicated."

On 10/9/13, Petitioner reported to Dr. Warren that his mood and affect were improved with Cymbalta, and that he started to sleep more, mainly as naps during the day, but still couldn't sleep through the night. Melatonin was advised.

Petitioner followed up with Dr. Mercurio on 10/16/13 with complaints of worsening headaches over the past week. There was slight improvement in the dizziness/vertigo and sleep with medication from an ENT. He wanted to work but was concerned about getting dizzy. Petitioner indicated he wanted to treat with Mercurio instead of Dr. Curtain. Dr. Mercurio opined that the dizziness may be a component of post-concussion syndrome. Dr. Mercurio increased the dosage of the gabapentin and was awaiting neuropsych testing results. (Px10).

Petitioner visited the MacNeal Hospital ER via ambulance on 10/22/13 with complaints of a 6 hour history of non-specific chest discomfort, increased with movement and palpation. Nitroglycerine and ASA did not resolve

the pain in the ambulance. Petitioner reported he'd had this pain intermittently in the past. Petitioner reported a head injury three years prior with subsequent dizziness and memory problems. Petitioner's work up was normal, he was diagnosed with costochondritis and discharged home. (Px12). The ambulance report notes the Petitioner appeared at the fire station, reporting chest pain that started out of nowhere and worsened when he laid down. He also reported difficulty with deep breathing.

On 11/15/13, Petitioner saw Dr. Evans-Beckman. He reported sleeping only 3 to 4 hours per night, chest wall pain and that he almost fell over when bending due to dizziness and lightheadedness. Diagnoses were insomnia, vertigo, depression, chest wall pain, post-concussion syndrome and migraines. He was advised to continue with Dr. Warren, balance therapy and neuropsych and neurology evaluations and follow ups. Medications were also prescribed. (Px4). He followed up with Dr. Evans-Beckman in 2013 for high blood pressure and a while body rash. The last note of 1/21/14 indicates a disability form was completed, and that Petitioner was to return in June 2014. (Px4).

On 1/13/14, Dr. Warren noted Petitioner had new diagnoses of hypertension and costochondritis, and that he was now sleeping 5 hours per night. (Px8). On 2/5/14, Petitioner reported improvement with a more stable mood and decreased headaches and dizziness. Dr. Mercurio increased the gabapentin to 600 mg three times a day. He had been started on hypertension medication. Petitioner reported he was out of short term disability and was applying for full disability, as his job would not let him return to work due to dizzy spells. Dr. Mercurio agreed to complete disability paperwork. (Px10).

On 2/19/14, Dr. LoSavio, Petitioner reported ongoing symptoms with minimal improvement with medication, including having photosensitivity with dyazide. He had only undergone 2 sessions of vestibular therapy and was advised to restart it. Meclizine was prescribed. (Px11). Audiology testing performed that day noted Petitioner had normal hearing on the left, while on the right it was normal to 3000 Hz, with mild to moderately severe hearing loss from 4000 to 8000 Hz. At 8000 Hz, it was worse than the previous testing session. (Px11).

On 9/5/14, Petitioner reported worse headache/body pain due to the heat, and reported intermittent dizziness for which he was seeing an ENT. Dr. Mercurio again increased the dosage of gabapentin, though it appears he had a supervising doctor, Dr. Cheponis, who was concerned about bumping up gabapentin any further as he may not be able to "clear" higher doses given his chemistry profile. (Px10). Petitioner also saw Dr. LoSavio that day. The audiology results were noted ("while mild and slowly progressive he continues to have decreases in his hearing, most recently with a small drop in his left ear in addition to his baseline loss in the right ear."), and possible Meniere's disease was also noted. HCTZ was prescribed, and if no improvement, repeat VNG as well as VEMP (vestibular evoked myogenic potential) testing was recommended. (Px11).

On 10/10/14, Petitioner reported some improvement of dizziness with HCTZ, but worsening hearing. As the improvement with HCTZ made Meniere's disease more likely, this was increased. Dr. LoSavio indicated a suspected combination of post-concussive syndrome and inner ear hydrops with likely Meniere's disease. (Px11).

Petitioner established treatment with primary provider Dr. Dalawari on 11/18/14, reporting dizziness, insomnia and unilateral hearing difficulty, as well difficulty with concentration, for which he was taking Adderall. He requested medication refills and referral to a pain doctor. Current medications indicated included HCTZ, Cymbalta, Gabapentin, Meclizine, Norco, Adderall, Metroprolol, Amlodipine Besylate and Melatonin. Diagnoses included hypertension, chronic pain syndrome, dizziness, unilateral hearing loss and insomnia. He was referred to Dr. Jido, an anesthesiologist. Petitioner returned on 12/9/14 seeking a referral to a different pain doctor because he was not provided Norco and that he needed this for pain. He was referred to Dr. Alzoobi. On 2/16/15,

Petitioner reported he was not taking any pain medications and wanted to try a sleep medication. Zolpidem Tartrate was prescribed. On 3/10/15, Petitioner reported twisting his left ankle. (Px29).

On 12/3/14, Petitioner was seen by Dr. Donkoh in the Advocate Pain Clinic for chronic pain syndrome. Petitioner reported his work accident as well as "surgery and multiple injuries which he says contributing to his chronic pain." He reported pain throughout the right side of his body. He had been unable to tolerate therapy in the past due to vertigo. Petitioner reported running out of Norco, but indicated he didn't find his medications really effective anyway. Lidocaine gel was prescribed along with amitriptyline, but Petitioner was advised that opioids would not be prescribed for chronic noncancer pain. (Px29).

On 3/13/15, Petitioner saw both Dr. Cheponis and Dr. Mercurio. Both doctors examined Petitioner and concluded that Petitioner had a severe concussion causing headaches and dizziness following a head injury. Gabapentin was increased to 3600 mg. per day. Dr. Cheponis was concerned that Petitioner still had not established with a new primary provider, due to insurance issues, to monitor hypertension medications and routine health. (Px10).

On 7/24/15, Dr. LoSavio noted Petitioner wanted to try vestibular therapy again. (Px11).

On 9/2/15, Petitioner saw Dr. Shah, physical medicine and rehabilitation, at Rehab Associates of Chicago for evaluation of balance and gait difficulty after suffering a concussion. The report notes Petitioner had continuing intermittent headaches and vertigo that were slowly improving. Petitioner was to undergo 4 to 6 weeks of vestibular therapy, strengthening and balance and gait training. (Px27).

On 11/27/15, Dr. Shah noted Petitioner's balance was improving with therapy. (Px27).

On 12/17/15, 4/28/16 and 8/25/16, Dr. Dalawari noted Petitioner followed up for his usual medical problems and for medication refills. (Px29).

On 1/26/16, Petitioner had a right ear canal abrasion, likely due to a Qtip, and Dr. LoSavio continued HCTZ and therapy. (Px11). On 2/24/16, Petitioner returned to Dr. Shah reporting continued joint pain with strenuous activity. He was to continue his therapy regimen, and Norco was prescribed. (Px27). On 6/16/17, Petitioner told Dr. Dalawari that he injured his right hand two weeks prior and needs "SR". He was referred to Dr. Sandhu for major depressive disorder without further specificity. (Px29). On 9/1/16, Dr. LoSavio noted essentially no change. He was to continue HCTZ and to obtain an updated audiogram. Otherwise, he was advised to follow up in a year. (Px11).

On 9/28/17, Petitioner reported complaints of twitching, sometimes arms and legs. He was prescribed CarBAMazeprine for a psychological condition. (Px29). On 10/10/16, Dr. Shah noted Petitioner reported continued intermittent headaches and vertigo that was affecting his ability to perform daily activities. Norco was refilled, and Petitioner was to begin vestibular therapy. (Px27). Petitioner attended therapy at ATI from 1/23/17 to 3/24/17. While this appeared to be mainly vestibular in nature, there is also reference to neck pain being addressed. (Px28).

On 4/13/17, Dr. Shah's report notes Petitioner indicated he now had severe sharp/shooting/burning pain on the right side of his body with strenuous activity. A lumbar MRI was prescribed to determine if a nerve injury was responsible for Petitioner's symptoms, with a note that CRPS would also be considered as a possible diagnosis. (Px27).

On 12/29/17, Petitioner saw Dr. Mamdani for headache complaints, noting he'd had it for quite some time but it got worse the last couple days. Noted he had previous follow up but no clear etiology. Petitioner underwent x-rays of multiple joints. A brain CT scan reflected sinusitis with no other acute abnormalities. (Px29).

Petitioner testified that he continued to treat with Drs. Mercurio, Topel and LoSavio into 2016 and 2017. Every six months he is put into a situation of doing activities to keep himself balanced with weights, tilting, etc. Dr. Dalawari provides his prescriptions for Norco, Gabapentin, Cymbalta and Meclizine. Petitioner testified he continued to see Dr. Dalawari from 2014 through 2017 for the same complaints. He continues to go to Rush for examinations every 6 months. He testified that he last visited Rush about a month or so prior to hearing when he saw Dr. LoSavio, noting he tries to see all five of his doctors there around the same time, including LoSavio and Dr. Smith, his new neurologist. He testified that over the last two years he has noticed issues with focus, concentration, dizziness, memory loss and depression. He feels fatigued after being active. He noted hearing loss in the right ear, as well as daily pain from his ankle to the neck/head/ear on the right. He indicated that he can't focus on tasks and gets lost, such as when playing games with his children, and that this depresses him. Bright light and moving too quickly makes him lightheaded and dizzy due to vertigo. He testified that his short-term memory is "gone", and he will forget things 10 minutes after he is told. He used to have a busy work and personal life and his inabilities cause him to feel depressed. He can no longer run due to his right ankle wants to give out. He testified that he sustained hearing loss on the right due to the accident, agreeing that he as a child he was struck in the right head with a baseball bat, with a helmet on. He testified that he was told his eardrum popped, but he did not notice hearing loss until the work accident.

Petitioner testified that he has daily headaches, with the pain near his scar and up to the top of his head. A headache will last a couple of hours. Gabapentin helps this, so it is worse when it wears off or he hasn't taken it. The headaches can cause blurred vision and tiredness. Petitioner testified he has had insomnia since 2012, sleeping 3 to 4 hours a night, and he sees a sleep specialist on referral from Dr. Heniff.

Petitioner currently takes Gabapentin, Mazapoan (vertigo), Norco for pain, and two insomnia medications, Trazadone and Cymbalta. He takes a medication for blood pressure. He testified he was not taking any medications prior to 2/17/10. Petitioner testified that he had none of the described problems and was not under the care of any doctors prior to the accident. His job often involved working at heights, and he performed work both looking overhead and looking below waist level.

Prior to applying to union Local 17, Petitioner testified that he worked in home construction and repairs, a non-union position. On cross examination, Petitioner reiterated that he joined the local in Chicago, and completed the asbestos abatement class at the union hall in 2007. His first work within the union was with Respondent following the call from BA Glenn. He had to complete the abatement class to obtain certification to be able to work for the union, and he estimated he completed this and obtained Illinois and Indiana certification in approximately May 2007. He testified he would have to have his certification documentation at all job sites in Illinois and Indiana for an inspector to the site. Petitioner agreed he completed his initial paperwork and took his drug test on his first day of work in Indiana at the Dyer job site, and wouldn't have been able to start work until these things were completed.

Petitioner agreed he initially missed work from following the 2/17/10 accident through approximately 3/22/10. He initially returned to light duty for about two to four months before resuming full duty. He then continued to work until mid-February 2012, and agreed he hadn't had any treatment otherwise between March 2010 and when he saw Dr. Evans-Beckman in January 2012. He testified he fell asleep while driving in February 2012 and again was off work for about five months before initially returning to light duty. Petitioner has not worked anywhere

since 7/22/13. Petitioner has been receiving Social Security disability since August 2016, receiving approximately $1,640 per month, and has no other income sources.

Petitioner testified that he would have to take additional drug tests at larger facilities that he would be sent to work at by Respondent in both Indiana and Illinois. This was not so much the case with smaller jobs. He testified he has to recertify for asbestos abatement once a year with a refresher class at the local union hall in Illinois. The union does not have a local in Indiana.

Respondent's CEO, Peter Castellarin, testified that to his recall the Petitioner was off work following his February 2010 injury. He testified that the Environmental and Insulation portions are separate businesses, but workers are shifted between the two of them, and are considered employees of both entities so long as they are members of Local 17. Mr. Castellarin believed Petitioner started with Respondent in 2007 and was off work for about a month after the 2/17/10 accident, then returned to work for about a year and a half. He hasn't worked for Respondent since. He believed Petitioner was working at U.S. Steel in Gary on 2/17/10. He testified that union members would have to undergo and pass training classes, normally done at the union hall, and then apply for licensure in whatever particular state they planned to work. Petitioner was hired by Respondent as a hazardous waste handler, which required him to have training course certification and state licensure. At each new job site, the worker must present the certificate and a medical form indicating physical capability to perform the job, including respirator use. With regard to Respondent's employment paperwork, Mr. Castellarin testified this would be completed at the job site "as you're being hired, or after you're hired." Without this paperwork/documentation, the person cannot start work. Most of the customer facilities where they work require initial and random drug testing. The union also requires drug testing, both initially and randomly every 3 years. M&O only requires drug testing from non-union employees, otherwise any testing comes is a part of Local 17.

On cross examination, Mr. Castellarin testified that M&O Insulation work involves the installation of insulation covering on steam pipes and boiler pipes. There is some degree of working at heights. Castellarin agreed that employees would be shifted back and forth to work for both M&O Insulation and Environmental based on company need. The foreman would tell the workers where to report the next day, based on instructions from Respondent's superintendents. Mr. Castellarin agreed that "you could say" the superintendents are all based in East Hazel Crest. Respondent also has an office in Peoria. As a negotiator on the union contract, Castellarin is familiar with Local 17's union contract. He agreed that a union worker is entitled to show up time, but only after they are hired.

Dr. Neri examined the Petitioner on his own behalf on 7/9/15, and provided his deposition testimony on 5/20/16. (Px24). He is board certified in internal medicine, neurology and psychiatry. He testified that Petitioner's significant other also attended the exam, and helped to "fill in the blanks a little bit." Dr. Neri testified his examination found "extremely severe" spasm in the upper trapezius, posterior cervical and sternomastoid muscles bilaterally, evidence of spasm throughout the paraspinals, and reduced cervical range of motion. Petitioner body language and appearance indicated Petitioner appeared depressed and anxious. He "obviously" showed diminished concentration and focus, as he had to be re-cued on many occasions and his significant other had to "fill in from time to time and even make corrections." Neurologic examination was normal, and Neri testified it was mainly the neck musculature and mental status changes that were obviously abnormal. (Px24).

Following his review of Petitioner's medical records (Methodist Hospital, Comprehensive Care, Dr. Grevious, Dr. Evans-Beckman, Dr. Curtin, Dr. Heniff, Dr. Warren, Rush University Hospital including neurologists Drs. Mercurio, Topen and Cheponis and ENT specialist, Dr. LoSavio), Dr. Neri provided four diagnoses of the Petitioner which he felt were related to the work accident. First, Petitioner had a closed head injury syndrome

with changes in mood, personality, memory, concentration and focus, leading to sleep disturbance, which he felt is permanent. He was not certain that treatment for this should stop, but didn't believe there would be significant improvement. The second diagnosis was a severe flexion-extension injury of the cervical spine with chronic changes which included cervical vertigo and severe "chronic and unremitting" musculovascular headaches. Cervical vertigo is a feeling of unsteadiness and lack of balance/coordination, which is likely permanent. He testified he based this diagnosis on history and exam, noting even if the prior records "didn't determine anything in that direction, I still feel that was the case." Petitioner had palpable spasms, with muscles that were significantly tighter than they would be from stress or other tensions. This is suggestive of a flexion-extension injury, i.e. whiplash, which Petitioner had at the time of the accident. Dr. Neri believed the headaches were due to both post-concussion and whiplash with muscle tension, and that these were likely permanent.

The third diagnosis was of a mild lumbar strain. The fourth diagnosis was a sleep disturbance secondary to the closed head and cervical injuries, causing hypersomnia, mood changes and memory difficulties. He testified that even a mild concussion will involve sleep disturbance, and if untreated can lead to sleep deprivation problems, which eventually add on to the original injury symptoms. Petitioner also reported being highly irritable and short-tempered, which Dr. Neri felt was due to sleep deprivation, which was due to the head injury. Sleep deprivation impacts focus and concentration, and so Dr. Neri would not have the Petitioner operating a vehicle or any power equipment, and "so I can't imagine any physical activities in a competitive environment that he could do safely." He also didn't believe the Petitioner could do any mentally-focused job, and thus didn't see any job the Petitioner could perform now safely and competitively. He opined that the problems were permanent given five years since the accident and no substantial improvement in any area in that time. (Px24).

Dr. Neri testified that Petitioner's 9/23/13 neuropsychological evaluation was important to determine brain function, as well as to determine if someone is trying to deceive and to see if secondary gain is involved. Dr. Neri noted that the examiner found that Petitioner gave a 100% valid effort. Testing also indicated Petitioner had significant trouble with verbal comprehension (3rd percentile) and working memory (9th percentile). The evaluation showed that he had depression that seemed to be more associated with stopping work, which Dr. Neri believed showed a strong work ethic. Dr. Neri testified that the neuropsychological exam also showed problems with sleep and that post-concussion syndrome. He opined that the results of the neuropsychological evaluation correlated perfectly with thoughts, and that they agreed on the presence of cognitive difficulties and sleep disturbance were likely due to the post-concussion syndrome. (Px24).

Dr. Neri agreed that Dr. LoSavio concluded that Petitioner could be suffering from Meniere's disease, which involves gradual hearing loss, first at higher frequencies, as well as episodes of severe vertigo. He agreed Petitioner had a prior head trauma at 15 years old, and it was unclear to Dr. Neri if this had anything to do with Petitioner's hearing loss. He opined that Meniere's disease would not be related to the Petitioner's work accident. As to whether the gap in Petitioner's treatment from 2/23/10 to 1/9/12 was significant, Dr. Neri testified he didn't know what Petitioner did during that time, but it was significant to him that Petitioner "just continued to try to push through it and do what he had to do to keep living." (Px24).

On cross examination, Dr. Neri agreed that he did not provide treatment for the Petitioner and is involved only as an expert. While Dr. Neri acknowledged that the Petitioner was going through a divorce when his sleep deprivation began, the Petitioner said his mood and actions were probably the reason the divorce occurred. He supposed that someone could fake depression. but didn't think he would be fooled. He agreed there are different degrees of concussion and that 10 different people can have 10 different results. Dr. Neri testified that lethargy/sleepiness is very common to see early on after a concussion, and that vertigo and light sensitivity are also common following a concussion. Dr. Neri did not order a second neuropsychological test as there was no reason to order one, noting that deceit will show up, but did testify it would be interesting to review one taken

within a month or two after the accident and then when Petitioner's was done to see if there is any change, as "he shouldn't get worse. If he gets worse, then you would begin to wonder why he is getting worse." (Px24).

Dr. Neri testified that while Petitioner reported he did not have loss of consciousness at the time of the accident, when you have amnesia of the event, "how do you know if you were unconsciousness?", adding that "time is very unusual when you get hit in the head." He agreed other people can fill in the blanks for someone who doesn't remember, and that can then become their own memory. Petitioner indicated that no one witnessed the accident. Dr. Neri opined that insomnia can lead to hypersomnia. He testified that a concussion can last for days or years, it depends how bad it is and whether or not you aggressively treat the things that impact it, in particular insomnia, for which there are studies indicating initial aggressive treatment results in less post-concussive symptoms. Dr. Neri distinguished two types of vertigo. "True" vertigo is an inner ear problem, such as is seen in Meniere's disease, where one feels spinning and with nausea, vomiting and the inability to walk, though there are degrees to this. Any true vertigo Petitioner had from the head trauma has likely cleared. Dr. Neri believed Petitioner had what he called "cervical" vertigo, which he called a tremendous feeling of instability or loss of place in space, such as symptoms with turning the head, which is a common feeling with head injuries. (Px24).

Dr. Neri reiterated that Meniere's disease is not due to an injury, and while it is thought it could be from a virus or autoimmune disorder, the cause is unknown. It is a progressive condition involving inflammation of an inner ear nerve that usually ultimately results in complete hearing loss in the impacted ear. Once the hearing is completely gone, you no longer have the associated vertigo. Dr. Neri agreed that Dr. LoSavio's diagnosed possible Meniere's disease, but testified he is not an expert in that field, though he believed that LoSavio agreed there is also a diagnosis of possible post-concussion injury. Dr. Neri agreed that sleepiness can be a side-effect of gabapentin, but did not believe the drug was causing Petitioner's ongoing insomnia, given his young age and his gradual increase in dosage – while it could cause an acute impact, gradual dose increase builds up a tolerance to side-effects, which wane over time. Dr. Neri did not know the Petitioner's highest school grade level, but he testified that this is somehow taken into account in neuropsych testing and is automatically adjusted. He testified that education level does not impact intelligence or the ability "to use that part of your brain." He testified: "I'm sure they found out what level of education he had. That's automatic that they do in the neuropsych test in their history part." Asked about whether he needed to know Petitioner pre-accident baseline, Dr. Neri testified that regardless of his education level, Petitioner "needed these parts of his brain working way better than the 3rd percentile to get there. The 3rd percentile is basically, you know, severe retardation level." He did agree that education level "made it more difficult to interpret" neuropsych testing. Dr. Neri was aware that Petitioner's brain MRI was normal, but testified MRI does not show what is going on in the brain on a cellular or chemical level or how a brain is functioning cognitively, so it had no significance to him. (Px24).

On redirect, Dr. Neri opined that Dr. Foreit's conclusions "amaze me", as Petitioner's symptoms were increasing during his treatment and his exam findings were decreasing, eventually telling Petitioner he would have to live with his condition. At the last visit Petitioner continued to complain of severe headaches, and he had tender points in the cervical spine, which he concluded was unrelated to the accident. Dr. Neri suspected that Petitioner's treatment ended because Dr. Foreit indicated he would have to see a private doctor for his headaches. (Px24).

The Petitioner was examined at the request of the Respondent on 10/28/15 by Dr. Kohn. He provided his testimony via deposition on 7/11/16. Dr. Kohn testified he is board certified in neurology, but also trained in psychiatry and psychoanalysis, and he treats people for psychosomatic complaints and more primarily psychological complaints. He reviewed Petitioner's medical records both before and after the examination. Dr. Kohn testified that Petitioner told him that he fell or was tossed from the cage of a man lift while wearing a harness, sustaining injuries to his knee, head and back. A scalp laceration was sutured, and Petitioner was off

work a few weeks before returning to light duty. He had long standing prior knee problems. Initial head CT scan was unremarkable. He was released by Dr. Foreit on 3/16/10, and on 4/5/10, Dr. Foreit noted Petitioner's headaches were minimal, neck spasm was gone and he was pleased with his progress. Petitioner returned for a re-check due to headaches on 8/2/10, but there was no history of what occurred between 4/5/10 and 8/2/10 that may have brought back the headaches. Dr. Kohn agreed with Dr. Foreit's conclusion that these headache symptoms were related to sinusitis and not the accident, as well as that the headache complaints at the last visit of 9/23/10 were related to sinusitis. He opined that the 8/2 and 9/23/10 visits were unrelated to the Petitioner's accident. (Rx3).

Dr. Kohn testified that there was a 15-month gap until the next treatment on 1/9/12, and Dr. Kohn testified he had no information to suggest continuous severity to the level where he sought further treatment. Dr. Kohn was unsure as to what Petitioner meant when he complained of continuous headaches to Drs. Evans-Beckman on 1/9/12, and later to Dr. Curtin, as there was no notation as to the frequency of the continuous headaches. After seeing Dr. Curtin, Petitioner then had another 10 month gap in treatment before going to Advocate Christ Medical Center for headache and insomnia complaints. He was noted to have an upper respiratory infection (URI). Dr. Kohn testified that the insomnia was a new complaint on 2/4/13 for which he could not identify a cause, and that this could be due to sinusitis, irritability, a divorce or medication prescribed to him. Dr. Kohn noted Klonopin withdrawal can cause insomnia. (Rx3).

Dr. Kohn opined that the Petitioner's chronic headache complaints in February 2013 were not related to the accident, that Gabapentin prescribed for headaches could cause either insomnia or sleepiness, and that the Gabapentin use was unrelated to the accident and thus the insomnia was unrelated to the accident. He testified that Petitioner initially complained, per his review of the records, of lightheadedness and dizziness to Dr. Evans-Beckman on 6/11/13, and that these conditions also were unrelated to the accident. There was nothing to link a migraine diagnosis to the accident. He opined Petitioner's complaints of fatigue to Dr. Curtin on 7/15/13 were not related to the accident. Dr. Kohn opined that nothing in the medical records showed that Petitioner sustained a major head trauma with loss of consciousness, as he reported to Dr. Warren on 7/22/13, and that the medical records indicated a minor head trauma and did not support a diagnosis of concussion. It appeared that Petitioner initially complained of a short history of vertigo prior to visiting Dr. LoSavio on 7/25/13. Dr. Kohn opined it would not be related to the accident. Meniere's disease is related to the inner ear, and is very hard to examine and diagnose, even at autopsy. Petitioner first complained of photophobia and sonophobia to Dr. Mercurio on 7/31/13, basically sensitivity to light and sound, and Dr. Kohn opined these also were not related to the accident. (Rx3).

Dr. Kohn opined that the issues raised by Dr. Barnard in the Petitioner's 9/23/13 neuropsychological evaluation were not related to the accident. He also opined that the costochondritis for which Petitioner received care on 10/22/13, as well as hypertension after that, were unrelated to the accident. Petitioner's reports to physicians of a severe head injury was not supported by the contemporaneous medical records. Petitioner reported that his irritability led his wife to talking about leaving in summer of 2014, and that they divorced in December 2014, but they still had some sort of relationship when he saw Kohn. Dr. Kohn opined Petitioner's headaches were not related to the accident and there were no corresponding objective findings. Dr. Kohn noted that there were potential psychological causes for insomnia, and that this wasn't even addressed by Petitioner's treaters. Vertigo is an inner ear problem, and while it's not clear if its trauma related, "to have onset years after the trauma would be unusual. Years after the trauma would be still more unusual." He had a much more severe head injury in the past with the baseball bat. Dr. Kohn testified: "So he has a number of things which are not unusual in someone his age, but none of them can be linked up by a reasonable causal mechanism to the incident – the workplace incident under discussion." (Rx3).

As to migraine, Dr. Kohn testified that the diagnosis has not been established, the headaches have been intermittent, and a number of non-migraine causes had been identified and treated. He found no medical cause for any sleep problem, noting Petitioner had no ongoing excessive daytime drowsiness or any impairment of consciousness. Dr. Kohn opined that Petitioner would benefit from ongoing care with a primary provider informed of Petitioner's history and attuned to psychological factors, but that any further treatment would be unrelated to the accident. He further opined that Petitioner had reached maximum medical improvement as to the work accident and could work without restrictions. He had a minor scalp laceration, and by the time Dr. Foreit and Dr. Grevious returned Petitioner to work, "he was at the point where full recovery would be expected and full recovery is described in the records", and that is when he reached MMI. Dr. Kohn opined that the number of medications and refills the Petitioner has received "reflect lack of care, coordination and unitary diagnostic thinking." (Rx3).

On cross-examination, Dr. Kohn agreed that the Petitioner flipping over a bar and striking his rib cage could cause a chondritis, but it would not be reasonable to related the onset of a chondritis a year or more later. He agreed that a bruised and tender nose would indicate Petitioner hit his nose during the accident. He agreed he did not document Dr. Nally's 2/22/10 note indicating complaints of forgetfulness and post-concussion syndrome, but did document complaints of 10/10 head pain. Whether the Petitioner had a concussion depends on the severity of the blow and whether it transmits energy to the brain through the skull. Normally there is no effect to sudden withdrawal from Gabapentin, but headache or insomnia might be experienced. There is an indication in the records that Petitioner was taking Klonopin, while there is no prescription for this noted in the records. Dr. Kohn testified that Petitioner never linked his insomnia to his divorce in his mind. Dr. Kohn testified that the inference was his. Dr. Kohn agreed that Dr. Foreit never referred Petitioner to a specialist for his complaints of headache. (Rx3).

CONCLUSIONS OF LAW

WITH RESPECT TO ISSUE (O), DOES ILLINOIS HAVE JURISDICTION OF THE PETITIONER'S CLAIM, THE ARBITRATOR FINDS AS FOLLOWS:

In this case, the Arbitrator finds that the Petitioner has sustained his burden of proving Illinois jurisdiction over his claim.

Pursuant to Section 1(b)2 of the Act, there are three methods of showing that a work injury is under Illinois jurisdiction: 1) the contract of hire was made in Illinois, 2) the accident occurred in Illinois, or 3) the employment relationship is "principally localized" in Illinois. The Arbitrator finds both that the contract of hire was made in Illinois, as well as that the employment relationship of the parties was principally localized in Illinois.

As far as the contract of hire, under Illinois law, the question is whether the last act necessary to create an employment relationship took place within or outside of Illinois. *F & E Erection Company v. Industrial Comm'n*, 514 N.E.2d 1147 (1987).

In this case, the Petitioner testified that he applied for work within Local 17 while residing in Illinois, and completed the process in Chicago with completion of the application and abatement classes. He then was in Illinois when he was called by his union BA, also from Illinois, to work for the Respondent the next day in Indiana. He testified that the only thing he did when he appeared for work in Indiana the next day, per the BA's instructions, was to complete tax forms and to take a drug test. The Arbitrator does not see any evidence which would indicate that the completion of the tax forms was a condition precedent to his starting work. As to the

drug test, it also appears to not have been a condition precedent given that he started working and completed his first day without having the results of the drug test. Further, based on the testimony of Mr. Castellarin, the Respondent's CEO, the drug test was not required by the Respondent, but rather by the Respondent's customer. He testified that many of their customers require a drug test of all Respondent workers. As such, this does not appear to have been a condition of the employment relationship between Petitioner and Respondent.

In *Hunter Corp. v. Industrial Comm'n*, 645 N.E.2d 259 (1995), the court addressed the issue of when the last act required to give validity to the employment contract occurred in a similar factual scenario. The claimant, an Illinois resident, was referred by his Illinois union to a job site in Indiana where he was injured. He completed required tax forms and an employment "sign-up form", not a job application, at the job site before starting work on the first day. In finding that the contract of hire took place when the claimant accepted the job referral from his union, the court noted that the union contract made the union the sole referral agent for the employer and the members of the union. The court also found relevant the employer's right to reject a referred union member only for physical incapacity or incompetency without the filing of a grievance. The court also noted that a prospective employee was allowed two hours of show-up pay if no work was provided. *Id.*

In the present case, Article I of the union contract between the parties recognizes Local 17 as the "sole and exclusive collective bargaining representative for the employees" and that its members "shall perform all of the covered" by the contract. (Px13). Article II of the contract requires an employer to provide an explanation on a form provided by the union should a referred member not be accepted by the employer. Article V., Section 11 of the contract states that employees shall be considered "at work" for a shop at the time they accept employment. In this matter, Petitioner accepted employment with Respondent when he told union BA Glenn that he accepted the job offer. Petitioner, like the claimant in *Hunter Corp.*, was guaranteed two hours of show-up pay should the Respondent not provide work ("An employee who reports for work at the regular starting time and remains at this site and for whom no work is provided shall receive pay equivalent to two (2) hours."). (Px13, Art. 5, Sec. 9).

The employment relationship appears to have been established via the union, and any necessary conditions precedent, including the last act necessary, must have taken place in Illinois. The Arbitrator sees nothing that occurred in Indiana that would be considered the last act necessary pursuant to the Act and case law.

Additionally, the employment relationship between Petitioner and Respondent appears to have been centrally located in Illinois as well. The issue of whether an employment relationship is principally localized in Illinois was addressed in *Cowger v. Illinois Workers' Compensation Comm'n* 313 Ill. App 3d 364 (2000). The case involved an over-the-road truck driver, and the court followed the definition of "principally localized" stated in the Model Act for Workers' Compensation. This definition focuses first and foremost on the situs where the employment is centered. The court noted five factors relevant to the determination of the situs of the employment relationship: (1) where the employment relationship is centered, i.e. the center from which the employee works; (2) the source of remuneration to the employee; (3) where the employment contract was formed; (4) the existence of a facility from which the employee received his assignments and is otherwise controlled; and (5) the understanding that the employee will return to that facility after the out-of-State assignment is complete. *Cowger* 313 Ill. App. at 373. In *Cowger*, claimant truck driver, an Illinois resident, was both hired and injured outside of Illinois. He received his daily dispatches and his remuneration from Indiana. The claimant maintained that his employment was principally localized in Illinois because he received 25% of his dispatches while in Illinois. The court found that the claimant's primary purpose in returning home to Illinois was to "take time off" before resuming his travels.

In this case, the employment relationship is centered in Illinois in East Hazel Crest, as that is where the Respondent's local facility is located. The Respondent also has a secondary facility in Peoria, which is also in

Illinois. The Petitioner testified in unrebutted fashion that his paychecks, whether from M&O Environmental or Insulation, came from the East Hazel Crest location. As noted above, the Arbitrator has determined that the employment contract was formed in Illinois. The last factor does not appear to be applicable here, as it does not appear that the Petitioner returned to the Respondent's facility following the completion of an out of state assignment, however the Petitioner's job was different than that of an over-the-road truck driver in that he would return home daily following his work assignment, and his home was also in Illinois. While the Petitioner testified that he worked in Illinois and Indiana on an approximate 50/50 basis, all other relationship ties appear to have been located in Illinois. The Arbitrator finds that the preponderance of the evidence supports the finding that the employment relationship between the Petitioner and Respondent was principally localized in Illinois.

Based on the above, the Arbitrator finds that there is Illinois jurisdiction over the Petitioner claim at bar.

WITH RESPECT TO ISSUE (O), DOES THE STATUTE OF LIMITATIONS BAR THE PETITIONER'S CLAIM, and WITH RESPECT TO ISSUE (F), IS THE PETITIONER'S PRESENT CONDITION OF ILL-BEING CAUSALLY RELATED TO THE INJURY, THE ARBITRATOR FINDS AS FOLLOWS:

In this case, as noted by the parties on the record prior to the hearing date, the issue of whether the claim was filed within the applicable statutory period is intertwined with whether the Petitioner's post-8/2/10 treatment is causally related to the workers' compensation claim. If it is not, the Petitioner conceded that the claim was not filed within three years from the date of accident, as required by Section 6(d) of the Act. If it is, the Respondent concedes that the claim was filed within two years of the last payment of causally related benefits to the Petitioner, and thus also pursuant to Section 6(d) of the Act, the claim would not be barred by the statute of limitations.

The Arbitrator finds that the Petitioner has failed to prove that his condition subsequent to 8/2/10 is causally related to the 2/17/10 accident.

The Petitioner clearly suffered a head trauma in this case, as well as what appears to have been a contusion-type injury to the rib/abdominal area when he hit the bar of the man lift that he ultimately was flipped over on the date of accident. The Arbitrator also does take note that the Petitioner had been treating with what appears to essentially have been the company occupational health clinic while he was seeing Dr. Foreit. While Dr. Neri makes a good point in his testimony that the Petitioner was continuing to have headache complaints when he stopped treating as of 8/2/10, the facts remain that he had minimal treatment, if any, from 3/16/10 to 8/2/10, and then had no evidence whatsoever of treatment between 8/2/10 and 1/9/12. There is no evidence that he sought any treatment in this time. The evidence indicates he continued to work his regular job after 3/16/10, other than a short period of light duty, until 1/9/12.

Dr. Neri testified that Dr. Foreit essentially discharged the Petitioner in 2010 despite ongoing severe headache complaints, and that Foreit's statement to Petitioner that any further treatment after 8/2/10 should be treated via Petitioner's private insurance basically served as a "chilling" effect on the Petitioner resulting in his failure to seek further treatment and toughing out continuing to work for the Respondent. However, this ignores the fact that the Petitioner was released on 3/2/10 with on and off headaches but no complaints of dizziness or lightheadedness. Petitioner at that time also reported no change in cognition. He did on 2/22/10 report being somewhat forgetful since the accident and that he had 10 out of 10 head pain, but there were no other references to forgetfulness or cognition problems after that date. The initial visit was in follow up care post-accident. It is noted on 3/16/10, that "The patient has had no headache." "He reports no other problems with the head." In

follow up, the petitioner complains of headaches, which are diagnosed as congestive sinus pressure. The determination of the doctors is that the head pain is not work related.

The Arbitrator notes that the contemporaneous medical at the time of the accident does not support the Petitioner suffering a loss of consciousness. Despite this, reports were made to subsequent providers that he did have such loss of consciousness. The Arbitrator believes that the contemporaneous medical is a more reliable indication of what occurred on the date of accident than subsequent histories that may have been presented. While Dr. Neri testified that the Petitioner may have suffered an amnesia type episode at the time of the accident which could have led the Petitioner to not recall that he lost consciousness, there is no indication in the initial ER records from Methodist Hospital of any type of amnesia episode at the time of the accident. This appears to be a revision history after the fact, including the Petitioner's testimony at hearing. The Petitioner testified that there were no witnesses to his accident, and therefore the Arbitrator must conclude that the history he provided at the ER came from the Petitioner himself and, again, there was no history provided of a loss of consciousness or amnesia regarding the accident itself and what occurred.

When the Petitioner sought treatment with Dr. Evans-Beckman on 1/9/12, his complaints included severe headaches since the accident, but he was also there for his knee, which had preexisted the accident, and was referred for a right knee MRI. While the Petitioner testified he was referred to Dr. Curtain, the Arbitrator did not see this reflected in the records of Evans-Beckman. He was advised to follow up in 6 months. Petitioner did see Dr. Curtain in April of 2012 and was sent for a sleep study and CT scan. In addition to noting the records of this physician were extremely difficult to read due to poor handwriting, the Petitioner subsequently did not then again seek treatment until 2/4/13 at the Advocate Christ Hospital ER. At that time he complained of a 6 to 7 month history of headache and insomnia. That would relate back to August or September of 2012. It is unclear to the Arbitrator how a restart or increase in headaches and the onset of insomnia approximately two and a half years post-accident would relate back to that accident. On 7/25/13, Petitioner saw Dr. LoSavio and reported a two week history of vertigo, with an episode of bloody drainage from his right ear a week before that, as well as increasing headaches over the prior year. Dr. Beckman then sees the Petitioner on 11/5/13, at which time he states that he now has vertigo, depression, and post-concussion syndrome, in addition to the headache, dizziness and light headedness, all of which were not part of the diagnosis immediately after the accident and throughout the treatment post-accident.

The Petitioner was complaining of headaches in various histories going back to the accident date. However, it is unclear how he would have been able to work for over two years with whatever level of headaches he had and then years later develop headaches that became debilitating which would relate back to that accident. Additionally, other than the one comment about being "somewhat forgetful" to Dr. Foreit on 2/22/10, there are no indications whatsoever of any other cognitive or sleep issues until 2013. Dr. Curtain did refer Petitioner for a sleep study in April 2012, however the Arbitrator cannot determine from his records the specific reason this was performed. Further, he had no indication of any complaints of hearing loss until 2013, and even then he noted he had been struck in the head with a baseball bat as a youth and was diagnosed with a possible TM perforation injury at that time.

The Arbitrator also notes with interest the fact that the Petitioner has been diagnosed with possible Meniere's disease. Dr. Kohn testified that this diagnosis is difficult because there is no specific objective test, and both he and Dr. Neri agree such condition would not be related to the accident. This condition was noted to include symptoms of hearing loss and vertigo, which are part of Petitioner's delayed complaints. It appears entirely possible to the Arbitrator, if not probable, that a large part of the Petitioner's worsening condition in 2012 and 2013 is related to this disease. Again, there appears to be no definitive way to make the diagnosis, but it is clear

that such condition has been significantly considered. This tends to negatively impact any argument by Petitioner in terms of a chain of events analysis, as does the large gaps in treatment.

The Petitioner's objective testing of the head and brain has been normal since the accident date. His sleep study was notable for a complete absence of respiratory events, limb movements or sleep fragmentation, and Dr. Warren believed Petitioner may have an element of "sleep state misperception."

Much of the causal connection opinions in favor of the Petitioner in this case are based on his history of ongoing headaches and other notable symptoms since the accident date. The initial records and the very large gaps in treatment just do not support this stated history. Dr. Kohn's testimony in this regard is also notable in terms of his opinion that multiple treaters were addressing the Petitioner's complaints without any significant collaboration between the different branches of medicine.

The Petitioner clearly suffered a head trauma. There is an indication in the record that he had a hardhat on at the time, and that the hardhat is what may have caused the laceration on his forehead. However, there is no real indication that the Petitioner suffered a brain injury that somehow resulted in a significant array of symptoms which, other than headaches, onset years after the accident. As noted by Dr. Neri, in discussing neuropsychological testing, "he shouldn't get worse. If he gets worse, then you would begin to wonder why he is getting worse." In the same vein, with regard to his headache and other complaints, it doesn't make sense that he would have these worsening symptoms years after the accident date, including the onset of symptoms he did not have at the time of the accident, if a causal relationship existed.

The Arbitrator finds that the causal relationship of the Petitioner's symptoms to the accident ended as of 8/2/10. Given the Arbitrator's finding in this regard, the Petitioner has failed to file his claim within the required three year period after the accident date, and failed to file his claim within the required two year period after the Respondent's last payment of benefits for a causally related condition.

WITH RESPECT TO ISSUE (J), WERE THE MEDICAL SERVICES THAT WERE PROVIDED TO PETITIONER REASONABLE AND NECESSARY AND HAS RESPONDENT PAID ALL APPROPRIATE CHARGES FOR ALL REASONABLE AND NECESSARY MEDICAL SERVICES, THE ARBITRATOR FINDS AS FOLLOWS:

Based on the Arbitrator's findings above, this issue is moot.

WITH RESPECT TO ISSUE (K), WHAT AMOUNT OF COMPENSATION IS DUE FOR TEMPORARY TOTAL DISABILITY, TEMPORARY PARTIAL DISABILITY AND/OR MAINTENANCE, THE ARBITRATOR FINDS AS FOLLOWS:

Based on the Arbitrator's findings above, this issue is moot.

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

Based on the Arbitrator's findings above, this issue is moot.

STATE OF ILLINOIS	)		
	) SS.		
COUNTY OF COOK	)		

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

DEBORAH SILLMAN,

Petitioner,

vs. NO: 10 WC 18749

THE CITY OF CHICAGO,

Respondent.

19IWCC0294

DECISION AND OPINION ON THIRD REMAND

This matter comes before the Commission pursuant to a third Remand Opinion and Order of the Circuit Court of Cook County, Law Division, Tax and Miscellaneous Remedies Section, in *Sillman v. Illinois Workers' Compensation Commission, and the City of Chicago*, 18 L 50682, entered May 17, 2019.

Background

Petitioner previously appealed the June 18, 2013 §19(b) Decision of Arbitrator Kane finding that Petitioner failed to prove she sustained accidental injuries arising out of and in the course of her employment on October 15, 2009, that Petitioner's current condition of ill-being is not casually related to the alleged accident and denying compensation. Relying on the opinions of Respondent's examiners, Dr. Wehner, an orthopedic and spine surgeon, Dr. Ghanayem, an orthopedic and spine surgeon, and Dr. Noren, a pain specialist, Arbitrator Kane found Petitioner had significant long-standing cervical, thoracic and lumbar spine chronic pain syndrome well-documented in treating records of Dr. Joseph and Chiropractor Regan from treatment from 2002 through October of 2009. The Arbitrator further found that that Dr. Joseph, Petitioner's treating physician, noted that on October 19, 2009, four (4) days after the alleged October 15, 2009 injury, Petitioner had severe worsening of her neck and upper back pain since her work-related injury on November 4, 2002, increasingly disabling and more severe even with less strenuous tasks. Dr. Joseph's office visit notes on October 19, 2009 failed to mention any other work-related injury

other than Petitioner's prior work injury of November 4, 2002. The Arbitrator concluded Petitioner failed to prove she sustained a compensable accident on October 15, 2009, and that there was no causal connection between Petitioner's present condition of ill-being and the alleged accident, rendering all other issues moot.

On July 3, 2013 Petitioner filed a Petition for Review of the Arbitrator's decision, raising issues of accident, notice, causal connection, medical expenses, TTD, and penalties and fees, and arguing that Petitioner sustained an aggravation and acceleration of her pre-existing cervical and myofascial condition and a new injury to her lumbar spine on the date of accident while lifting a bag of mortar.

The Commission[1], in a July 14, 2014 Decision, unanimously affirmed and adopted the decision of the Arbitrator. Petitioner sought review of the Commission's Decision and Opinion on Review.

In a March 5, 2015 Order, the Circuit Court of Cook County ("Court") remanded the decision of the Commission "for the purpose of weighing the evidence to determine whether the 2009 Accident aggravated Employee's preexisting condition." The Court stated that within the Commission's decision "the only reference to a preexisting injury in the analysis is contained in the first paragraph of page eleven (11) of the adopted decision stating '...[Employee's] pain on October 15, 2009 was a manifestation of her pre-existing illness...'" The Court further stated that "this sentence alone, though reasoned by the Commission, does not weigh the evidence as to Employee's argument that the 2009 Accident aggravated a preexisting injury. The Commission failed to both address Employee's claim that the 2009 Accident aggravated Employee's preexisting condition, and make a permissible inference on the matter."

Pursuant to the Court's March 5, 2015 Remand Order, the Commission further addressed the Petitioner's claim that her October 15, 2009 alleged accident aggravated her preexisting condition. First the Commission addressed the Court's statement that "the only reference to a preexisting injury in the analysis is contained in the first paragraph of page eleven (11) of the adopted decision stating '...[Employee's] pain on October 15, 2009 was a manifestation of her pre-existing illness...'" The Commission cited references to a preexisting injury analysis.

The Commission noted it had also reviewed all of the evidence and concluded that the Decision of the Arbitrator was more than sufficient in its explanation of the Commission's view of the evidence. The Court's concerns were duly noted and considered.

Further, the Commission's Decision on first Remand noted though Petitioner may aver that the Decision of the Commission on Review does not do justice to her arguments relative to an

[1] The Commission Panel A that issued the July 14, 2014 Decision and Opinion on Review, the December 10, 2105 Decision and Opinion on Remand and the September 19, 2018 Decision and Opinion on Second Remand was comprised of Commissioners Kevin Lamborn, Thomas Tyrrell and Michael Brennan. The current Panel A is comprised of Commissioners Thomas Tyrrell, Maria Portela and Deborah Simpson. Both Commissioners Portela and Simpson have affixed their signatures to comply with the Court's Order on Third Remand.

aggravation of a pre-existing condition, there can be no doubt that the Commission considered and soundly rejected this argument. The Commission further noted Petitioner's argument is undone by the records of her treating physician, Dr. Joseph. He did not attribute the problems about which the Petitioner complained to any work accident in 2009. His records note that this was a continuum of a myriad of problems that cascaded from 2002 until 2009.

Again, the Commission trusted that the Court would recognize that the Commission had considered all of the Petitioner's arguments regarding an alleged accident and/or aggravation and rejected same. It was hoped that this Decision on (first) Remand would allay any concerns that the Court may have regarding the Commission's consideration of the record and adoption of the Arbitrator's Decision as its own.

Pursuant to the Court's Remand Order, and upon receipt of the record of proceedings in this matter, the Commission issued a Decision and Opinion on Remand on December 10, 2015 and expressed its finding the Arbitrator properly weighed the evidence to determine whether the 2009 accident aggravated Petitioner's preexisting condition, and thereby affirmed and adopted the Arbitrator's decision, denying compensation based upon Petitioner's failure to prove she sustained an accidental injury arising out of and in the course of her employment on October 15, 2009, for the reasons stated therein and further expounded upon herein.

On Second Remand, the Circuit Court concluded that the Commission, on (first) remand, failed to address the Employee's (Petitioner's) claim the 2009 accident aggravated her preexisting condition and "make a permissible inference on the matter." Further, the Court Order states "that the Commission failed to follow the Court's directives and weigh the evidence in this matter and ignored the only objective evidence in this case, the MRI, without any explanation or basis."

The Court concluded the Commission further ignored the unrebutted evidence in this case and that the Commission's conclusions on first remand are against the manifest weight of the evidence. Therefore, the Circuit Court reversed the Commission's first Decision and Opinion on Remand and remanded the matter to the Commission for determination of the benefits the Employee shall receive finding Petitioner's preexisting condition was aggravated and that her on duty 2009 accident caused a new injury to her lower back.

In the Commission Opinion and Decision on Second Remand, entered on September 19, 2018, the Commission noted that although it did not subscribe to the Circuit Court's analysis of the record, it was bound to follow the Court's directive. Pursuant to the Court's Second Remand Order, and upon receipt of the record of proceedings in this matter, the Commission found the Petitioner's preexisting condition was aggravated and that her on duty 2009 accident caused a new injury to her lower back, albeit in the form of a temporary fleeting aggravation of a pre-existing condition. The Commission having weighed the facts and opinions of the experts relied upon the facts, the Petitioner's medical records, Dr. Wehner's expert opinion, and what Dr. Wehner described as a "paucity of any type of radiologic or clinical finding" to arrive at this conclusion. The Commission also found specifically that Petitioner lacks credibility. Petitioner reported to Dr. Wehner that her low back was not a problem prior to the specific injury in October 2009, however, Dr. Wehner noted that low back treatment was well documented in the medical records.

In the Commission Opinion and Decision on Second Remand, the Commission further found the MRI report, in this instance, reflects exactly what is on the actual MRI diagnostic film, and no treating orthopedic doctor opined that there was anything of significance in the MRI report that would warrant treatment other than the treatment the Petitioner was already seeking at RIC for the seven years following her 2002 work injury.

The Commission, therefore, relied, in part, on the Petitioner's testimony and in part upon her treating doctors when finding that Petitioner sustained a temporary fleeting aggravation of her pre-existing condition. After Petitioner's prior work accident in 2002, she was released to full-duty work in March 2003. (T, pp. 44, 45) Petitioner testified after her 2002 accident, Chiropractor Regan treated her for her lower back not for an "injury" but "maybe if I was sore one day when I went in." On the day after the subject incident, Petitioner went to see her chiropractor, Dr. Regan, with whom she had been treating with "twice a week," "sometimes maybe three" for seven years, from April 2003 up to and through the alleged second date of accident in October 2009. (T, p. 45)

Petitioner did not seek emergency treatment following the subject incident. Instead, Petitioner treated with the chiropractor, Dr. Regan, on Thursday and Friday following the subject incident and the following Monday saw Dr. Petra Joseph at the Rehabilitation Institute of Chicago (RIC) with whom she had also been treating for the same seven-year period between 2002 and 2009. (T, p. 31) Petitioner had also conceded it was possible Dr. Petra Joseph treated her for her lower back after the 2002 accident "if I was sore." (T, p. 49)

Four days after the subject incident, on October 19, 2009, when Petitioner saw Dr. Joseph at RIC, the office note described "Visit type" as "follow-up," four weeks after the last visit on 9/13/09. "Paperwork needed (for) future participation in Interdisciplinary Pain Program and Recommendation for Carpal Tunnel Release prior to Pain Program and Also plans to have foot surgery in near future." Petitioner's Chief Complaint did not include any low back complaint. The office visit notes documented:

> "Chronic worsening neck, upper back, shoulders radiating into back of head and turning into Migraine at times, pressure, pulsing associated with numbness left side forehead and body, needles in spine sensation, difficulty turning head to Left. ...aggravated by use of her arms...by stress, repetitive movement...has been treated regularly by chiropractor 3x a week, helps temporarily."

The Pain assessment also omitted any mention of low back pain; instead it noted: "Fibromyalgia tender points: bilateral lower cervical regions, right occiput, C7 spinous process, bilateral trapezius muscles, bilateral supraspinatus muscles." The Impression and Plan also omitted any reference to low back complaints at that visit which took place only four days after the subject incident.

Petitioner testified during those seven years, between 2002 and 2009, Dr. Joseph had urged her to enroll in the pain management program at the Rehabilitation Institute of Chicago (RIC). (T, p. 22, 30)

19IWCC0294

Without ever undergoing physical therapy, only chiropractic treatment, Petitioner consulted Dr. Joseph Weistroffer at Orthopedic Surgery on August 4, 2010. Dr. Weistroffer conducted a physical examination and found a negative, normal motion from flexion to stand, spine musculature with good tone, no atrophy nor spasm, negative SLR and negative XSLR; normal gait and station, normal heel and toe walk, difficulty with tandem. His assessment was cervicalgia and lumbago. He ordered the lumbar spine MRI and referred the Petitioner to the neurology department at Northwestern/Dr. Jack Rozental. (Px12)

The lumbar spine MRI was accomplished on August 11, 2010. (Px13) Petitioner returned to Dr. Rozental on October 5, 2010 with headache complaints. Dr. Rozental ordered a cervical spine MRI. On December 16, 2010, nurse Sarah Jackson left a message for Petitioner to return her call. Nurse Jackson documented she would advise her Dr. Rozental reviewed (the) MRI of the Cervical Spine and Carotid Doppler reports and both were within normal limits (WNL). On December 17, 2010 Nurse Jackson spoke with Petitioner who was concerned "that tests are normal but still having symptoms." A message was left on the patient's private voicemail on January 21, 2011 confirming that Dr. Rozental reviewed MRI and Doppler Study results. Both were WNL. (Px 14) There is no other mention of the lumbar spine MRI results or recommendations in reliance thereon.

Petitioner eventually enrolled in the RIC pain management program. Three years after the subject incident, on December 3, 2012, the RIC doctors, under the Spine-Pelvis section, noted: "lumbar range of motion limited due to conditioning, not pain, -cervical range of motion limited due to tightness, not to pain, she limits self" (Px12, pp. 57, 58)

The same records document Petitioner "does not take any prescription medication." The Impression and Plan state: "1. Chronic myofascial pain in cervical, upper thoracic, lumbar areas with tender points as listed above; 2. Sleep disorder; 3. Mood disorder/anxiety; 4. Poor posture; 5. Obesity." (Px12, pp. 57, 58) Therefore, in the Commission Opinion and Decision on second remand, the Commission found all these conditions to be pre-existing and therefore, that when the new injury occurred, it was fleeting and only temporarily aggravated her pre-existing conditions.

Based upon the Order of the Circuit Court, and as instructed to do so, the Commission's Opinion and Decision on Second Remand found that Petitioner sustained a new injury on October 15, 2009, one that was a temporary fleeting aggravation of her pre-existing condition, and further finds that there is no causal connection between her present condition of ill-being and the alleged work accident. The temporary fleeting aggravation caused no change in Petitioner's pre-existing condition.

Therefore, relying on Dr. Wehner's opinion that Petitioner's condition was pre-existing, Petitioner was at MMI and could return to work, full-duty without restriction, the Commission in the Opinion and Decision on second remand, found Petitioner suffered a temporary fleeting aggravation of a pre-existing condition, therefore, Petitioner was not entitled to compensation.

Third Remand

The Court's Third Remand Order finds the Commission's Decision and Opinion on Second Remand is directly contradictory to the Courts' October 14, 2016 Order. The Court notes:

> The Commission was instructed to assess an award of benefits based on the Court's determination regarding Petitioner's condition in relation to the 2009 accident. Instead of doing so, the Commission made additional findings, containing the same defects in reasoning that led to reversal the last time this matter came before the Court. Accordingly, the Court reverses the Commission again.

Further the Court ordered:

> Respondent shall pay Petitioner's costs for medical bills in the amount of $61,425.31; the remaining balance for 176 and 2/7 weeks of TTD, in the amount of $62,881.22; and maintenance in the amount of $2,943.30.

Based upon the Court's May 17, 2019 remand Order, the Commission is required to find that Petitioner suffered an accident on October 15, 2009 and that Petitioner's condition of ill-being is causally related to the October 15, 2009 work-related accident and Petitioner is entitled to TTD, maintenance and medical expenses. Therefore, the Commission reverses the Arbitrator's §19(b) Decision for the reasons stated herein regarding accident, and the Commission finds that Petitioner's condition of ill-being is causally related to the accident, and that Petitioner is entitled to TTD, maintenance and medical expenses for the reasons stated herein, and 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).

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed June 18, 2013, is hereby reversed regarding accident and the Commission finds that Petitioner's condition of ill-being is causally related to the accident for the reasons stated herein.

IT IS FURTHER ORDERED BY THE COMMISSION that the Respondent pay to Petitioner the sum of $62,881.22 representing $981.10 for a period of 176-2/7 weeks, commencing October 15, 2009 to March 1, 2013, totaling $172,953.92, that being the period of temporary total incapacity for work under Section 8(b) of the Act, less a credit of $110,072.70 for amounts paid in TTD and ordinary disability benefits.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $981.10 for a period of three weeks, commencing May 2, 2013 to May 23, 2013, that being the period of maintenance under Section 8(a) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the cost for medical bills in the amount of $61,425.31 pursuant to Sections 8(a) and 8.2 of the Act.

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

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

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

No county, city, town, township, incorporated village, school district, body politic or municipal corporation is required to file a bond to secure the payment of the award and the costs of the proceedings in the court to authorize the court to issue such summons. *820 ILCS 305/19(f)(2)*. Based upon the named Respondent herein, no bond is set by the Commission. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: JUN 1 4 2019
DLS/bsd
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Deborah L. Simpson
Deborah Simpson

Thomas J. Tyrrell
Thomas J. Tyrrell

Maria Elena Portela
Maria Portela

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

William Galeski,

Petitioner,

vs. NO: 16WC 24547

Nascote Industries, Inc.,

19IWCC0295

Respondent.

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed August 14, 2017, 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.

19IWCC0295

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

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

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $7,100.00. 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: JUN 17 2019
O061119
MEP/jrc
049

Maria Portela

Deborah Simpson

Thomas J. Tyrrell

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

GALESKI, WILLIAM
Employee/Petitioner

Case# **16WC024547**

19IWCC0295

NASCOTE INDUSTRIES INC
Employer/Respondent

On 8/14/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.14% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

4075 FISHER KERHOVER COFFEY ET AL
JASON COFFEY
1300 1/2 SWANWICK ST POB 191
CHESTER, IL 62233

5364 LAW OFFICE PATRICK JENNETTEN
316 SW WASHINGTON ST
UNITE 1A
PEORIA, IL 61602

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

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

William Galeski
Employee/Petitioner

v.

Nascote Industries, Inc.
Employer/Respondent

Case # **16** WC **24547**

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 **Melinda Rowe-Sullivan**, Arbitrator of the Commission, in the city of **Mt. Vernon**, on **July 6, 2017**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. [ ] Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?

B. [ ] Was there an employee-employer relationship?

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

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

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

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

G. [ ] What were Petitioner's earnings?

H. [ ] What was Petitioner's age at the time of the accident?

I. [ ] What was Petitioner's marital status at the time of the accident?

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

K. [x] Is Petitioner entitled to any prospective medical care?

L. [x] What temporary benefits are in dispute?
[ ] TPD [ ] Maintenance [x] TTD

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

N. [ ] Is Respondent due any credit?

O. [ ] Other ____________________

FINDINGS

On the date of accident, **April 6, 2016**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

On this date, 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.

Per the stipulation of the parties, in the year preceding the injury, Petitioner earned **$41,074.55**; the average weekly wage was **$789.90**.

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

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

Respondent shall be given a credit of **$0** for TTD, **$0** for TPD, **$0** for maintenance, and **$14,363.44** for non-occupational indemnity disability benefits, for a total credit of **$14,363.44.**

Respondent is entitled to a credit **for all benefits paid through group insurance** under Section 8(j) of the Act.

ORDER

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

Respondent shall pay the reasonable and necessary medical services as included in Petitioner's Exhibit 8 as provided in Sections 8(a) and 8.2 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 the provider(s). 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 is entitled to a credit for all benefits paid under its group health plan under Section 8(j) of the Act.

Respondent shall pay Petitioner temporary total disability benefits of **$526.60**/week for **40 5/7** weeks, **for the timeframe of September 26, 2016 through July 6, 2017,** as provided in Section 8(b) of the Act.

Respondent shall be given a credit of **$0** for TTD, **$0** for TPD, **$0** for maintenance, and **$14,363.44** for non-occupational indemnity disability benefits, for a total credit of **$14,363.44.**

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.

19IWCC0295

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

Melinda M. Rowe-Sullivan
Signature of Arbitrator

8/10/17
Date

ICArbDec19(b)

AUG 14 2017

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(B)

William Galeski
Employee/Petitioner

Case # 16 WC 24547

v.

Consolidated cases: N/A

Nascote Industries, Inc.
Employer/Respondent

MEMORANDUM OF DECISION OF ARBITRATOR

FINDINGS OF FACT

Petitioner testified he is currently 63 years old and formerly worked for Nascote Industries. He testified he worked for the Respondent for 23 years as a general production worker. He testified that he assembled auto parts in various locations throughout the assembly through his career with Respondent. He testified that he suffered a work injury on April 6, 2016 when he was awkwardly bending over to pick up ten brackets out of the very back of a shipping tote and felt something pop in his lower back. Petitioner testified that he reported the incident to Chuck Rowell, his supervisor, and sought medical attention.

At the time of arbitration, Petitioner outlined his medical treatment and noted that he saw a nurse at Nascote via their early intervention screening program. He testified that he also subsequently treated with his primary care physician, who recommended x-rays and an eventual MRI. He testified that following the MRI, he was referred to an orthopedist, Dr. Matthew Gornet. According to Petitioner, Dr. Gornet had referred him for three shots with Dr. Boutwell. He testified that the shots gave him only temporary relief, and that Dr. Gornet was now recommending surgery. Petitioner stated that his quality of life was not good and indicated that he has trouble sleeping and difficulty walking without a great deal of low back pain.

Petitioner estimated that the ten brackets he was picking up at the time of the injury weighed approximately 20-25 pounds. He characterized this job duty as a usual part of his employment with Respondent. He stated he would normally take ten brackets at a time out of a shipping tote, that he would take them over and put them right in front of his work table and then he would put metal clips on the brackets to be put through a scanning system to verify that all the brackets had clips on them. He testified that he would then go back to the tote to pick up ten more brackets.

Petitioner testified that he worked light duty following the injury from April 6, 2016 to the very last week of September of 2016. He testified that he has not been released to full duty at any point since April 6, 2016. He testified that he was still willing to work light duty beyond September of 2016, but was told by his supervisor they did not have any light duty available. He testified that he has returned to the facility to fill out papers for disability, but has not returned to perform any work. He denied have any had treatment for his low back prior to April 6, 2016.

On cross examination, Petitioner agreed he had given a specific history to his family doctor as to how the work injury occurred. He also agreed the event precipitating this even was bending over. Petitioner acknowledged having seen Dr. Cantrell at the request of his employer and that he told Dr. Cantrell that the low back pain began as he was bending over. However, the Petitioner asserted he believed he told Dr.

Cantrell the pop he felt in his low back was associated with both the bending over and lifting because the brackets were in his hands at the time of the injury. but that he was bending over when the injury occurred.

On redirect examination, Petitioner testified that testified the brackets he was picking up at the time of the injury were all the way at the back of the tote so he was reaching and bending at the same time.

Charles Rowell was called as a witness by Respondent at the time of arbitration. Mr. Rowell testified that he has been working for Respondent for 20 years. He testified that he is currently an assembly supervisor over the inline vehicle sequencing day shift department. He testified that he has been a supervisor for ten years and that on the date of accident, he was Petitioner's direct supervisor. Mr. Rowell testified that Petitioner told him he was bending over a tote and felt a twinge in his back. He denied that Petitioner stated anything about lifting when he felt the pop. He confirmed there was a video of the incident in question and that he had reviewed it. He testified that he did not believe the ten brackets would have weighed in excess of ten pounds. He testified that as to the incident described by Petitioner of bending over and reaching to get brackets, Petitioner would do this maybe six times per day.

On cross-examination, Mr. Rowell admitted to knowing Petitioner for approximately 20 years. He testified that he knew Petitioner well and that he would never give him a reason to think he was not being truthful.

On cross examination, Mr. Rowell testified that Respondent has now changed the way the job of obtaining brackets is done. He explained there is a lift table there now and that the totes are now tilted toward the employee to make it safer for the employee to reach and grab them.

Respondent also called Natalie Billimoria as a witness at the time of arbitration. Ms. Billimoria testified that she has worked for Respondent for seven years as a health and safety clerk. She testified that she weighed the brackets and that each one weighed less than a pound.

On cross-examination, Ms. Billimoria admitted that she did not weigh ten brackets. She testified that she weighed one bracket.

The medical records of NovaCare Work Strategies were entered into evidence at the time of arbitration as Petitioner's Exhibit 1.[1] The document dated April 6, 2016 noted that Petitioner was seen by a clinician by the name of "Valerie" who noted a date of onset/symptom duration of April 6, 2016. It was noted that the Mode of Onset was that of bending forward and hearing a "pop" and that Petitioner wanted to see his primary care physician and have x-rays but agreed to come see therapy first. The Daily Treatment Note dated April 8, 2016 noted that Petitioner stated that Naproxen was not really helping, that he had difficulty sleeping at night and sitting for long periods of time and that he had a decreased and guarded cadence. The Daily Treatment Note dated April 11, 2016 noted that Petitioner reported an inability to sleep at night and that he reported the only time he felt relief was when he was up walking around. The Daily Treatment Note dated April 18, 2016 noted that Petitioner continued to awaken 3-4 times per night even while taking a muscle relaxer and that he stated the pain was in one location and then moved more central and then to the opposite side. The Daily Treatment Note dated April 20, 2016 noted that Petitioner reported some numbness down his right lower extremity and that he was sore and that the numbness also went down the posterior leg and into the foot. (PX1).

The records of NovaCare Work Strategies reflect that Petitioner underwent an Onsite Rehabilitation Evaluation on April 21, 2016, at which time it was noted that the chief complaint was that of constant center low back pain radiating to the right buttock, posterior thigh and down to the right foot including paresthesias in the right foot. It was noted that Petitioner reported that on April 6, 2016 he was reaching forward and

[1] Please note that the circling of dates in the records was not made by the Arbitrator.

felt a pop in his low back with immediate pain. The Daily Treatment Note dated April 22, 2016 noted that Petitioner voiced soreness and stated that he slept as instructed by physical therapy and was able to rest more than prior but was not back to normal. It was noted that Petitioner ambulated very guarded. The note dated April 25, 2016 noted that Petitioner stated that he continued to be "sore" in the low back with pain down the back of the right leg and numbness in the right foot. It was noted that Petitioner described his pain as a "tooth ache" while rating it at 6-7/10 that had not really changed. It was noted that Petitioner also stated that he was waking 6-7 times per night due to pain and was unable to fall back asleep. (PX1).

The medical records of Dr. David Kapp were entered into evidence at the time of arbitration as Petitioner's Exhibit 2. The records reflect that Petitioner was seen on April 6, 2016, at which time it was noted that he stated that he was leaning over a tote to pick up brackets and that when he leaned forward, he heard a pop in his lower back. It was noted that Petitioner presented with back pain and that the discomfort was most prominent in the lumbar spine. It was noted that Petitioner characterized it as "tight" and stiffness and that he stated that the current episode of pain started 3-4 hours ago. It was noted that the event which precipitated the pain was bending over, that he denied radicular leg pain, numbness in the legs and weakness in the legs and that he noted some pain relief with ice and lying flat with the legs elevated. The assessment was noted to be that of low back pain. Petitioner was prescribed Naproxen. Petitioner was also given work restrictions at that time. (PX2).

The records of Dr. Kapp reflect that Petitioner was seen on April 13, 2016, at which time it was noted that the discomfort was most prominent in the lumbar spine that he characterized as "tight" and stiffness. It was noted that the event which precipitated the pain was bending over and that he denied radicular leg pain, numbness in the legs and weakness of the legs. It was noted that Petitioner noted some pain relief with ice and lying flat with his legs elevated, that he had been popping with bending and twisting and had seen therapy at work and was given stretches. The assessment was noted to be that of low back pain, persistent spasm and SI joint dysfunction. Petitioner was recommended to start physical therapy. Petitioner was also issued work restrictions. At the time of the April 27, 2016 visit, it was noted that Petitioner complained of low back pain and that associated symptoms included numbness in the right thigh, right lower and right foot. It was noted that Petitioner denied weakness to the legs and that he noted that the pain was relieved by lying flat and with ice but that it continued to hurt when he got up from this position. It was noted that Petitioner stated that he had been going to therapy and continued the exercises at home, but that he felt his back was hurting more now than before. It was noted that Petitioner stated that he was having trouble sleeping at night due to the pain. The assessment was noted to be that of persistent low back pain that had not responded to physical therapy. It was noted that x-rays of the lumbar spine showed primarily degenerative changes and disc space narrowing at L5. Petitioner was referred to a neurosurgeon, Dr. Vaught. (PX2).

The medical records of Perry County Memorial Hospital were entered into evidence at the time of arbitration as Petitioner's Exhibit 3. The records reflect that Petitioner underwent x-rays of the lumbar spine on April 27, 2016, which were interpreted as revealing (1) no lumbar compression; (2) subtle Grade I anterolisthesis of L4 over L5; (3) posterior facet degenerative changes were noted at L4 and L5; (4) no pars interarticularis defects; (5) decrease in diskal height was noted at the L1-2, L2-3 and L5-S1 disks; (6) the lumbar canal appears stenotic at L5. Petitioner also underwent an MRI of the lumbar spine on May 19, 2016, which was interpreted as revealing (1) no lumbar compression; (2) Grade I anterolisthesis of L4 over L5; (3) acquired spinal stenosis at the L3-4 and L4-5 disks; (4) at L5-S1, 3 mm left paracentral and left lateralizing herniation superimposed on a circumferential bulge with marginal osteophyte; narrowing of each lateral recess and each neuroforamen was noted. (PX3).

The transcript of the deposition of Dr. Matthew Gornet was entered into evidence at the time of arbitration as Petitioner's Exhibit 4. Dr. Gornet testified that he is a board-certified orthopedic surgeon whose practice is exclusively focused on spine surgery. (PX4).

Dr. Gornet testified that he first saw Petitioner on August 8, 2016 and that his main complaint was low back pain, particularly to his right buttock, right posterior thigh, calf, bottom of his foot with numbness and tingling in his right thigh and leg. He testified that Petitioner felt that his current problem began on or about April 6, 2016 when he went over and was at an awkward angle to pick up some brackets out of a tote, his arms were extended and he picked up ten brackets at once which he estimated weighed about 25 pounds. He testified that Petitioner indicated that he had fairly instant pain that was reported that day and that he was seen by occupational medicine and then his primary care physician. He testified that Petitioner was referred to Dr. Scott Gibbs in Cape Girardeau, but that Dr. Kapp was unaware that Dr. Gibbs had passed away. He testified that Petitioner was then sent for an IME with Dr. Cantrell, a physiatrist, and was then released. (PX4).

Dr. Gornet testified that Petitioner's physical examination in August 8th correlated with his subjective complaints of right buttock and right thigh to his calf, that he had decreased EHL function, ankle dorsiflextion and plantar flexion on the right at 4/5 which indicated L5 and S1 abnormalities or irritation and that he also had decreased sensation in the S1 dermatome on the right. He testified that he believed that Petitioner had aggravated his underlying condition of spinal stenosis at L4-5 and that he also aggravated his joints at L5-S1 as he had a facet cyst on the side which correlated with his right buttock and right leg pain. He testified that he recommended conservative care, including steroid injections at L4-5 and L5-S1, muscle relaxants and anti-inflammatories. He testified that he also placed Petitioner on light duty. (PX4).

Dr. Gornet testified that he next saw Petitioner on December 1, 2016, and that Petitioner had undergone the treatment he had previously recommended. He testified that the injections gave Petitioner limited relief and that he was still having pain in his right buttock and numbness in his right leg. He testified that he thought that a portion of Petitioner's pain had improved but not enough that he felt substantial improvement in quality of life. He testified that he discussed with Petitioner that the next option would be facet rhizotomies or ablation and that if he failed that, he would be referred for further work-up for surgery. He testified that he next saw Petitioner on February 2, 2017 and that he had undergone rhizotomies on December 22, 2016 that had helped a portion of his pain but not enough to allow him to return back to work full duty. He testified that Petitioner still had objective weakness on physical examination in his EHL, ankle dorsiflexion and plantar flexion as well as decreased sensation, and that he recommended a CT myelogram of his lumbar spine and a new MRI. He testified that he asked Petitioner whether he could live with his current symptoms and accept permanent restrictions, and that Petitioner indicated to him that he felt his quality of life was too impaired. (PX4).

Dr. Gornet testified he next saw Petitioner on February 23, 2017 and that he had undergone the updated MRI and CT myelogram. He testified that the MRI revealed loss of disk height at L5-S1, foraminal stenosis at L5-S1 left and to a lesser extent on the right side and that he had a facet cyst at L4-5 and bilateral facet arthropathy. He testified that Petitioner also had moderate changes at L3-4 and L2-3, and that they talked again about his spinal fusion. He testified that he thought that the diagnostics were consistent with Petitioner's pain complaints and the findings on physical examination. He testified that he believed that surgery could help Petitioner with his quality of life if he had not already suffered nerve damage. (PX4).

Dr. Gornet testified that he believed that Petitioner's current condition is causally related to the work injury on April 6, 2016 as there was no information that he had seen that Petitioner had any problems of significance prior to that and that but for the lifting incident, he did not believe that Petitioner would be in the same condition he was in. (PX4).

On cross examination, Dr. Gornet agreed that he took a history of injury from Petitioner of him picking up brackets that weighed approximately 25 pounds when he felt pain in his back lifting those brackets. He testified that this history was one of the bases for his opinion on causation, and that the other was that Petitioner's subjective complaints correlated with his objective physical examination. (PX4).

On cross examination, Dr. Gornet testified that the relatively acute annular tear seen on the May 19, 2016 films over time "faded away" and was not present as much on the February films. He testified that he did not believe that the annular tear was impinging on the nerve root and that he believed that there was a structural injury to the disk. (PX4).

The medical records of Dr. Matthew Gornet were entered into evidence at the time of arbitration as Petitioner's Exhibit 5. The records reflect that Petitioner was seen on June 15, 2017, at which time it was noted that he stated that he was on Social Security Disability. It was noted that Dr. Gornet asked whether or not his pain was severe enough to warrant treatment even though he was not working, and that Petitioner was fairly emphatic. It was noted that the current plan was AP fusion L4 to S1 and that posteriorly, Petitioner would require three incisions to decompress him at what Dr. Gornet believed was L4-5 and L5-S1 bialterally. It was noted that Petitioner had already failed conservative measures including therapy, RFAs and steroid injections and that Petitioner's quality of life was severely affected. (PX5).

The medical records of MRI Partners of Chesterfield were entered into evidence at the time of arbitration as Petitioner's Exhibit 6. The records reflect that Petitioner underwent an MRI of the lumbar spine on February 23, 2017, which was interpreted as revealing (1) annular disc bulge with a superimposed right foraminal annular tear and protrusion at L3-4, with associated posterior element hypertrophy resulting in mild central canal stenosis and right greater than left foraminal stenosis; (2) degenerative Grade I anterolisthesis at L4-5 with severe erosive facet arthropathy, annular disc bulge, ligamentum flavum hypertrophy, a small midline facet synovial cyst and a left foraminal annular tear with a central broad-based protrusion; moderate to severe central canal stenosis and moderate left greater than right foraminal stenoses are present; (3) left lateral recess epicenter broad-based 5.5-6 mm protrusion with a right paracentral annular tear and resulting moderate to severe bilateral foraminal stenoses at L5-S1; no central canal stenosis is observed at this level. (PX6).

The medical records of CT Partners of Chesterfield were entered into evidence at the time of arbitration as Petitioner's Exhibit 7. The records reflect that Petitioner underwent a CT myelogram on February 13, 2017, which was interpreted as revealing annular disc bulges with facet arthropathy at all lumbar levels; there is 7 mm degenerative grade I anterolisthesis at L4-5 with severe erosive facet arthropathy at this level; overall, severe L4-5 and mild L3-4 central canal stenoses are observed; there is bilateral foraminal stenosis at all lumbar levels, most severe bilaterally at L5-S1. (PX7).

The Medical Bills Exhibit was entered into evidence at the time of arbitration as Petitioner's Exhibit 8.

The Response to 19(b) Petition was entered into evidence at the time of arbitration as Respondent's Exhibit 1.

The Accident Reports were entered into evidence at the time of arbitration as Respondent's Exhibit 2. The Workers' Compensation – First Report of Injury or Illness referenced a date of injury/illness of April 6, 2016. It was noted that Petitioner was "getting the bracket from the tote" when the accident occurred and that Petitioner was "leaning over getting [prackits] and I felt something pop in my lower back." The report was prepared on April 8, 2016 by Monica Zapp. The Illinois Form 45: Employer's First Report of Injury was dated April 7, 2016 and was prepared by Monica Zapp. It was noted that Petitioner was clipping the 363 side bracket when the accident occurred and that he was getting the bracket from the tote. As to the question of what object or substance, if any, directly harmed the employee, it was noted "None that I see in the video. The video is on in the safety file under (Bill Galeski back)." (RX2).

The Employee Statement of Safety Incident was entered into evidence at the time of arbitration as Respondent's Exhibit 3. The statement noted that "I was leaning over getting [prackets] and I felt something pop in my lower back." (RX3).

The Wage Statement was entered into evidence at the time of arbitration as Respondent's Exhibit 4. The Job Description was entered into evidence at the time of arbitration as Respondent's Exhibit 5. The Denial Letter was entered into evidence at the time of arbitration as Respondent's Exhibit 6. The Medical Benefits Payout was entered into evidence at the time of arbitration as Respondent's Exhibit 7. The Group Disability Payments Payout was entered into evidence at the time of arbitration as Respondent's Exhibit 8.

The office note of Dr. Kapp dated April 27, 2016 was entered into evidence at the time of arbitration as Respondent's Exhibit 9. The record was duplicative of that as contained in Petitioner's Exhibit 2. (RX9; PX2).

The Interpretive Report for the MRI of the Lumbar Spine performed on May 19, 2016 was entered into evidence at the time of arbitration as Respondent's Exhibit 10. The record was duplicative of that as contained in Petitioner's Exhibit 3. (RX10; PX3).

The IME Report of Dr. Cantrell was entered into evidence at the time of arbitration as Respondent's Exhibit 11. The IME report noted that Petitioner reported that on the date of onset of his back pain complaints, he was bending forward at the waist to retrieve some brackets from a tote and reported that in the process of bending forward and even before he lifted any brackets, he felt a pop in his lower back with the acute onset of lumbar back pain. It was noted that Petitioner presented with subjective complaints and clinical findings consistent with an L4 radiculopathy and that although the MRI scan revealed a left lateralizing disc herniation at the L5-S1 level, the finding was incidental and did not correlate with the distribution of Petitioner's complaints. It was noted that Dr. Cantrell opined that Petitioner also had multi-level degenerative disc disease and a Grade I anterolisthesis at L4 on L5 and that he reported that the onset of his pain complaints occurred when he was simply bending forward at the waist and even prior to lifting any brackets. It was noted that it was Dr. Cantrell's opinion that simply bending forward at the waist did not represent an unusual strain to the lower back as a result of Petitioner's work activities, and that although he had temporally reported his complaints occurring as a result of that incident, it was his opinion that the multi-level degenerative disc disease, the spondylolisthesis at L4-5 and the incidental finding of a disc herniation to the left at L5-S1 were pre-existing medical conditions. It was noted that independent of causation, Petitioner might benefit from a right L4 selective nerve root block for both diagnostic and therapeutic purposes and that an estimated date of maximum medical improvement would be dependent upon his reported response to the right L4 selective nerve root block. (RX11).

The transcript of the deposition of Dr. Cantrell was entered into evidence at the time of arbitration as Respondent's Exhibit 12. Dr. Cantrell testified that he specializes in physical medicine and rehabilitation and that he routinely treats patients that have spinal conditions including back pain and radicular symptoms. He testified that he is board-certified in physical medicine and rehabilitation. (RX12).

Dr. Cantrell testified that he performed an IME of Petitioner on May 16, 2016. He testified that he provided a diagnosis of a right L4 radiculopathy. He testified that he has not seen Petitioner since May of 2016 and has not reviewed additional medical records, and that he was not in a position to testify as to whether a proposed surgery would be reasonable or necessary for his condition. (RX12).

Dr. Cantrell testified that he took a history from Petitioner that he was bending forward at the waist to retrieve some brackets from a tote and that in the process of bending forward and even before he lifted any brackets, he felt a pop in his lower back with the acute onset of low back pain. He testified that the history was significant to him and that generally speaking, an injury would typically require some type of an unusual strain and that the simple act of bending which is done on a daily basis did not constitute, in his opinion, an injury. He testified that it was his understanding of the history was that there was no lifting and that the pop and the pain started just from bending over. He testified that he did not feel that the work activities described to him by Petitioner were a causative or aggravating factor in the development of the symptoms of low back pain with radicular complaints because he did not feel that the simple act of bending

forward itself constituted an injury given that it was done on a daily basis independent of the type of work that Petitioner was doing. (RX12).

When asked if the MRI findings of May 19, 2016 were suggestive of trauma in any way, shape or form, Dr. Cantrell testified that the one thing that could be described as potentially traumatic in nature would be the herniation lateralizing to the left at the L5-S1 level but that Petitioner had not associated left leg symptoms. He testified that the level at which there was a described herniation at L5-S1 did not correlate with the distribution of Petitioner's symptoms and weakness that he noted on examination in the right lower extremity. He testified that he thought that the cause of Petitioner's low back pain with radicular complaints was the combination of pathologies that were present at the L4-5 level and that this was something that could come on gradually over time for individuals like Petitioner based upon the degenerative process. (RX12).

On cross examination, Dr. Cantrell agreed that he has not seen any medical records for the treatment of Petitioner since May 16, 2016. He agreed that he was provided a video from Nascote Industries. He agreed that he saw that Petitioner had to reach down into a large tote square to pick up parts. He testified that Petitioner was bending and reaching simultaneously. He testified that he did not make specific comment on the motions that Petitioner was engaging in after lifting up the brackets. (RX12).

On cross examination, Dr. Cantrell agreed that he stated that because the L5-S1 disc herniation was lateralizing to the left, Petitioner's pain symptoms should be on the left if it was causally connected. He testified that no abnormality at L5-S1 would be expected to cause L4 nerve root distribution symptoms and that what confirmed for him that this was an L4 nerve root issue was the distribution of weakness that Petitioner had. (RX12).

The Job Video was entered into evidence at the time of arbitration as Respondent's Exhibit 13. The video shows Petitioner in an orange or red shirt with his back to the camera at what the Arbitrator assumes is his work station. The video shows Petitioner turning, facing the camera and walking over to a large shipping container. The video shows Petitioner bending down and reaching into the shipping container and grabbing certain items. Petitioner pulls the items out of the container as he is twisting to his right to carry them back to his work station. Before Petitioner begins walking back to his work station, his right arm goes behind his back and he grabs an area of his lower back. The Arbitrator notes that the brackets appear to be in Petitioner's left arm when he makes this maneuver. Petitioner then proceeds back to his work station and the video ends. (RX13).

CONCLUSIONS OF LAW

With respect to disputed issue (C) pertaining to accident, the Arbitrator finds that Petitioner sustained an accident that arose out of and in the course of his employment with Respondent on April 6, 2016.

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 (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 "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.* There are three categories of risk 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. *Springfield Urban League v. Illinois Workers' Compensation Comm'n*, 2103 IL App (4th) 120219WC, ¶ 27; *Young v. Illinois Workers' Compensation Comm'n*, 2014 IL App (4th) 130392WC. 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. *Id.*

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. "Injuries sustained on an employer's premises, or at a place where the claimant might reasonably have been while performing his duties, and while a claimant is at work, or within a reasonable time before and after work, are generally deemed to have been received in the course of the employment." *Johnson v. Illinois Workers' Compensation Comm'n*, 2011 IL App (2d) 100418WC, ¶ 21.

In the case at hand, the Arbitrator finds that Petitioner was performing a task incidental to his employment when his injury occurred. The Arbitrator finds to be significant in this case Petitioner's testimony that he was awkwardly bending over to pick up ten brackets out of the very back of a shipping tote and felt something pop in his lower back, which the Arbitrator notes appears to comport with the video of the incident as depicted in Respondent's Exhibit 13. The Arbitrator notes that Petitioner appears to be reaching to the very back of the tote during the course of the maneuver at issue, which the Arbitrator finds to be distinguishable from the task of simply bending over so as to do such activities as tying one's shoes. Finding Petitioner to have been a credible witness at the time of arbitration and noting that he appeared to testify in a forthright manner, the Arbitrator finds that Petitioner met his burden of proof in establishing that he sustained accidental injuries that arose out of and in the course of his employment with Respondent.

With respect to disputed issue (F) pertaining to causation, the Arbitrator finds that Petitioner has met his burden of proving that his current condition of ill-being is causally related to the accident.

The Arbitrator notes that the undisputed facts demonstrate that Petitioner was working full duty prior to this accidental injury. The Arbitrator notes that it appears to be undisputed that Petitioner did not seek medical treatment specifically for his low back until after his work injury on April 6, 2016, as no evidence was proffered at the time of arbitration by Respondent suggesting otherwise. Furthermore, the Arbitrator notes that Petitioner credibly testified that he had never sought medical treatment for his low back prior to his work injury on April 6, 2016. As the Arbitrator finds the opinions of Dr. Gornet, an orthopedic surgeone specializing in spine surgery, to be more persuasive than those of Dr. Cantrell, a physician specializing in physical medicine and rehabilitation, the Arbitrator finds that Petitioner has met his burden of proving that his current condition of ill-being is causally related to the accident.

With respect to disputed issue (J) pertaining to necessary medical services, in light of the Arbitrator's aforementioned conclusions, the Arbitrator finds that Petitioner's care and treatment was reasonable, necessary and causally related to his work accident of April 6, 2016. As a result thereof, Respondent shall pay all reasonable and necessary medical services as contained in Petitioner's Exhibit 8, as provided in Sections 8(a) and 8.2 of the Act, subject to the fee schedule. Respondent shall be given a credit for all medical benefits that have been paid, and Respondent shall hold Petitioner harmless from any

claims by any providers of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act.

With respect to disputed issue (K) pertaining to prospective medical treatment, in light of the Arbitrator's finding as to the issue of causation, the Arbitrator finds that Respondent shall authorize the treatment recommended by Dr. Gornet, including, but not limited to, the recommended surgery.

With respect to disputed issue (L) pertaining to temporary total disability benefits and temporary partial disability benefits, the Arbitrator notes that Petitioner seeks temporary total disability benefits from September 26, 2016 through July 6, 2017. (AX1).

The Arbitrator notes that Petitioner was willing to work restricted duty and apparently did so from the date of accident through September 25, 2016. Only after being told there was no restricted duty available to him did Petitioner cease working, and the Arbitrator notes that Respondent offered no evidence to refute Petitioner's testimony on this issue. In light of the Arbitrator's conclusions regarding all other issues herein, the Arbitrator finds that Petitioner was temporarily and totally disabled for the timeframe of September 26, 2016 through July 6, 2017, a total of 40 5/7 weeks, for which he is entitled to benefits under Section 8(b) of the Act.

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

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

SONJA HILLER,

Petitioner,

vs. NO: 15 WC 26838

UNIQUE PERSONNEL CONSULTANTS, **19IWCC0296**

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of causation, medical expenses, prospective medical treatment, and temporary total disability and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof. 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 27, 2017, 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 $37,148.00. 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: JUN 17 2019

Maria E. Portela

Thomas J. Tyrrell

Deborah L. Simpson

MEP/dmm
O: 50719
49

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

HILLER, SONJA
Employee/Petitioner

Case# **15WC026838**

UNIQUE PERSONNEL CONSULTANTS
Employer/Respondent

19IWCC0296

On 9/27/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.17% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

4342 REHN & SKINNER LLC
JOHN REHN
5 E SIMMONS ST
GALESBURG, IL 61401

0766 HENNESSY & ROACH PC
RYAN McCARTHY
140 S DEARBORN ST 7TH FL
CHICAGO, IL 60603

19IWCC0296

STATE OF ILLINOIS)

)SS.

COUNTY OF ROCK ISLAND)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

Sonja Hiller
Employee/Petitioner

v.

Case # 15 WC 26838

Unique Personnel Consultants
Employer/Respondent

Consolidated cases: n/a

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable William R. Gallagher, Arbitrator of the Commission, in the city of Rock Island, on August 3, 2017. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. [ ] Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?

B. [ ] Was there an employee-employer relationship?

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

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

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

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

G. [ ] What were Petitioner's earnings?

H. [ ] What was Petitioner's age at the time of the accident?

I. [ ] What was Petitioner's marital status at the time of the accident?

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

K. [x] Is Petitioner entitled to any prospective medical care?

L. [x] What temporary benefits are in dispute?
[ ] TPD [ ] Maintenance [x] TTD

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

N. [ ] Is Respondent due any credit?

O. [ ] Other ____

19IWCC0296

FINDINGS

On the date of accident, July 17, 2015, Respondent was operating under and subject to the provisions of the Act.

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

On this date, 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 $12,709.56; the average weekly wage was $380.00.

On the date of accident, Petitioner was 53 years of age, married with 0 dependent child(ren).

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

Respondent shall be given a credit of $1,848.00 for TTD, $0.00 for TPD, $0.00 for maintenance, and $0.00 for other benefits, for a total credit of $1,848.00.

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

ORDER

Respondent shall pay reasonable and necessary medical services as identified in Petitioner's Exhibits 11A, 11 B, 11C, 11 D and 11H, as provided in Section 8(a) and 8.2 of the Act. subject to the fee schedule. The bills for medical services as identified in Petitioner's Exhibits 11 E, 11F and 11G are denied.

Respondent shall pay Petitioner temporary total disability benefits of $253.33 per week for 104 1/7 weeks commencing July 30, 2015, through August 3, 2017, as provided in Section 8(b) of the Act.

Respondent shall authorize and pay for prospective medical treatment including, but not limited to, the right hip arthroscopic surgery recommended by Dr. Shane Nho.

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

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

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

William R. Gallagher, Arbitrator
ICArbDec19(b)

September 22, 2017
Date

SEP 27 2017

Findings of Fact

Petitioner filed an Application for Adjustment of Claim which alleged she sustained an accidental injury arising out of and in the course of her employment for Respondent on July 17, 2015. According to the Application, Petitioner slipped on a wet floor and sustained an injury to her right knee and hip (Arbitrator's Exhibit 2). This case was tried in a 19(b) proceeding and Petitioner sought an order for payment of medical bills and temporary total disability benefits as well as prospective medical treatment. Respondent stipulated that Petitioner sustained a work-related accident; however, Respondent disputed liability on the basis of causal relationship. In regard to temporary total disability benefits, Petitioner claimed she was entitled to temporary total disability benefits of 104 1/7 weeks commencing July 30, 2015, through August 3, 2017 (the date of trial). Respondent claimed that Petitioner was entitled to temporary total disability benefits of eight and four-sevenths (8 4/7) weeks, commencing August 1, 2015, through September 29, 2015 (Arbitrator's Exhibit 1).

Respondent was a temporary employment agency and, on July 17, 2015, Petitioner was assigned by Respondent to work at Cornelius Review. Cornelius Review was a company whose business consisted primarily of rebuilding/reconditioning beverage machines used in convenience stores. On July 17, 2015, Petitioner began working at 5:00 AM and clocked out at 11:00 AM to go to lunch. Petitioner testified that she proceeded to go to the break room and initially stepped on a portion of the floor that was covered by a floor mat. Petitioner stated that the floor was polished concrete and that the break room was not air conditioned. Because of the heat, humidity and lack of air conditioning in the break room, the concrete floor would "sweat." When Petitioner stepped off of the floor mat and onto the concrete floor, her right foot slipped out from under her causing her to fall down on the concrete floor landing on her right knee.

Petitioner was able to complete her shift on the day of the accident. Because the accident occurred on a Friday, Petitioner did not work on either Saturday or Sunday. However, Petitioner testified that the pain symptoms in the right knee and right hip worsened over that weekend. Petitioner was able to work on Monday, July 20, but was only able to perform duties while remaining seated.

After the end of her shift on July 20, 2015, Petitioner went to the ER of St. Mary Medical Center. When seen there, Petitioner complained of right knee and right hip pain. X-rays of the right knee and right hip were taken which were negative. It was recommended Petitioner use an ACE bandage on her right knee and see her primary care physician (Petitioner's Exhibit 8; pp 14-20).

Respondent sent Petitioner to Dr. Robert Ayers, a physician associated with OSF Occupational Health Network. Petitioner was initially seen by Suzanne Wilton, a Nurse Practitioner associated with Dr. Ayers on July 21, 2015. At that time, Petitioner primarily complained of right knee pain which traveled upward to the right hip. NP Wilton opined Petitioner had sustained a right knee contusion and strain. She authorized Petitioner to return to work, but limited to sit down work (Petitioner's Exhibit 6; p 61).

Petitioner worked at Cornelius Review for a few days, but then was informed she was no longer needed. Respondent provided modified work to Petitioner, but only for a few days. On July 29, 2015, Petitioner worked for a few hours and stopped because of her pain symptoms. Petitioner has not returned to work since that time.

Petitioner was seen by Dr. Ayers on July 30, 2015. At that time, Petitioner complained of right knee and right hip pain. Dr. Ayers authorized Petitioner to be off work and recommended physical therapy (Petitioner's Exhibit 6; p 54).

Petitioner was again seen by Dr. Ayers in August, 2015, and Dr. Ayers continued to recommend physical therapy. When Dr. Ayers saw Petitioner on August 17, 2015, he recommended Petitioner undergo an MRI of both the right hip and right knee because of her ongoing symptoms. He continued to authorize Petitioner to remain off work (Petitioner's Exhibit 6; pp 43-44).

On August 25, 2015, Dr. Ayers sent a letter to Dr. Doug Sloan, Petitioner's family physician, and he advised that Petitioner's workers' compensation claim had been disputed. He noted that Petitioner had been seen for right knee and right hip pain, but that she had recently been having more hip than knee pain. He noted that Petitioner had advised him that she landed straight down on her knee jamming her hip as a result of the impact (Petitioner's Exhibit 6; p 39).

Petitioner received physical therapy from September 10, through September 30, 2015. Petitioner received therapy for both right knee and right hip symptoms. When seen on September 30, 2015, the therapist noted that there was possible meniscal involvement in the right knee and a possible labral issue in the right hip. Therapy was discontinued because of the lack of progress and because referral to an orthopedic surgeon and diagnostic imaging was indicated (Petitioner's Exhibit 2; p 58).

At the direction of Respondent, Petitioner was examined by Dr. Troy Karlsson, an orthopedic surgeon, on September 21, 2015. In connection with his examination of Petitioner, Dr. Karlsson reviewed medical records provided to him by Respondent. Dr. Karlsson opined Petitioner had sustained a right knee contusion with chondromalacia of the patella and possible trochanteric bursitis of the right hip. He opined Petitioner could return to work without restrictions; however, he also stated Petitioner was not at MMI and should receive some additional treatment including physical therapy, an injection to the greater trochanter and an MRI of the right knee to rule out internal derangement (Respondent's Exhibit 1; Deposition Exhibit 2).

On October 6, 2015, Petitioner contacted Dr. Sloan's office and spoke to Toni Horton, an RN. She referred Petitioner to Dr. Steven Potaczek, an orthopedic surgeon (Petitioner's Exhibit 5).

Dr. Potaczek initially evaluated Petitioner on October 8, 2015. At that time, Petitioner complained of right knee and right hip pain. Dr. Potaczek opined Petitioner had sustained a contusion to the right knee and administered an injection. An MRI scan of the right knee was performed on October 14, 2015, which revealed of popliteal cyst, but was otherwise unremarkable (Petitioner's Exhibits 4 and 6).

Petitioner was subsequently seen by Dr. Potaczek on October 25, 2015, primarily for right hip pain. Dr. Potaczek ordered a bone scan which was performed on November 5, 2015. It was normal. On November 12, 2015, Dr. Potaczek administered an injection to the right hip (Petitioner's Exhibit 4).

Dr. Potaczek again saw Petitioner on January 15, 2016. At that time, Dr. Potaczek opined that an MRI of the right hip was not indicated and that Petitioner could return to work. He noted Petitioner had right hip pain, subjective greater than objective and right knee pain with negative work up (Petitioner's Exhibit 4).

On February 8, 2016, Petitioner sustained a fall at her residence and apparently reinjured her right hip. Petitioner did not testify as to how she sustained the fall and there was no description as to its occurrence in the medical records. Examination revealed some swelling of the trochanteric bursa, some medications were prescribed and Petitioner was discharged (Petitioner's Exhibit 8; pp 62-74).

At the direction of her attorney, Petitioner was examined by Dr. Lawrence Li, an orthopedic surgeon, on April 4, 2016. In connection with his examination of Petitioner, Dr. Li reviewed medical records and the MRI of Petitioner's right knee. When examined, Petitioner complained of right hip pain and Dr. Li recommended Petitioner undergo an MRI/arthrogram of the right hip to determine if Petitioner had sustained a labral tear (Petitioner's Exhibit 14).

An MRI/arthrogram was performed on April 28, 2016. It revealed a small incomplete detachment tear of the anterior labrum (Petitioner's Exhibit 7).

Dr. Li subsequently reviewed the MRI/arthrogram and prepared a supplemental report dated May 23, 2016. Dr. Li agreed the diagnostic test revealed a tear of the anterior labrum. He opined that the tear was related to Petitioner's work-related injury. He recommended Petitioner be seen by Dr. Shane Nho, an orthopedic surgeon who specialized in hip arthroscopy (Petitioner's Exhibit 15).

Petitioner was evaluated by Dr. Nho on August 15, 2016. At that time, Petitioner advised Dr. Nho that she injured herself at work on July 17, 2015, when she slipped and fell on a concrete floor and landed on her right knee and experienced right hip pain immediately thereafter. On examination, Dr. Nho noted Petitioner had a decreased range of motion of the right hip. He noted Petitioner had undergone an MRI scan of the hip, but it was not available for him to review at that time (Petitioner's Exhibit 3; pp 15-16).

Dr. Nho subsequently saw Petitioner on October 10, 2016, and reviewed the MRI/arthrogram of Petitioner's right hip. He agreed that the study revealed a labral tear. Dr. Nho recommended Petitioner undergo arthroscopic surgery on the right hip. He also noted that, in the future, Petitioner might require a hip replacement (Petitioner's Exhibit 3; p 38).

Again, at the direction of Respondent, Dr. Karlsson examined Petitioner on September 1, 2016. In connection with his examination of Petitioner, Dr. Karlssan reviewed medical records and the MRI/arthrogram of Petitioner's right hip. Dr. Karlsson opined Petitioner had trochanteric bursitis, a nondisplaced detachment of the labrum without flap tear and subjective complaints beyond objective findings. He stated that the findings observed in the MRI/arthrogram were "very minor," and that arthroscopic surgery was not indicated, Petitioner was at MMI and could return to work without restrictions. In regard to causality, Dr. Karlsson opined some mild trochanteric bursitis was related to the accident, but that the focal detachment of the labrum was not related, but a degenerative change (Respondent's Exhibit 1; Deposition Exhibit 3).

Dr. Nho was deposed on January 27, 2017, and his deposition testimony was received into evidence at trial. Dr. Nho testified that he was an orthopedic surgeon with a subspecialty in arthroscopic surgery of the hip, shoulder and knee. In regard to his examination, diagnosis and surgical recommendation, Dr. Nho's testimony was consistent with his medical record. In regard to the arthroscopic surgery he recommended, Dr. Nho explained that it would be a surgical repair of the labrum, removal of excessive bone around the socket and ball and close the capsule. He also stated that posteroperatively, Petitioner would have physical therapy. In regard to causality, Dr. Nho testified that Petitioner's need for the arthroscopic surgery he recommended was related to the accident. He further explained that Petitioner's falling on her kneeprovided an axial force which compressed the hip joint which could damage the labrum (Petitioner's Exhibit 19; pp 5, 14-16, 26).

Dr. Karlsson was deposed on April 10, 2017, and his deposition testimony was received into evidence at trial. On direct examination, Dr. Karlsson's testimony was consistent with his medical reports and he reaffirmed the opinions contained therein. When he explained his opinion regarding causality, Dr. Karlsson testified that there was no forceful twisting or abduction of the hip at the time Petitioner sustained the accident. Dr. Karlsson also testified that the arthroscopic surgery recommended by Dr. Nho was unlikely to resolve Petitioner's right hip complaints (Respondent's Exhibit 1; PP 20, 35).

At Trial, Petitioner still had significant complaints in regard to her right hip. Petitioner stated that it feels like there is a "golf ball" in her right hip. She is unable to sit for extended periods of time, standing is limited to about 45 minutes and she continues to experience persistent swelling and pain. Petitioner stated she has not been able to work since she was let go by the Respondent and wants to proceed with the arthroscopic surgery recommended by Dr. Nho.

Conclusions of Law

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

The Arbitrator concludes that Petitioner's current condition of ill-being in regard to her right hip is causally related to the accident of July 17, 2015.

In support of this conclusion the Arbitrator notes the following:

There was no dispute that Petitioner sustained a work-related accident on July 17, 2015, when she slipped and fell on a wet concrete floor and landed on her right knee.

Petitioner's testimony that she experienced immediate pain in her right knee and right hip was unrebutted and was consistent with the medical records.

Initially, most of Petitioner's complaints/symptoms were in regard to her right knee; however, over time Petitioner's right hip condition worsened.

Dr. Potaczek opined that an MRI of the right hip was not indicated; however, when an MRI/arthrogram was subsequently performed, it revealed Petitioner had a torn labrum.

Petitioner's Section 12 examiner, Dr. Li, recommended Petitioner undergo an MRI/arthrogram. He reviewed the study after he was performed and opined that it revealed a tear of the labrum. He further opined that Petitioner's right hip condition was related to the accident.

Dr. Nho, an orthopedic surgeon with a subspecialty in arthroscopic hip surgery examined Petitioner, reviewed the MRI/arthrogram and opined that her right hip condition was related to the accident.

Respondent's Section 12 examiner, Dr. Karlsson, opined that Petitioner had sustained some mild trochanteric bursitis of the right hip as result of the accident, but that the torn labrum was not related. Dr. Karlsson acknowledged that at least some of Petitioner's right hip symptoms are related to the accident.

Based upon the preceding, the Arbitrator finds the opinions of Dr. Li and Dr. Nho to be more persuasive than that of Dr. Potaczek and Dr. Karlsson in regard to causality.

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

The Arbitrator concludes that all of the medical treatment provided to Petitioner, except that specifically referenced herein, was causally related to the accident of July 17, 2015, and Respondent is liable for payment of the medical bills incurred therewith.

Respondent shall pay reasonable and necessary medical services as identified in Petitioner's Exhibits 11A, 11 B, 11C, 11 D and 11H, as provided in Section 8(a) and 8.2 of the Act, subject to the fee schedule. The bills for medical services as identified in Petitioner's Exhibits 11 E, 11F and 11G are denied.

In support of this conclusion the Arbitrator notes the following:

The medical bills in Exhibits 11A, 11B, 11C, 11D and 11H were for medical services provided to Petitioner as a result of the accident of July 17, 2015.

The bill for medical services in Exhibit 11E is for medical services provided to Petitioner after her fall at her residence on February 8, 2016. As noted herein, there was no evidence presented as to exactly how Petitioner sustained the fall.

The bills in Exhibit 11 F are for services provided to Petitioner on April 12, April 17, April 18 and May 1, 2017. There was no evidence that they were incurred in connection with Petitioner's work-related injury.

The bill in Exhibit 11G is for a CT scan Petitioner had on November 10, 2016. There was no evidence that this diagnostic test was performed in connection with Petitioner's work-related accident.

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

The Arbitrator concludes Petitioner is entitled to prospective medical treatment including, but not limited to, the right hip arthroscopic surgery as recommended by Dr. Nho.

In support of this conclusion the Arbitrator notes the following:

Dr. Nho is an orthopedic surgeon with a subspecialty in arthroscopic hip surgery.

As aforestated, the Arbitrator found Dr. Nho's opinion in regard to causality to be persuasive. The Arbitrator likewise finds Dr. Nho's opinion to be more persuasive than that of Dr. Karlsson in regard to Petitioner's need for prospective medical treatment, specifically, the arthroscopic hip surgery.

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

The Arbitrator concludes Petitioner is entitled to temporary total disability benefits of 104 1/7 weeks commencing July 30, 2015, through August 3, 2017.

In support of this conclusion the Arbitrator notes the following:

Petitioner has been under active medical care and unable to work because of her work-related injuries since July 30, 2015.

William R. Gallagher, Arbitrator

STATE OF ILLINOIS)
) SS.
COUNTY OF SANGAMON)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

JOHN RICHARDSON,
Petitioner,

vs. NO: 16 WC 5761

CITY OF SPRINGFIELD,
Respondent.

19IWCC0297

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed July 17, 2017, is hereby affirmed and adopted.

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

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

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

DATED: JUN 17 2019

Maria E. Portela

Thomas J. Tyrrell

Deborah L. Simpson

MEP/dmm
o050719
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ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

RICHARDSON, JOHN
Employee/Petitioner

Case# **16WC005761**

CITY OF SPRINGFIELD
Employer/Respondent

19IWCC0297

On 7/17/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.12% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

2217 SHAY & ASSOCIATES
STEPHANIE I SHAY-WILLIAMS
1030 DURKIN DR
SPRINGFIELD, IL 62704

0332 LIVINGSTONE MUELLER ET AL
DENNIS O'BRIEN
620 E EDWARD ST
SPRINGFIELD, IL 62705

STATE OF ILLINOIS)

)SS.

COUNTY OF Sangamon)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

John Richardson
Employee/Petitioner

Case # 16 WC 005761

v.

Consolidated cases:

City of Springfield
Employer/Respondent

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Edward Lee**, Arbitrator of the Commission, in the city of **Springfield**, on **March 28, 2017**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

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FINDINGS

On **October 15, 2014**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$93,327.78**; the average weekly wage was **$1,794.77**.

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

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

Respondent *has 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**.

ORDER

Respondent shall pay the medical bills, as set forth in Petitioner's Exhibit 6, directly to the medical providers pursuant to the Medical Fee Schedule set forth in Section 8(a) of the Act, and reimburse Petitioner for any out- of- pocket expenses paid.

Respondent shall pay Petitioner permanent partial disability benefits of $735.37/ week for 32.25 weeks, because the injuries sustained cause the 15% loss of the left leg, as provided in Section 8(e) of the Act.

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

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

Edward Lee 7/17/17

Signature of Arbitrator Date

JUL 17 2017

STATEMENT OF FACTS

I. Petitioner's Testimony and Review of Medical Records

John Richardson was working for the Respondent, the City of Springfield, on October 15, 2014 during which he was locating and marking underground utility wires. It had been raining and the ground was slick. While locating wiring for a utility meter installation, he stepped onto a piece of plywood, causing him to twist and fall onto the ground. (PX 1). Petitioner injured his left shin, left wrist, and left knee. Petitioner timely reported the occurrence to his supervisor and completed an injury report. (PX 1).

Petitioner testified that the first time Dr. Diane Hillard- Sembell would render treatment to his left knee was on January 8, 2015. That day he presented with complaints of pain with squatting, kneeling, and pain in the inside and back of his left knee. He further complained of catching and sharp pain medially. Upon physical examination, his left knee revealed full range of motion but pain with extremes of hyperflexion and forced hyperextension, and a painful McMurray's maneuver. He was diagnosed with left knee pain. A MRI of the left knee was ordered to rule out a medial meniscus tear. (PX 2).

Petitioner testified that he first discussed his left knee injury with Dr. Hillard- Sembell during an office visit for treatment of his right knee, which he injured during an unrelated prior workplace injury. Petitioner had hoped that his left knee injury would resolve on its own as Dr. Hillard- Sembell would not treat Petitioner's left knee injury until she finished treatment for his right knee. Petitioner and Dr. Hillard- Sembell testified that she treated the injuries separately since they were both work related.

Petitioner testified that he was restricted from work for approximately two to three weeks following his November 14, 2014 surgery for his right medial meniscus tear which he sustained when twisting his knee at work while locating on August 7, 2014. During this time, he was also able to rest his left knee. He testified that between the October 15, 2014 occurrence and when he was taken off work following the November, 2014 surgery, he was able to work full duty, but that his left knee was sore and tender.

In December, 2014, Petitioner was released to return to work performing light duty work, of which he was restricted from climbing stairs, poles, and bending. He testified that he was given a position performing clerical work, primarily sitting and resting both of his knees. He returned to work full duty on December 8, 2014. However, he exercised caution to prevent reinjury.

Following the November, 2014 surgery, Petitioner underwent physical therapy for his right knee, as referred by Dr. Hillard- Sembell. He testified that during the physical therapy sessions, he was also able to perform exercises on and rehabilitate his left knee. The therapist had him perform strengthening and mobility exercises on both knees. He further testified that he had informed his physical therapists of his left knee injury, so they would not have him perform any exercises which would cause further injury.

On February 9, 2015, Petitioner underwent a MRI of the left knee which revealed tears of the body and posterior horn of the medial meniscus; mild chondral thinning and irregularity involving the articular cartilage; mild chondral irregularity involving the anterior aspect of the medial femoral condyle; and a small to moderate sized popliteal cyst. (PX 3).

On February 19, 2015, Dr. Hillard- Sembell reviewed the MRI and opined that it revealed a left knee medial meniscus tear. Surgery was recommended. (PX 2).

On May 27, 2015, a cortisone injection as administered into the left knee which was only temporarily beneficial. Mr. Richardson also underwent physical therapy for his left knee from May 28, 2015 through June 25, 2015, which helped strengthen the knee but did not resolve the pain. (PX 2).

On July 20, 2015, Mr. Richardson met with Dr. Hillard- Sembell and decided to move forward with surgery as conservative treatment had failed. (PX 2).

On August 6, 2015, Dr. Hillard- Sembell performed a left knee arthroscopy with partial medial meniscectomy and chondral debridement of the patellofemoral joint. The post- surgical diagnoses were a left knee medical meniscus tear and patellar chondral injury with osteoarthritis. (PX 4).

On August 17, 2015, Mr. Richardson presented to Dr. Hillard- Sembell with instruction that he had much symptom alleviation following surgery. He testified that at that time, he still experiencing some pain, tenderness, and swelling, but was informed that it was to be expected. He was instructed to begin a home exercise program and follow- up as needed. (PX 2).

Petitioner testified that the home exercise program helped strengthen his left knee and gain mobility. Petitioner described that currently his left knee is "pretty good", but that he still has trouble climbing stairs, playing on the floor with his grandchildren, and working on his car. Petitioner testified that when standing from a bent or seated position, he has to grab something to help push him up. Petitioner added that the cold cause his left knee to be achy. Petitioner still takes Ibuprofen and uses an ice pack with increased use.

CONCLUSIONS OF LAW AND FACT

With regard to issue (F), Causal Connection, the Arbitrator finds:

To satisfy the causal connection requirement, it must be shown that the injury had its origin in some risk connected with, or incidental to, the employment so as to create a causal connection between the employment and the accidental injury. *Caterpillar Tractor Co. v. Industrial Comm'n*, 129 Ill.2d 52, 58, 133 Ill.Dec. 454, 541 N.E.2d 665 (1989). Stated otherwise, "an injury arises out of one's employment if, at the time of the occurrence, the employee was performing acts he was instructed to perform by his employer, acts which he had a common law or statutory duty to perform, or acts which the employee might reasonably be expected to perform incident to his assigned duties. A risk is incidental to the employment where it belongs to or is connected with what an employee has to do in fulfilling his duties." *Caterpillar Tractor*

Co. v. Industrial Comm'n, 129 Ill.2d at 58, 133 Ill.Dec. 454, 541 N.E.2d 665; *Sisbro, Inc. v. Indus. Comm'n*, 207 Ill. 2d 193, 203-04, 797 N.E.2d 665, 672 (2003).

It has long been recognized that, in preexisting condition cases, recovery will depend on the employee's ability to show that a work-related accidental injury aggravated or accelerated the preexisting disease such that the employee's current condition of ill-being can be said to have been causally connected to the work-related injury and not simply the result of a normal degenerative process of the preexisting condition. *Caterpillar Tractor Co. v. Industrial Comm'n,* 92 Ill.2d 30, 36–37, 65 Ill.Dec. 6, 440 N.E.2d 861 (1982). Thus, even if an employee has a preexisting condition which may make his more vulnerable to injury, recovery for an accidental injury will not be denied as long as he can show that the employment was also a causative factor (emphasis added). *Sisbro*, 207 Ill. 2d at 205; *Swartz v. Illinois Industrial Comm'n*, 359 Ill. App. 3d 1083, 1086 (2005).

Respondent asked Petitioner about prior workplace occurrences involving the left knee in May, 2013 and February, 2014. However, this is entirely irrelevant as the occurrences were during his work for Respondent, properly reported, and Petitioner sought no medical treatment.

The evidence deposition of Dr. Diane Hillard- Sembell, a board certified orthopedic surgeon was taken on October 13, 2016. (PX 5). Dr. Hillard- Sembell's primary practice focus is knees and sports medicine. Dr. Hillard- Sembell testified that as far as the October 20, 2014 visit, "I don't recall that specific visit, but because it was work comp and there were two separate injuries involved, and the referral was for the right knee, that visit was kept for the right knee injury". (PX 5, pp. 7-8). She added that the October 20, 2014 office note does not document whether the left knee was examined at that time. (PX 5, p. 53).

She added, "I said later on, I remember talking about let's just keep the left knee until the right knee is done because we only have referral for the right knee". (PX 5, p. 29). She added, "I do remember him saying at some point, you know, the left knee, and we are going to have to do something with that, but let's finish up the right knee because that's what you're here for. I remember that conversation, but I don't remember when". (PX 5, p. 49).

When asked by Respondent, "What you could have done in your office records, if you wanted to keep injuries separated, is note that the complaint was made but further note that you were not treating it and would deal with that later, correct?", Dr. Hillard- Sembell stated, "Yes. In retrospect, I certainly wish that was done. And I think it was just kind of brushed away". (PX 5 p. 36).

In regard to whether there was any mention of left knee treatment during the 2014 physical therapy sessions for the right knee, Dr. Hillard- Sembell testified, upon review of the records, that the physical therapy notes did not specify whether the treatment was for the left knee or right knee. (PX 5, p. 52).

Dr. Hillard- Sembell testified within a reasonable degree of medical certainty that the October 15, 2014 occurrence either caused or was a contributing factor to the left medial meniscus tear. (PX 5, p. 21). She testified that meniscus tears are usually caused when the knee is in a loaded position with a flexion twisting mechanism. (PX 5, p. 24). She testified that the

meniscus tear was an injury on top of a probably already degenerative type of meniscus. (PX 5, p. 25). She testified, "I believe he had an acute injury plus/ minus preexisting changes. So again, I can't say because he may have had a tear even before and it wasn't symptomatic, and then he had an injury and it became symptomatic, or it became bigger and symptomatic". (PX 5, pp. 55-56). She further testified that the October 15, 2014 fall could have temporarily aggravated the pre-existing arthritic condition. (PX 5, p. 21).

When asked about the significance of the injection to his left knee providing no relief, she testified, "the fact that it didn't take care of his pain, and the fact that he continued to have pain and catching, implied to me that the majority of the pain and problem was the meniscus and not arthritis". (PX 5, p. 15).

Dr. Nathan Mall, a board certified orthopedic surgeon, and Respondent's Section 12 physician, testified by way of evidence deposition on November 7, 2016. (RX 1). Dr. Mall diagnosed Petitioner with a left knee medial meniscus tear and a grade 1 MCL strain. (RX 1, p. 24). Dr. Mall testified that he did not see any mention of the left knee in the medical records prior to January 8, 2015. (RX 1, pp. 16-17). However, Dr. Hillard- Sembell previously testified that she specifically did not treat Petitioner's left knee until the right knee treatment had concluded.

Dr. Mall testified that the October 15, 2014 workplace accident was the type of occurrence which could cause a medial meniscus tear and MCL strain. However he testified that grade 1 MCL strains typically resolve in six to eight weeks. (RX 1, p. 25). As such, he could not relate the grade 1 MCL to the October 15, 2014 occurrence, rather opining that it was his belief that it occurred at some later event. (RX 1, pp. 25-26). Regardless, following Dr. Mall's logic, six to eight weeks preceding the April 27, 2015 IME would have still been several weeks after the February 19, 2015 MRI of the left knee showing the medial meniscus tear. Dr. Mall testified that the medial meniscus tear and grade 1 MCL strain could have arisen from two separate events, but that the type of injury Petitioner sustained on October 15, 2014 was the type of occurrence which could also cause a MCL strain. (RX 1, pp. 53-54).

Dr. Mall testified, "I don't think that there's any question in my mind that a twisting injury that he described to me can cause a meniscus tear. Like that's sort of the classic injury mechanism for a meniscus tear". (RX 1, pp. 47-48). Dr. Mall testified that there is nothing in the records other than the October 15, 2014 occurrence which could have caused the medial meniscus tear. (RX 1, p. 49). Dr. Mall further opined that he did not anticipate that Petitioner's meniscus tear was simply caused by arthritis because he didn't have a lot. (RX 1, p. 57).

While Dr. Mall testified that he does not believe that the grade 1 MCL tear occurred on October 15, 2014, Petitioner has not claimed said injury is related to the workplace injury. Dr. Hillard- Sembell, the treating physician who actually looked inside Petitioner's knee when performing his surgery, never diagnosed a MCL sprain. Her August 6, 2015 surgery was to repair the medial meniscus tear and had absolutely nothing to do with a potential MCL strain. Additionally, there is nothing in the records to support a second injury event. Even if there was some "second injury", which is entirely unsupported by the evidence, it does not change the fact that Petitioner's MRI and subsequent surgery both revealed a left medial meniscus tear for which

both Petitioner's and Respondent's physicians opined was causally related to the October 15, 2014 occurrence.

The Arbitrator does not find the opinions of Dr. Mall to be as persuasive as that of Dr. Hillard- Sembell. (*See Christman v. Indus. Comm'n*, 180 Ill. App. 3d 876, 882, 536 N.E.2d 773, 777 (1989), holding the Commission was entitled to rely on the conclusions of petitioner's treating physician and to accord less weight to any contrary conclusions of respondent's examining physician.) Dr. Mall did not treat, or aid in the treatment of Petitioner. Dr. Mall examined him on one occasion during an Independent Medical Examination, ordered by Respondent. As such, the Arbitrator finds that Petitioner's left medial meniscus tear is causally related to the October 15, 2014 occurrence.

With regard to (J), Medical, the Arbitrator finds:

Under Section 8(a) of the Illinois Workers' Compensation Act, an employer is required to provide or pay for "all the necessary first aid, medical and surgical services, and all necessary medical, surgical and hospital services thereafter incurred, limited, however, to that which is reasonably required to cure or relieve from the effects of the accidental injury." 820 ILCS 305/8(a). An employer's liability under this section of the Act continues as long as the medical services are required to relieve the injured employee from the effects of the injury. *Efengee Electrical Supply Co. v. Industrial Comm'n,* 36 Ill.2d 450, 453, 223 N.E.2d 135 (1967); Elmhurst Memorial Hospital, 323 Ill.App.3d at 764. *Morrison Senior Dining v. Illinois Workers' Comp. Comm'n*, 2013 IL App (1st) 120979WC-U. The claimant bears the burden of proving, by a preponderance of the evidence, his entitlement to an award of medical expenses under Section 8(a). *Max Shepard, Inc. v. Industrial Comm'n,* 348 Ill.App.3d 893, 903, 284 Ill.Dec. 401, 810 N.E.2d 54 (2004); *Westin Hotel v. Indus. Comm'n of Illinois*, 372 Ill. App. 3d 527, 546, 865 N.E.2d 342, 359 (2007).

The standard of reasonableness is that which is usual and customary for similar services in the community where the services were rendered. *General Tire & Rubber Co. v. Industrial Comm'n*, 221 Ill.App.3d 641, 650, 164 Ill.Dec. 181, 187, 582 N.E.2d 744, 750 (1991); *Ingalls Mem'l Hosp. v. Indus. Comm'n*, 241 Ill. App. 3d 710, 717, 609 N.E.2d 775, 781 (1993). Dr. Huss testified in his evidence deposition that all of his treatment and work restrictions were reasonable and necessary to treat Petitioner's injuries as related to her July 25, 2013 workplace injury. (PX 13, p. 36).

Dr. Hillard- Sembell testified that all of Petitioner's treatment was reasonable and necessary and causally related to the October 15, 2014 workplace injury. (PX 5, pp. 21-22). In Dr. Mall's evidence deposition, Respondent admitted that they did not dispute the reasonableness and necessity of Petitioner's treatment, only the causality for which Petitioner addressed above.

Therefore, the Arbitrator finds that the Respondent shall pay the medical bills, as set forth in Petitioner's Exhibit 6, directly to the medical providers pursuant to the Medical Fee Schedule set forth in Section 8(a) of the Act, and reimburse Petitioner for any out- of- pocket expenses paid.

With regard to issue (L), Nature and Extent, the Arbitrator finds as follows:

With regard to subsection (i) of §8.1b(b), the Arbitrator notes that Petitioner did not undergo an AMA evaluation, and thus provides no weight to this factor.

With regard to subsection (ii) of §8.1b(b), the occupation of the employee, the Petitioner has been employed by the Respondent, City of Springfield, since 1980. He has worked various positions for Respondent including groundsman, journeyman electrician, and cable splicer. He has worked as a Locator marking underground wires for roughly eight to ten years.

Petitioner graduated from high school prior to working for Respondent. He also completed an electrician apprenticeship with the Respondent. The Petitioner is now retired. Therefore, the Arbitrator assigns little weight to this factor.

With regard to subsection (iii) of §8.1b(b), the Arbitrator notes that Petitioner was 57 years old at the time of the accident, and is currently 59 years old and retired. Therefore, the Arbitrator assigns little weight to this factor.

With regard to subsection (iv) of §8.1b(b), the Arbitrator notes that the Petitioner retired on January 16, 2015. As such, the Arbitrator assigns little weight to this factor.

With regard to subsection (v) of §8.1b(b), evidence of disability corroborated by the treating medical records, the Arbitrator notes that Dr. Hillard- Sembell testified that the left medial meniscus had a large flap tear extending on the posterior horn of the meniscus fifty percent of the width. (PX 5, p. 16). Dr. Hillard- Sembell testified that the surgery required removing meniscus pieces that are unstable, and that this type of tear is not amendable to stitching. (PX 5, p. 17). She further testified that the partial meniscectomy procedure slightly increases the contact forces on the medial femoral condyle and the medial tibial plateau, leading to more pressure on the articular cartilage potentially aggravating osteoarthritis. (PX 5, p. 22).

Dr. Hillard- Sembell testified that Petitioner was seen only once post-operatively on August 17, 2015 and opined that physical therapy was not necessary but home exercises were. (PX #5 pp.18-21).

Based on the above factors, including the Petitioner's medical records and bills, evidence deposition of Dr. Hillard- Sembell, and testimony of the Petitioner, the Arbitrator finds that the Petitioner sustained a permanent partial disability to the extent of 15% loss of use of the left leg, pursuant to §8(e) of the Act.

STATE OF ILLINOIS)
) SS.
COUNTY OF WILL)

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

TEQUILA SMITH,

Petitioner,

vs. NO: 11 WC 44525

SCHNEIDER LOGISTICS,

Respondent.

19IWCC0298

DECISION AND OPINION ON REMAND

This matter comes before the Commission on remand from the Appellate Court, Third District, whose Order held:

> The Commission erred when it found no causal connection existed between claimant's work accident and her condition of ill-being after October 9, 2011, based only on claimant having reached maximum medical improvement on that date. The Commission's finding that claimant was entitled to temporary and total disability benefits from the date of her work accident only until October 9, 2011, was not against the manifest weight of the evidence. *Order at 1.*

The Court stated:

> In this case, we disagree with the Commission's causal connection analysis and determination. In finding claimant established causal connection only through October 9, 2011, the Commission relied on Dr. Gleason's addendum report of October 9, 2011, in which he opined that claimant had reached maximum medical improvement on that date. Based on Dr. Gleason's addendum report – which only referenced maximum medical improvement and not causal connection – the Commission concluded that claimant "established causal connection between her low back and left hip condition only through the date of Dr. Gleason's addendum report of October 9, 2011."

> We find the Commission has conflated the issues of causal connection and maximum medical improvement. [Citation omitted.] The Commission only identified Dr. Gleason's addendum report in support of its determination that the causal connection between claimant's work accident and her condition of ill-being ended on October 9, 2011. We find the only other reference to the date of October 9, 2011, is contained in Dr. Gleason's deposition testimony where he stated as follows: "As of 10-9-2011 I was in receipt of a report of an MRI scan of the pelvis performed on 9-30-11 *** with [the] impression *** being negative ***." Dr. Gleason further testified "[i]t was my opinion that [claimant] had reached maximum medical improvement with respect to the 5-10-11 work injury." Nothing in Dr. Gleason's addendum report or deposition testimony identified any changes with respect to claimant's condition of ill-being or an intervening event breaking the causal chain of events as of October 9, 2011. [Citation omitted.]
>
> Here, emergency room medical records establish claimant's left-sided symptoms began on the date of her work accident in May 2011. Medical records further reveal that claimant continued to complain of left-sided pain throughout her numerous medical appointments well after Dr. Gleason's second independent medical examination on October 9, 2011. In fact, in May 2012, Dr. Gleason conducted another independent medical evaluation at which time he noted claimant's complaints of low back pain with radiation into the posterior left thigh to the mid-thigh area with associated tingling. As stated, the Commission *did* find, as an initial matter, a causal connection existed between the work accident and claimant's complaints of low back and left hip pain. The Commission *did not* find these complaints had resolved by October 9, 2011, or were otherwise no longer causally related to claimant's work accident. Instead, it found a causal connection no longer existed after October 9, 2011, based only on Dr. Gleason's addendum report in which he stated claimant had reached maximum medical improvement, a finding which is irrelevant to the issue of causal connection. In other words, the Commission gave no valid reason for finding claimant's condition of ill-being in her low back and left hip after October 9, 2011, was no longer causally related to her work accident.
>
> Given that the Commission's causal connection determination appears to have been premised on a flawed analysis, we must remand the matter for its consideration of the issue anew. By this decision, we express no opinion whether claimant's condition of ill-being in her low back and left hip is or is not causally related to her work accident. *Order at 11-13.*

We note that, although the Court remanded this case on the issue of causation, it affirmed the Commission's finding that Petitioner was not entitled to temporary total disability after October 9, 2011, because it was not against the manifest weight of the evidence. *Order at 14-15.*

On the issue of medical expenses, the Court wrote:

> Based on the Commission's finding of maximum medical improvement, which we herein affirm, claimant's entitlement to an award of medical expenses after the date of

> maximum medical improvement would properly be limited to expenses relating to palliative care only. Accordingly, the Commission's decision to deny an award of medical expenses for non-palliative care, *i.e.* expenses for medical treatment, is affirmed. On remand, if the Commission finds a causal connection for claimant's condition of ill-being exists after October 9, 2011, it should consider whether claimant is entitled to any further medical expense award relating to palliative care only. Further, consistent with the above, we affirm the Commission's decision to deny an award for prospective medical treatment consisting of a revision surgery at L5-S1. *Order at 16.*

Analysis

The Commission previously affirmed and adopted the arbitrator's decision in this case. The arbitrator found that, after her accident on May 10, 2011, Petitioner's physicians "noted some objective findings during these first months correlating Petitioner's reported symptoms to the left hip and left low back." *Dec. at 12.* However, an MRI was performed on June 20, 2011, and the arbitrator found, "Contrary to the localization by Petitioner of symptoms on the left, the MRI showed a mild disc bulge at L5-S1 on the right side with associated mild right lateral recess stenosis." *Id.* The arbitrator wrote, "When Petitioner saw her first orthopedic surgeon, Dr. Farrell, on June 28, 2011 he noted tenderness to palpation over the sacroiliac area and left – not right – lateral buttock. He also noted no spasms, normal hip range of motion, and an unremarkable straight leg raise. Dr. Farrell diagnosed a low back contusion and referred Petitioner to one of two pain management physicians in his group. Petitioner saw Dr. Sharma for pain management." *Id.* On September 20, 2011, Dr. Farrell noted that Petitioner continued to report low back pain but there was no referred pattern of radiculopathy. He did not make any surgical or further treatment recommendations. He released Petitioner from care from an orthopedic perspective and deferred any ongoing care to Dr. Sharma for pain management. *Id.*

The arbitrator noted that Respondent's §12 physician, Dr. Gleason, opined on September 13, 2011, that the mild right-sided disc bulge at L5-S1 was not causally related to her work accident and she could return to work full duty. However, he wanted to see a new pelvis MRI before he declared her at maximum medical improvement (MMI). The MRI of the pelvis was performed on September 30, 2011, which was interpreted as negative by the radiologist. After reviewing this MRI, Dr. Gleason opined on October 9, 2011 that Petitioner was at MMI with regard to her low back and left hip. *Id.*

As instructed by the Appellate Court, we clarify that Petitioner's work injury caused a contusion to the left hip and left thigh, as diagnosed by the emergency room physician at Provena St. Joseph Hospital on May 10, 2011. It also caused a contusion to the left low back, per Dr. Farrell's diagnosis on June 28, 2011. Further, Dr. Gleason testified that, as of his examination on September 13, 2011, Petitioner had some findings suggesting sacroiliitis, which would be related to an aggravation of preexisting degenerative changes in her sacroiliac joint. *Rx1 at 12.*

However, we find Petitioner failed to prove that the June 20, 2011 lumbar MRI findings, which reflect *right-sided* abnormalities including the mild right-side disc bulge at L5-S1, are causally related to her work injury or her subjective left-sided symptoms. A December 1, 2011

discogram revealed concordant pain at L5-S1. The post-discogram CT scan only showed a small *right* lateral contained protrusion at L5-S1 which produced a very mild indentation on the *right* S1 nerve root. That report specifically stated, "there is no other disc protrusion or spinal stenosis." *Px5, Px6.*

The Appellate Court affirmed that, per Dr. Gleason, Petitioner had reached MMI as of October 9, 2011, and any non-palliative treatment beyond that date was not causally related to her work injury. We clarify that Petitioner's contusions to the left hip, left thigh, and left low back, along with her aggravation of the sacroiliac joint had resolved by October 9, 2011. While Petitioner may have continued to voice left-sided complaints after October 9, 2011, we find persuasive the testimony of Dr. Gleason that as of his re-examination on May 29, 2012, Petitioner had no positive objective findings on physical exam relative to the low back and pelvis. *Rx1 at 16.* Dr. Gleason also testified that, in addition to having no positive objective findings, Petitioner also presented with certain findings such as withdrawing even to gentle palpation and touch over the lumber spine and left lower para-lumbar area, suggesting magnification and possible exaggeration. *Id. at 21.*

Although Dr. Gleason referred to "maximum medical improvement," the Commission finds Petitioner also failed to prove that any of her conditions of ill-being, as of October 9, 2011, remained causally related to her work accident. In our previous decision, we affirmed the Arbitrator's findings regarding causation along with the analysis as to why the opinions of Dr. Gleason were more persuasive than those of Dr. Lorenz or Petitioner's other physicians. It is, therefore, unnecessary to reiterate that analysis again. However, based on the reasoning in our previous decision along with the above, we clarify and find that all of Petitioner's work-related conditions had resolved by October 9, 2011, and, after that date, any condition of ill-being and continued treatment, including palliative care, is not causally related to her work injury.

IT IS THEREFORE 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.

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

DATED: JUN 17 2019

Maria E. Portela

Thomas J. Tyrrell

Deborah L. Simpson

SE/
O: 6/11/19
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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 R. LANE, SR.,
Petitioner,

vs. NO: 14 WC 41110

DECATUR PUBLIC SCHOOL DIST. #61, **19IWCC0299**

Respondent.

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed May 2, 2017, 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.

19IWCC0299

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

DATED: JUN 17 2019

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Maria E. Portela

Thomas J. Tyrrell

Deborah L. Simpson

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

LANE SR, ROBERT R
Employee/Petitioner

Case# 14WC041110

DECATUR PUBLIC SCHOOL DISTRICT #61
Employer/Respondent

19IWCC0299

On 5/2/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.97% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

3063 LAKE LAW FIRM
DOUGLAS S LAKE
505 E WILLIAM ST
DECATUR, IL 62523

0771 FEATHERSTUN GAUMER
DANIEL GAUMER
PO BOX 1760
DECATUR, IL 62525

19IWCC0299

STATE OF ILLINOIS)
)SS.
COUNTY OF Sangamon)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Robert R. Lane, Sr.
Employee/Petitioner

v.

Decatur Public School District #61
Employer/Respondent

Case # 14 WC 41110

Consolidated cases: n/a

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Nancy Lindsay**, Arbitrator of the Commission, in the city of **Springfield**, on **February 28, 2017**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **June 24, 2014**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**45,780.80**; the average weekly wage was $**880.40**.

On the date of accident, Petitioner was **41** years of age, ***married*** with **1** dependent child.

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

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

Respondent has paid for medical services as provided in Sections 8(a) and 8.2 of the Act, for which credit is allowed under section 8(j) of the Act. Respondent is to hold Petitioner harmless for any claims for reimbursement from the group medical plan, and shall provide payment information to Petitioner relative to any credit due.

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 $**6,913.10** in medical bills paid by its group medical plan for which credit is allowed under Section 8(j) of the Act.

ORDER

Respondent has paid for medical services as provided in Sections 8(a) and 8.2 of the Act, for which credit is allowed under section 8(j) of the Act. Respondent is to hold Petitioner harmless for any claims for reimbursement from the group medical plan, and shall provide payment information to Petitioner relative to any credit due.

Respondent shall pay Temporary Total Disability benefits of **$586.93 per week** for **5 4/7 weeks,** commencing **September 25, 2014**, through **November 2, 2014**, as provided in Section 8(b) of the Act.

Respondent shall pay Petitioner the sum of **$528.24 per week** for a further period of **28.5 weeks**, as provided in Section 8(d)2 of the Act, because the injuries sustained caused **15% loss of use of Petitioner's left hand.**

Respondent shall pay Petitioner compensation that has accrued between **June 24, 2014** and **February 28, 2017** and shall pay the remainder of the award, if any, in weekly installments.

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

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

[signature]
Signature of Arbitrator

April 27, 2017
Date

MAY 2 - 2017

FINDINGS OF FACT AND CONCLUSIONS OF LAW

Petitioner alleges repetitive trauma injuries to his left hand as a result of his job duties for Respondent.

The Arbitrator finds:

Petitioner was involved in a motorcycle accident on November 3, 2001 at which time he collided with a deer and was thrown over the handlebars, landing on his outstretched left hand. He sustained a complex closed highly comminuted left distal radius fracture and a closed right base of the thumb metacarpal fracture. He was treated in his hometown initially and then seen at St. Mary's ER for further treatment and then sent to Mayo Clinic where he was admitted from November 8, 2001 through November 12, 2001. While admitted, Petitioner underwent an open reduction and internal fixation while there. Prior to surgery Petitioner was thoroughly counseled on the severity of his injury and the likely consequences of his injury with the increased chance of radiocarpal arthritis and wrist abnormalities. Upon discharge he was to follow up with his local hometown doctor. (PX 2, pp. 31 – 33, 40 – 42, 45 - 48)

Petitioner returned to the Hand Clinic at Mayo Clinic in 2003 for follow-up of a "right [sic] wrist injury" going back to 2001. By history, Petitioner had followed up with his local doctor after being discharged in 2001 and returned to work doing maintenance after a period of time "although he was never able to get back to full duty work." Petitioner reported an increase in his wrist pain and was referred back to Mayo Clinic by his hometown doctor for possible further surgery/second opinion. Petitioner reported complaints of pain, but no numbness or tingling. Outside x-rays suggested post-traumatic arthritis in the radiocarpal joint. A CT scan performed that day showed some residual intra-articular incongruity post-surgery along with degenerative changes, especially in the radiolunate facet. On examination he had normal sensation bilaterally with some occasional paresthesia on the ulnar border of the left hand and a positive Tinel's sign over the left ulnar nerve at the elbow. Petitioner was wearing a cast he had initiated himself to see if it would control pain as he was working light duty with some difficulty and taking over-the-counter medication for symptom relief. Petitioner's diagnosis remained unchanged. An injection was attempted with no relief of symptoms. They discussed a radiolunate arthrodesis but no definitive plan was agreed upon as Petitioner wished to give it some thought. (PX 2, pp. 29-30, 39-40)

Petitioner subsequently contacted the Hand Clinic in December of 2003 advising the doctor he wished to proceed with a radiolunate arthrodesis. The procedure was performed on December 30, 2003. By April 5, 2004 Petitioner was back to work as a custodian with a five pound lifting limit and was no longer wearing a splint. His weight limitation was modified to ten pounds and he was told to continue wearing the protective splint. As of May 25, 2004 Petitioner was still working but mentioning that he was routinely being asked to lift things weighing up to 30 or 40 lbs. but was hesitant to complain. Dr. Amadio, his treating surgeon, was perplexed as to

why Petitioner's arthrodesis wasn't healing. The bone graft donor site from the distal radius hadn't healed either. He had no signs of infection. Petitioner denied smoking or chewing tobacco for several years. They decided to proceed with a repeat bone grafting. In the interim, Petitioner's weight restriction was reduced to 5 lbs. Petitioner underwent the repeat radiolunate arthrodesis on July 13, 2004. Dr. Amadio followed up with Petitioner post-operatively and Petitioner had some occupational therapy. As of November 8, 2004 Petitioner was reporting very little pain and his CT showed progressive union. Petitioner was pleased with the result and he was allowed to return to work with a 30 lb. lifting limit which would allow him to get back to his usual job as a custodian. He was told to taper out of his splint as comfort permitted and to return in two months for an anticipated final visit. (PX 2, pp. 10 -28, 35 – 40, 43-44)

As instructed, Petitioner was examined on January 10, 2005 at Mayo Clinic's Division of Hand Surgery regarding his left wrist. This was a normal follow-up visit after his prior surgery. Petitioner's employer was present with him. Petitioner was reportedly "back to work doing fine." His only complaint was some aching at the end of a hard day of work for which he was told to take Ibuprofen as needed. The doctor noted that Petitioner "often develops ulnar numbness with repetitive movement. Wakes up at night with pain." The doctor's diagnosis was post-traumatic arthritis of the left wrist. (PX 2, pp. 5 - 7)

On July 25, 2008 Petitioner underwent a lumbar spine MRI due to worsening back pain. The MRI revealed a fusion at T11-12 and herniated discs at L3-4 and L4-5. (RX 2)

Petitioner underwent a whole body scan with SPECT on August 21, 2008 due to low back pain after a motorcycle accident. Multi-level degenerative changes were noted, especially in the lumbar spine and a fusion of T11 and 12 was visualized. A subsequent lumbar spine MRI dated August 21, 2008 confirmed the prior fusion at T 11-12. (RX 2)

Petitioner presented to his family doctor, Dr. Rademacher, on December 7, 2009 with complaints of lower back pain and left foot/toe pain. (RX 2)

Petitioner again presented to Dr. Rademacher on May 12, 2010 due to complaints of severe back pain for which he was scheduled to have surgery with Dr. Pencek upon getting his weight down to 250 lbs. (RX 2)

On December 13, 2011 Petitioner underwent a left patellofemoral arthroplasty due to patellofemoral arthritis of the left knee having fractured his patella several years earlier and failing previous conservative treatment measures. (RX 5)

Petitioner was hospitalized on March 9 and 10, 2012 at St. Mary's Hospital in Decatur due to a history of excessive alcohol usage and emotional issues/changes. He was discharged upon a return to baseline on the 10th. (RX 5)

Petitioner was seen by PA-C Stacey Waddington at Springfield Clinic on July 27, 2012 for a diabetes check-up. Ms. Waddington noted that Petitioner's diabetes was uncontrolled on oral medication and his sugars were running high. Petitioner was checking his feet regularly. A request for a script regarding diabetic shoes was given. (RX 2)

PA-C Waddington again examined Petitioner on October 9, 2013 regarding his diabetes, noting his sugars were varying widely. He denied exercising or trying to lose weight. He wasn't taking his medications. A history of using vodka to sleep was noted. Treatment recommendations are not known as the records from that visit are incomplete. (RX 2)

Petitioner again presented to Stacey Waddington on May 28, 2014 due to foot pain, left shoulder pain and a lump in the umbilical area of his abdomen. He reported having "fall[en] into his refrigerator 2 weeks [earlier]." With regard to his bilateral foot pain, he felt like he was walking on pins and needles. Petitioner had been losing weight. Petitioner was felt to have sustained some bruising in his fall. He declined an ultrasound for his abdominal complaints. He was referred to Neurology for his foot numbness as he had been having longstanding uncontrolled diabetes. Petitioner's history included alcohol abuse and use as he used vodka to sleep. (RX 2)

Dr. Cecile Becker examined Petitioner on June 10, 2014 regarding Petitioner's bilateral foot problems. Petitioner gave a history of noticing that, at times, his feet were discolored and felt like he was walking on pins and glass. It had reportedly begun a couple of years earlier but was worsening. Petitioner also mentioned complaints of numbness in digits 3 and 4 of his left hand going on for a couple of months. Dr. Becker noted that Petitioner had undergone extensive surgery on his left wrist following an injury. He was also noted to be diabetic. Dr. Becker felt Petitioner had bilateral foot paresthesia possibly due to diabetic peripheral neuropathy and he ordered an EMG/NCS. He also felt the left hand numbness was most likely due to an entrapment mononeuropathy. He was to begin gabapentin for pain relief. (RX 1; PX 3, pp. 77 – 80, 106-109)

On June 24, 2014 Dr. Becker performed an EMG/NCS and concluded that Petitioner had moderate to severe left carpal tunnel syndrome. (RX 1; RX 2; PX 3, pp. 72-76, 92-93, 99-105)

Petitioner presented to Dr. Baker on July 9, 2014 regarding a consultation for left carpal tunnel syndrome which Petitioner felt was related to his job. According to the history, Petitioner "noticed [it] 2 months ago but thought numbness was related to his diabetes. Numbness much worse." He had undergone an EMG. Dr. Baker noted Petitioner's job duties included mopping, spray bottles, clean windows, lifting heavy objects, vacuuming, mowing, and trimming on a "daily basis." Petitioner's prior ORIF was noted along with Petitioner's carpal bone fusion. He described Petitioner's recovery from that as very good with no numbness. Petitioner reported his current symptoms were worsening, especially after work but "some symptoms are now always present." He denied any other peripheral nerve symptoms. Swelling of the volar aspect of Petitioner's wrist was noted. Durkan's test was positive at under twenty seconds. The assessment was "(1) Flexor synovitis of the left wrist; (2) left Carpal Tunnel Syndrome; and (3) history of dital radius fracture and carpal injury. (PX 3, pp. 66, 95)

A left wrist x-ray taken on July 10, 2014 at Decatur Memorial Hospital revealed post-operative changes of the ORIF distal radius, post-operative changes after an arthrodesis of the radial lunate with a fracture of two screws; an ulnar styloid fracture with nonunion, and degenerative changes and mild soft tissue swelling. According to the history, "Pain and numbness, fell left wrist, carpal tunnel region previous surgery." (PX 3, pp. 69, 96; RX 6)

As of July 23, 2014 Dr. Baker reported that Petitioner's left wrist and hand symptoms were worsening with numbness. He had decreased wrist range of motion and some volar flexor swelling. Durkan's sign was positive at fifteen seconds. (PX 3, pp. 65, 94)

On July 31, 2014 Petitioner completed Respondent's Employee Injury Report. (PX 5, pp. 119- 124) Petitioner reported an accident date of June 24, 2014 as it corresponded to an EMG test. For the location of the injury, he wrote "all schools." Petitioner reported an injury to his left hand and wrist due to repetitive use and pressure on the palm of his hand. He associated the injury with "mopping mainly with several other duties that require me to use repetitive movement of the left wrist." Jack Shenkel was listed as a witness.

Petitioner met with Dr. Baker on August 27, 2014 "to discuss what can be down with his wrist and whether it can be determined as workers' compensation." Dr. Baker noted that Petitioner worked 8 hours a day and his symptoms continued "to be worse" after working. Durkan's sign was noted to be positive at less than fifteen seconds. Volar swelling was still noted. Surgery was recommends. The office note sates "workers' comp." (PX 3, pp. 65, 94)

An MRI of Petitioner's right shoulder was taken on August 28, 2014. The report noted Petitioner's history of having fallen two months earlier. No full-thickness rotator cuff tear was noted although Petitioner had evidence of a partial tear of the supraspinatus tendon and probably subscapularis tendon as well. (RX 5)

Dr. Kefalas, an orthopedic surgeon, examined Petitioner on September 15, 2014 for Petitioner's four month history of right shoulder complaints of pain and popping after tripping over golf clubs and falling at home. During the exam, he noted Petitioner's hands, wrists, and digits were without pain and his pulse palpable. The doctor felt Petitioner had AC joint synovitis and injected the area. Petitioner was to return in four weeks. (RX 5)

Petitioner had a pre-op examination with Dr. Baker on September 22, 2014. (PX 3, p. 64)

Petitioner underwent surgery on September 25, 2014 for volar flexor synovitis of the left forearm and wrist, carpal tunnel syndrome, and an abnormal proximal insertion of the 3rd lumbrical. In his operative report Dr. Baker noted that Petitioner had persistent left carpal tunnel syndrome in spite of conservative measures. "His work activity significantly aggravated his symptomatology." Dr. Baker further noted that Petitioner had previously sustained an orthopedic injury to the left upper extremity at the wrist level that had completely recovered without any signs of carpal tunnel syndrome. "The carpal tunnel syndrome began well after all the orthopedic injury. Again, his work activities significantly aggravate his underlying symptomatology." Dr. Baker noted that Petitioner's median nerve was found to be constricted and encased with dense fibrous tissue with loss of epineural vascular pattern and constriction and overall bulk. He further noted an abnormally proximal insertion of the 3rd lumbrical, "which would contribute to the carpal tunnel syndrome." That was excised. (PX 3, pp. 90-91)

Dr. Baker examined Petitioner on October 1, 2014. He noted improving sensation of the left hand. (PX 3, p. 61)

PA-C Waddington examined Petitioner on October 6, 2014 for a suspected fractured rib sustained during a fall.[1] (RX 5)

Dr. Baker removed Petitioner's sutures on October 9, 2014. Petitioner was to return on October 22nd. (PX 3, p. 61)

On November 20, 2014 Petitioner signed his Application for Adjustment of Claim herein alleging left carpal tunnel syndrome. (PX 1)

Petitioner did not return to see Dr. Baker until January 12, 2015. At that time it was reported that Petitioner had all feeling back and an occasional "deep twinge." He was working well. Sensation was described as good. (PX 3, p. 58; RX 4)

PA-C Waddington examined Petitioner on February 6, 2015 regarding his diabetes, hypertension and dyslipidemia. His diabetes was noted to be uncontrolled on oral medication. He was not trying to lose weight but was encouraged again to do so. Lab work was reviewed. Petitioner reported increased problems with burning in his feet and had seen Dr. Becker who had him on gabapentin. (RX 5)

Petitioner presented to Dr. Gordon Allan, an orthopedic surgeon, on June 24, 2015 regarding left knee pain. He was prescribed Mobic. (RX 5)

Dr. Rademacher examined Petitioner on August 31, 2015 regarding Petitioner's diabetes. Petitioner was once again encouraged to work on diet and exercise. (RX 5)

Petitioner was examined by FNP Tammie Buzan on March 18, 2016 in regard to low back pain sustained after helping his son move out of the house the previous weekend. Petitioner was given an injection into his low back. (RX 5)

On July 8, 2016 Petitioner underwent an irrigation and debridement and repair of a 2 cm. right hand laceration and removal of a foreign body. By history, Petitioner had cut his right hand on July 3, 2016 when he fell while working in his house and/or yard. He denied any complaints of numbness or tingling. (RX 3)

Dr. Rademacher examined Petitioner on July 25, 2016 in regard to Petitioner's right foot that had been injured when he slipped in his garage the day before. X-rays were taken and medication prescribed. If any fractures were noted, Petitioner was to be referred to podiatry. (RX 5)

Petitioner was examined by Dr. Gonzalez at the Foot and Ankle Center of Illinois on July 27, 2016 regarding a broken right foot, having slipped on a garage floor. He was diagnosed with a Lisfranc fracture dislocation and right foot edema. He was placed in a below the knee cast and prescribed a rolling knee walker and medication. (RX 5)

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[1] Page 1 of the office visit is missing.

Petitioner was examined by Dr. Rademacher on August 9, 2016 prior to his upcoming right foot surgery. He was cleared for surgery with strict instructions regarding medication changes in connection with the surgery. (RX 5)

On January 30, 2017 Petitioner presented to Dr. Baker's office to discuss the upcoming deposition and the problem he had with his left wrist. According to the note, "Employer [is] trying to say it was related to the motorcycle accident he had." Petitioner reported he was not having any problems at all and it was "great" with regard to complete resolution of any symptoms and pain prior to last surgery. He no longer dropped objects and was using vibrating machines with only minimal discomfort. He had good sensation and motor function and was described as "doing very well." (PX 3, p. 58; RX 4)

The evidence deposition of Dr. Baker was taken on January 30, 2017. (PX 6) Dr. Baker is board certified in both plastic surgery and hand surgery. Dr. Lane recalled seeing Petitioner back in 2001 or 2002 but he began treating him in July of 2014. Petitioner presented for a consultation regarding left carpal tunnel syndrome as he felt it was related to his job. Dr. Baker testified to having Dr. Rademacher's earlier office note and the EMG available to him to review at that time. He also examined Petitioner's left hand noting limited flexion and extension of his wrist. There was swelling on the volar aspect of his wrist and Durkan's test was positive in less than twenty seconds indicating numbness in the index and long fingertips. Dr. Baker also testified that he noted some activities of mopping, spray bottles and such affiliated with Petitioner's job He explained that some portion of the job description were underlined because vacuuming, mowing and trimming on a daily basis involves a lot of vibratory tools. Dr. Baker diagnosed Petitioner with flexor synovitis of the left wrist, an electro-carpal tunnel syndrome and a history of a distal radius fracture and carpal injury. He recommended a left carpal tunnel release and removal of any inflammatory synovial lining around the flexor tendons. (PX 6, pp. 1 – 14, 15)

Dr. Baker testified that he ordered bilateral wrist x-rays and the left wrist x-ray showed evidence of an old fracture with surgical interventions. He also noted residual changes in the wrist architecture and some remaining portions of hardware in the left wrist due to the fusion. Dr. Baker testified that the x-rays showed that some of the hardware was loosening and there was a suggestion of some abnormal motion in the region of the arthrodesis involving the left wrist. An old ulnar styloid fracture was also seen with nonunion and some degenerative changes and mild soft tissue. (PX 6, pp. 14 – 15)

Dr. Baker testified that in subsequent visits, as noted in his records, Petitioner was getting worse and Petitioner reported worse symptoms after working each day. The doctor continued to recommend surgery. (PX 6, pp. 14 – 17)

Dr. Baker was asked if he felt Petitioner's symptoms as of August 27, 2014 were caused by the fracture that occurred ten years earlier and the doctor replied, "No." He explained stating, "He had been working, that is pain free, since about two to three years after he said, until I say him, of 2014. That interled [sic] had been essentially symptom-free in terms of any sensory change, pain, et cetera." (PX 6, pp. 17-18)

Dr. Baker testified to performing surgery on September 25, 2014. His post-operative diagnosis was flexor synovitis of the fundus of superficialis systems of the left wrist/hand, a compression of the median nerve and an abnormal insertion of the proximal portion of the third lumbrical, the latter of which was encountered during surgery. Dr. Baker explained that the third lumbrical can have a proximal insertion of the muscle into the carpal canal and is a congenital condition and probably made Petitioner more susceptible to carpal tunnel syndrome. (PX 6, pp. 18 – 20) Dr. Baker acknowledged that in his operative report he noted that Petitioner's work activities significantly aggravated his underlying symptomatology. (PX 6, p. 21)

Dr. Baker testified that Petitioner required some time off from work after surgery. He was doing quite well by October 19, 2014. As of October 22, 2014 he still had some numbness in his left thumb but all other numbness had resolved and he was released to return to work as of November 3, 2014. (PX 6, pp. 21 – 23)

Dr. Baker was shown a two page written job description for a custodian (Baker dep. ex. 2) Dr. Baker testified that the job description contained sections consistent with what Petitioner had told him. Based upon that job description and what Petitioner had told him, Dr. Baker was of the opinion that the work activities were a major contributor, if not the entire contributor, to Petitioner's carpal tunnel syndrome plexus synovitis disorder and that the surgery he performed on Petitioner was medically necessary and successful. (PX 6, pp. 23 – 25)

On cross-examination Dr. Baker acknowledged that carpal tunnel syndrome can result from non-occupational activities. He testified that he asked Petitioner about any unusual hobbies and he replied that he didn't have any. When asked what Petitioner might have told him about activities outside of work, Dr. Baker replied, "He told me mostly things around the yard, around the house." (PX 6, pp. 25-26)

Dr. Baker further testified that it would be fair to say that when a patient comes in to see him, his primary concern is diagnosis and treatment and not legal causation. He also testified that he relies upon the history. When asked about his first encounter with Petitioner in 2001 or 2001 Dr. Baker explained that Petitioner had come to see someone in the office and talked about his wrist problem and he told him that he probably needed to go to Mayo Clinic if he had a bad wrist problem. When asked how he could recall that when it wasn't in his office notes, Dr. Baker explained that he usually remembers people he sends or recommends to Mayo Clinic. (PX 6, pp. 26 – 28)

On further cross-examination Dr. Baker was asked about his office note taking procedures explaining that the top half of the note is written by his nurse and he completes the bottom half. He agreed that when Petitioner saw the nurse initially he indicated he wished to see Dr. Baker in consultation for left carpal tunnel syndrome that he felt was related to his job. He also agreed that he noted Petitioner's history of two months of numbness which he initially thought was due to his diabetes. (PX 6, pp. 28-29)

Dr. Baker testified that he was aware that Petitioner had previously been in a motorcycle accident and that he had undergone one surgery and maybe two more after that. He was also

aware that Petitioner said something about a fusion of the carpal bone and that he told the doctor he had no numbness following that injury. (PX 6, pp. 29 - 30)

Dr. Baker also agreed that he had x-rays taken of Petitioner's wrists and that he reviewed the reports and films. He agreed that the history of the x-ray for his left wrist stated "pain and numbness, fell left wrist, carpal tunnel region, previous surgery." He also acknowledged that the x-rays showed evidence of the post-operative changes and arthrodesis, a possible fracture of the two screws previously inserted, and some motion/probable loosening in the area of the arthrodesis, along with mild soft tissue swelling. (PX 6, pp. 30- 32)

Dr. Baker acknowledged being aware that Petitioner was diabetic. He also acknowledged having Dr. Rademacher's note of June 10, 2014 that showed a hemoglobin A1C of 8.1 and that he was on Metformin and Gabapentin. Dr. Baker agreed that uncontrolled diabetes could be a factor in carpal tunnel syndrome. He also testified that it can predispose one to carpal tunnel syndrome. The following exchange then occurred:

> Q. Now, if [Petitioner] had diabetes that was poorly controlled around the time of his onset of symptoms, might or could that diabetic condition have contributed to cause his carpal tunnel, Doctor? ...
>
> A. It could have increased his possibility of getting a carpal tunnel, yes. (PX 6, p. 33)

Dr. Baker was also asked about the interplay between obesity and carpal tunnel syndrome within the specific context of Petitioner who was six feet tall and weighed 280 lbs. Dr. Baker explained that characterizing Petitioner, or anyone, as obese based on height and weight alone is tricky because those two factors alone don't indicate if one is fat. One also needs to know about body mass as fat and muscle weight differently. In the end, Dr. Baker described Petitioner as pretty strong but probably carrying an extra 30 lbs. (PX 6, pp. 33 – 35)

Dr. Baker agreed that the fact Petitioner had a nonunion going on in the summer of 2014 could have contributed to cause swelling in his wrist. He further felt the swelling could have been a predisposing factor. However, he didn't think it would be a direct cause for the carpal tunnel syndrome to occur. (PX 6, p. 35) Dr. Baker agreed that the loosening of the bones, possible infection, or nonunion of the bones in Petitioner's left wrist could have led to swelling in the wrist but, again, it would be a predisposing factor. Because the arthrodesis involved a very small joint overall, he did not believe it would be enough to cause the carpal tunnel syndrome by and of itself. Dr. Baker agreed that the damage and findings shown on the x-ray films were all consistent with residuals from Petitioner's motorcycle accident and surgeries thereafter. (PX 6, pp. 35 - 37)

Dr. Baker acknowledged Petitioner did not tell him about falling at home in the months before he presented to him. (PX 6, pp. 37 – 38) Dr. Baker also agreed that if Petitioner had fallen and tripped over some golf clubs that episode might have caused or aggravated the symptoms

that led Petitioner to present to him. When asked if it could have led to the surgery that he performed, the doctor testified that he lacked enough information to make that decision. (PX 6, p. 38)

Dr. Baker was questioned by counsel as to whether he considers himself to be an advocate for his patients and the doctor replied, "I consider myself to be an advocate to give the best care I can to the patient." (PX 6, p. 38) When asked if he normally accepts the history given to him by a patient and tries to lend support therefore, he replied "No. I try to find out the truth." (PX 6, p. 38)

Dr. Baker felt Petitioner's surgery was successful. When he released Petitioner in January of 2015 he reported full recovery of sensation and feeling in his hand and fingers. He agreed that some of his patients continue to improve after they have been released from care. In Petitioner's case the doctor has had every expectation that he would make a complete recovery when he was released. He anticipated that Petitioner would regain the function he had lost related to the carpal tunnel syndrome but he didn't believe Petitioner would notice any benefit or gain from his prior 2001/2002 injury. (PX 6, pp. 38 – 40)

Dr. Baker acknowledged seeing Petitioner prior to the deposition. He did not arrange for Petitioner to come in; rather, he was simply advised by his staff that Petitioner was coming in. He didn't ask his staff to have Petitioner come in either. He had no knowledge as to whether Petitioner made the appointment or whether it was initiated by his staff. (PX 6, p. 41)

Dr. Baker testified that it would be "reasonable" to conclude that if Petitioner had been seen at Dr. Rademacher's office eight or nine times since January 15, 2015 for all types of problems and made no mention of carpal tunnel syndrome that he had made a complete recovery. He also testified that to a reasonable degree of medical certainty he would expect Petitioner, more likely than not, to make a full recovery without any disability or impairment following the treatment he received. (PX 6, pp. 41 – 42)

Dr. Baker acknowledged that Petitioner has a workers' compensation claim pending and when asked about how that might tie in with motive he explained that he is always looking at a patient's motivation and having to determine if the patient is appropriate or not. In Petitioner's case he found him to be "quite consistent and honest." (PX 6, pp. 42 – 43)

Dr. Baker agreed that Petitioner didn't say anything to him about falls in 2014. He further testified that with regard to job duties and specifics, Petitioner told him he sometimes seasonally did weed whacking and "very general statements like that." He agreed Petitioner might do a dozen things during a given day but it would be speculation on his part to address weights, positions of hands, and the forces involved. He did not believe that carpal tunnel syndrome was a normal degenerative process. He did not believe Petitioner's carpal tunnel syndrome was idiopathic. (PX 6, pp. 43 – 45)

Dr. Baker also agreed with Respondent's counsel that if a patient gives him an incomplete or erroneous history any opinion he might form as to the possible legal cause of the condition "could" be wrong. (PX 6, p. 45)

Dr. Baker has no appointments pending with Petitioner. He released him without restrictions. (PX 6, p. 45)

Dr. Baker was also asked if it is more normal to find carpal tunnel syndrome, when caused by a repetitive activity, to be in the dominant hand and he replied "No." He explained that it is the hand positioning and the usage that is more important than dominance. Dr. Baker agreed he hand no specific history regarding Petitioner's hand positions. (PX 6, pp. 45 – 46)

Dr. Baker acknowledged meeting with Petitioner's attorney prior to the deposition. (PX 6, p. 46) He also agreed that Petitioner told him he had been symptom free of numbness in his fingers since about a year or two after his motorcycle accident. (PX 6, p. 47)

The Arbitration Hearing

Petitioner's case proceeded to arbitration on February 28, 2017. The disputed issues were accident, causal connection, medical bills, temporary total disability benefits, and the nature and extent of any injury. Todd Covault was present as Respondent's representative. Petitioner was the sole witness testifying at the hearing.

Petitioner testified that he has been employed by Respondent as a full-time custodian since 1997. Petitioner testified that throughout his full-time employment with Respondent, it was typical for him to be assigned as a custodian to a particular school. Petitioner testified that during the spring of 2014, Petitioner was given a "rover" assignment, meaning that he went from school to school performing custodial duties. Petitioner testified that during the spring of 2014, there were several of his fellow employees that were on light duty, requiring him to complete extra work duties, including extra mowing and trimming. Petitioner testified, referring to Petitioner's Exhibit number 7 (Job Description – Custodian), that his responsibilities include completing work assignments necessary to keep the school building and grounds clean and in proper order. Petitioner testified that the spring of 2014 was particularly wet and rainy. Petitioner testified that the combination of several of his co-workers being on light duty, the fact that he was assigned to multiple schools, and the rainy season, resulted in him performing greater than usual mowing and trimming duties for Respondent. Petitioner testified that during the spring of 2014, he did not complete mowing and trimming duties at home, as he required his son to perform those duties.

Petitioner testified that keeping the grounds clean and in proper order required him to mow grass, trim trees, cut weeds, trim bushes, and pick up the grounds. Petitioner testified that during the spring of 2014, he was required to use an older non-self-propelled gas-powered push mower. Petitioner testified that he held the push mower handle with both of his hands, palms down, with his wrists curved. Petitioner testified that the motor of the older mower that he used was off-balance, such that it vibrated quite a bit and shook his hands and arms while he was operating and pushing the mower. Petitioner further testified that during the spring of 2014, he also used a gas-powered weed whacker. Petitioner testified that he used his right hand to hold the handle while he used his left hand to squeeze the trigger. Petitioner testified that when he used the weed whacker unit, it would cause the base of his left palm to get numb and tingly. Petitioner testified that the area of numbness in and about his left hand extended from the base of his left

palm up through the tips of the ring finger and middle finger of his left hand. Petitioner testified that during the spring of 2014, he used an electric hedge trimmer to trim the bushes at the various schools to which he was assigned. Petitioner testified that he used his right hand for the handle, and his left hand to squeeze the trigger of the hedge trimmer. Petitioner testified that while he trimmed bushes, he moved his hands and wrists around in such a fashion so as to follow the contour of each bush. Petitioner testified that he used the same electric hedge trimmer to trim trees. Petitioner testified that, after mowing and trimming, he would experience numbness and tingling in his left palm, through his left middle and ring fingers, especially in the evening time.

Petitioner testified that during the spring of 2014, he used the mower, weed whacker and hedge trimmer approximately three hours per day, three days per week.

Petitioner testified that during the spring of 2014, in addition to using vibrating tools while keeping the grounds clean, he also used vibrating tools on a regular basis while performing duties inside the schools. Petitioner testified that he operated two similar units: a scrubber and a walk behind scrubber. Petitioner testified that the walk behind unit is battery powered and it cleans the floor. The walk behind unit is equipped with two handles, requiring Petitioner to place each hand on a separate handle. Petitioner testified that each handle has a squeeze device on it, one to release the water, and the other to turn the pad. Petitioner testified that when he used the walk behind scrubber unit, that he felt numbness and loss of grip strength in and about his left hand. Petitioner testified that he would operate the walk behind unit for roughly two hours per day, two days per week. Petitioner testified that he also operated an electric scrubber device, which scrubs the floor to prepare it to be waxed. Petitioner testified that the electric scrubber device has two handles, both equipped with squeeze devices. Petitioner testified that operating the electric scrubber device required him to squeeze the trigger with his left hand continuously in order to keep the pad going. Petitioner testified that during the spring of 2014, he operated the electric scrubber device three hours per day, five days per week.

Petitioner testified that during the spring of 2014, he noticed that he started experiencing numbness and tingling in his left hand and wrist. Petitioner testified that he noticed that he would lose grip strength without notice and he began dropping things. Petitioner testified that when he started dropping things, like boxes, he became concerned about the safety of the school children and co-employees. Petitioner testified that he worked during the school day, when children were present, and when he became concerned about the safety of the school children, then that is when he made an appointment with his family doctor, Dr. Rademacher.

Petitioner testified that he saw Dr. Rademacher, who referred him to Dr. Becker. Petitioner testified that the EMG test was performed on June 24, 2014, and that he learned as a result of that test that he had moderate to severe carpal tunnel syndrome in his left hand and wrist. Petitioner testified that Dr. Becker referred him back to Dr. Rademacher, who referred him to Dr. Stuart F. Baker.

Petitioner testified that he became a patient of Dr. Baker, and first saw him on July 9, 2014. Petitioner testified that he told Dr. Baker that he worked for Respondent full-time, and he engaged in work duties including mopping, using spray bottles, cleaning windows, lifting heavy

objects, mowing and trimming on a daily basis. Petitioner testified that he treated with Dr. Baker, and that Petitioner ultimately underwent surgery for his carpal tunnel on September 25, 2014.

Petitioner testified at arbitration that he had been in a motorcycle wreck in 2001, approximately 13 years before being diagnosed with carpal tunnel syndrome. Petitioner testified that from the 2001 to 2004 timeframe, he underwent four surgeries to his left wrist, including a fusion procedure. Petitioner testified that from 2004 to 2014, he had no medical treatment to his left hand or wrist. Petitioner further testified that he had no problems with his left hand or wrist from 2004 to 2014.

Petitioner testified that he did not work as a typist and that he did not type on a regular basis. Petitioner testified that he does not have problems with his thyroid gland. Petitioner testified that he does not have rheumatoid arthritis in his left hand. Petitioner testified that he has had difficulty through the years controlling his type II diabetes, but those difficulties were not enough to keep him from working as a custodian for Respondent.

Petitioner testified during redirect examination that on July 9, 2014, after his first appointment with Dr. Stuart Baker, Dr. Baker sent him to Decatur Memorial Hospital to undergo x-rays to his left wrist.

Petitioner testified that the carpal tunnel surgery helped with his symptoms, but that after a day of weed whacking, he experiences numbness and tingling in his left palm and hand. Petitioner testified that his grip strength comes and goes, and is worse in the palm area of his left hand when he performs a day of weed whacking, or is using his left hand a lot. Petitioner further testified that his left hand is not as good as it was before he first experienced the symptoms of carpal tunnel syndrome.

The Arbitrator concludes:

With respect to issue C, Did Petitioner sustain an accident on June 24, 2014 that arose out of and in the course of his employment with Respondent?

With respect to issue F, Is Petitioner's current condition of ill-being causally related to the injury?

Petitioner sustained an accident on June 24, 2014 that arose out of and in the course of his employment with Respondent and is current condition of ill-being in his left hand/wrist is causally related to the injury. The Arbitrator bases her conclusion on Petitioner's credible testimony and the persuasive opinion and records of Dr. Baker and the records of Dr. Becker.

The Arbitrator finds that the record contains adequate evidence that Petitioner's job duties were sufficiently repetitive to support a finding that Petitioner suffered a repetitive trauma injury that arose out of and in the course of his employment with Respondent, *Three "D" Discount Store v. Ind'l Comm.*, 198 Ill.App.3d 43 (4th Dist., 1989). Respondent presented no witnesses rebutting Petitioner's description of his job duties. Petitioner's testimony regarding

those job duties was supported by the written job description. Petitioner's job duties included exposure to vibratory tools.

Petitioner sustained a very serious injury to his left hand and wrist in 2001 for which he underwent numerous major surgeries before receiving a full release in 2004. While Petitioner's hand/wrist was not the same as it was before the 2001 motorcycle accident he was able to return to work as a custodian. Petitioner testified to no further problems with his left hand/wrist until the spring of 2004. That testimony was corroborated by the lack of medical records indicating any ongoing problems or concerns until the spring of 2014.

In the spring of 2014 Petitioner noticed symptoms in his left hand/wrist which led him to his family doctor's office. Medical records reflect that Petitioner had been diagnosed as diabetic and had been having issues with his feet. Petitioner was sent to Dr. Becker's office for testing regarding both his feet as well as a new complaint of left hand numbness. Dr. Becker felt Petitioner's bilateral foot problems were due to diabetic peripheral neuropathy but his left hand numbness was felt to be, most likely, due to mononeuropathy entrapment, not diabetic neuropathy (RX 1, PX 3 – pp. 77-80, 106-109) Petitioner was then referred to Dr. Baker.

Petitioner's history to Dr. Baker and his nurse upon initially presenting to them was consistent with what had been going on. Given he was a diabetic Petitioner may have reasonably believed, at the beginning, that his left hand symptoms were possibly related to his diabetes. This however, was ruled out by Dr. Becker. Hence, he wondered if his left carpal tunnel syndrome was work-related and he addressed the issue with Dr. Baker.

The Arbitrator found Dr. Baker's testimony to be very persuasive and well thought out. He maintained throughout the deposition that Petitioner's 2001 injury and surgeries did not account for his left carpal tunnel syndrome. He also maintained that Petitioner's work duties, especially his exposure to vibratory tools, was a causative factor and/or significant aggravating factor in the development of Petitioner's left carpal tunnel syndrome. While Dr. Baker agreed that if the history was provided was inaccurate or incomplete his causation "could" be wrong, he never testified that his opinion "would" be wrong. There's a big difference between the two. He acknowledged being unaware of a fall at Petitioner's home in the months before the accident and being unaware of a trip/fall over golf clubs. However, neither fall involved injuries to Petitioner's left hand or wrist. The medical records pertinent to those histories indicate a bruised shoulder from the refrigerator incident (which wasn't a fall onto the floor but a fall "into" the refrigerator) and a right shoulder injury after tripping over golf clubs. Dr. Baker addressed Respondent's inquiries about the role of uncontrolled diabetes, obesity, Petitioner's 2001 injury, swelling in Petitioner's left hand/ and wrist, and Petitioner's left hand x-ray findings; however, he found all of the foregoing to either be a pre-disposing factor for carpal tunnel syndrome or a contributing factor to the development of Petitioner's carpal tunnel syndrome. At no time, however, did Dr. Baker indicate that Petitioner's job duties for Respondent were not a cause of Petitioner's left carpal tunnel syndrome.

The focus of Dr. Baker's deposition was causation with respect to Petitioner's left carpal tunnel syndrome. The Arbitrator also notes that Petitioner was diagnosed with flexor synovitis of

the left forearm and wrist which the doctor noted in his operative report of September 15, 2014 was significantly aggravated by his work activity. (PX 3, pp. 90-01)

The Arbitrator also found Petitioner to be, overall, a credible witness. It is true that during cross-examination Petitioner denied having any falls, accidents, or injuries at home or outside of work in the first six months of 2014. Petitioner also denied telling the hospital personnel on July 9, 2014 that he had fallen. The Arbitrator also notes that the record herein contains no evidence (other than the error stating the word "fell" in the July 9, 2014, radiology report) that Petitioner was involved in any fall involving the Petitioner's left hand and wrist. Accordingly, she gives little weight to that hospital entry/history. It does appear that Petitioner misspoke when he denied any falls, accidents, or injuries in the spring of 2014 as it appears he fell into a refrigerator and tripped over some golf clubs. Perhaps he did not understand those incidents to be considered by Respondent's counsel as "falls, accidents, or injuries." The Arbitrator cannot speculate as to that but, more importantly, neither incident involved Petitioner's left hand or wrist. Also, Petitioner's symptoms came on before he presented to Dr. Rademacher's office in May of 2014. Thus, they didn't begin with a supposed fall. They started earlier.

Even more importantly, absent the discrepancy in his testimony regarding prior falls in the spring of 2014, Petitioner, otherwise, appeared to be a credible witness. He was candid about his diabetes being sometimes out of control in 2013 and 2014 and he acknowledged saying nothing about his work and his hand to Dr. Becker or Dr. Rademacher. He was adamant throughout the hearing that he had no problems with his left wrist and hand between 2004 and the spring of 2014 and no records were introduced to suggest otherwise. Petitioner acknowledged some swelling in his left hand in May of 2014 but emphasized that it was the numbness and tingling and change in grip that caused him to contact his doctor. He was also very forthright about prior problems associated with excessive alcohol use but testified, without contradiction, that he had had no problems with it since an episode a couple of years earlier and the records from that episode were a part of the record.

Had Petitioner been less than candid about any falls involving alleged left hand and/or wrist symptoms, his denial of same might be viewed in a different light. However, Respondent provided no evidence of other falls, accidents, or injuries between 2004 and the spring of 2014 involving Petitioner's left hand/wrist. Therefore, the Arbitrator finds Petitioner's denial of prior falls not significant enough to diminish his overall credibility or to undermine Dr. Baker's causation opinion.

The Arbitrator has also given consideration to numerous medical statements contained in billings suggesting or stating that Petitioner's condition was unrelated to his employment. (RX 1, p. 7, pp. 8-9; RX 4, pp. 2 -5) The Arbitrator does not find the statements in these forms indicating Petitioner's condition was unrelated to his employment to be binding statements regarding the legal issue of causation. They were generated for insurance purposes. When Petitioner was examined by Dr. Becker and Dr. Rademacher's physician's assistant, Stacey Waddington, in the spring of 2014 Petitioner did not even know his condition was work-related. Petitioner's workers' compensation claim was later denied by Respondent and, thus, Petitioner proceeded to secure treatment through his personal insurance. Dr. Baker's statements as found in

his billings were done for purposes of securing payment. In the end, regardless of what the doctor marked on a billing form, his deposition testimony is given more weight.

Respondent did not obtain an IME report on causation nor did it have Petitioner undergo any type of examination for purposes of issues raised by this claim. Petitioner met his burden of proof on accident and causation.

With respect to issue K, whether temporary total disability benefits are due?

Petitioner is awarded temporary total disability benefits from September 25, 2014 through November 2, 2014, a period of 5 4/7 weeks.

Respondent did not dispute the dates that Petitioner has claimed that he is entitled to temporary total disability benefits. Therefore, based upon the Arbitrator's determination of accident and causal connection, the Arbitrator finds that Petitioner is entitled to temporary total disability benefits for the time period of September 25, 2014 through and including November 2, 2014, or 5 4/7 weeks.

With respect to issue L, What is the nature and extent of the injury?

Section 8.1(b) of the Act establishes the criteria for determining permanent partial disability. It states:

> In determining the level of permanent partial disability, the Commission shall base its determination on the following factors: (i) the reported level of impairment pursuant to subsection (a); (ii) the occupation of the injured employee; (iii) the age of the employee at the time of the injury; (iv) the employee's future earning capacity; and (v) evidence of disability corroborated by the treating medical records. No single enumerated factor shall be the sole determinant of disability.

Accordingly:

With regard to subsection (i) of §8.1b(b), the Arbitrator notes that no permanent partial disability impairment report and/or opinion was submitted into evidence. The Arbitrator therefore gives no weight to this factor.

With regard to subsection (ii) of §8.1b(b), the occupation of the employee, the Arbitrator notes that the record reveals that Petitioner was employed as a custodian at the time of the accident and that he is able to return to work in his prior capacity as a result of said injury. The Arbitrator notes that Petitioner testified that he is able to perform the essential functions of his job; however, he still experiences some numbness and decreased grip strength while performing his job duties. Because Petitioner has returned to work in his prior capacity, yet experiences some difficulty in doing so, the Arbitrator therefore gives some weight to this factor.

With regard to subsection (iii) of §8.1b(b), the Arbitrator notes that Petitioner was 41 years old at the time of the accident. Because of the fact that Petitioner will be required to endure

the disability in his left hand for up to twenty (20) years and possibly longer, the Arbitrator therefore gives some weight to this factor.

With regard to subsection (iv) of §8.1b(b), Petitioner's future earnings capacity, the Arbitrator notes that no testimony or opinion was submitted into evidence with respect to this factor. The Arbitrator therefore gives no weight to this factor.

With regard to subsection (v) of §8.1b(b), evidence of disability corroborated by the treating medical records, the Arbitrator notes that Petitioner underwent surgery on September 25, 2014 for volar flexor synovitis of the left forearm and wrist, carpal tunnel syndrome, and an abnormal proximal insertion of the 3rd lumbrical. Petitioner testified that he continues to experience occasional numbness and tingling in and about his left palm. Petitioner further testified that although the surgery did help alleviate some of his symptoms, he is still not the same as he was prior to the time that he first experienced symptoms of carpal tunnel syndrome. Petitioner further testified that he does not have the same grip strength as he used to have, and that he has good days and bad days. The Arbitrator further notes that the office note of Dr. Baker dated of January 30, 2017, indicates that Petitioner was using vibrating machines with only minimal discomfort. Petitioner reported no problems and stated "It's great." He no longer dropped objects and was noted to have good sensation and motor function. The Arbitrator has also considered Dr. Baker's testimony regarding the resolution of Petitioner's symptoms and prognosis. The Arbitrator gives considerable weight to this factor.

Based on the above factors, and the record taken as a whole, and noting that Petitioner was diagnosed with both flexor synovitis of the left forearm and wrist as well as carpal tunnel syndrome and that both were surgically operated on, the Arbitrator finds that Petitioner sustained permanent partial disability to the extent of 15% loss of use of the left hand (28.5 weeks) pursuant to §8(d)2 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 MC LEAN	)	☐ Reverse Choose reason	☐ Second Injury Fund (§8(e)18)
			☐ PTD/Fatal denied
		☒ Modify up	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Jason Crow,
Petitioner,

vs. No. 15 WC 21035

Illinois State University,
Respondent.

19IWCC0300

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by Petitioner herein and notice given to all parties, the Commission, after considering the issues of causal connection 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. The Arbitrator awarded Petitioner 2% person-as-a-whole under §8(d)2 of the Act for his injuries.

The underlying facts of this claim were well laid out in the Arbitrator's Decision, which is incorporated herein by reference. Petitioner, a 41-year-old building custodian, injured his low back on April 15, 2015 while lifting a 60-70 pound recycling container. He felt a sharp pain shoot down through the left side of his back, but continued working.

As Petitioner worked over the next few days, his back pain continued and his left hip also began to hurt. He sought treatment at Advocate Medical Group on April 21, 2015, where he received muscle relaxants and was given restrictions to avoid bending, twisting and lifting weights over 20 pounds.

Petitioner commenced treatment with Dr. Mary Chow, who increased his restrictions by limiting his lifting to only 10 pounds. Petitioner also treated with chiropractor John Zozzaro, who noted Petitioner had muscle spasms in his left side between his lower buttocks and his midback. Although following treatment, Drs. Chow and Zozzaro each released Petitioner from care by June 12, 2015, Petitioner's pain persisted. He returned to Dr. Chow on July 2, 2015, complaining of pain in his left buttock and twinges in his left thigh. Dr. Chow ordered a lumbar MRI, which Petitioner underwent on July 15, 2015. That test was interpreted as showing mild degenerative disc disease at L5-S1 with an associated small left paracentral disc herniation which encroached upon the left S1 nerve sleeve.

On September 15, 2015, neurosurgeon Dr. Patrick Tracy conducted an examination of Petitioner. Dr. Tracy also reviewed Petitioner's lumbar MRI, though he wasn't sure whether the findings thereon depicted a small disc herniation or only degenerative changes. While Dr. Tracy found Petitioner's condition to be much improved and in need of no further treatment, he acknowledged that Petitioner's acute low back pain could possibly be due to the tiny disc herniation.

At the arbitration hearing on October 29, 2018, Petitioner testified he still has pain in his low back, left hip and left leg. He acknowledged that he returned to his previous position and duties, but testified that almost every month he misses three to four days of work. His left side still feels weak when he lifts objects, and Petitioner has to sit down and rest after 5 minutes of mopping or waxing. He testified he can no longer play golf, go bowling, or install drywall – a side business which he had done all his life.

Regarding the nature and extent of Petitioner's injury, the Commission views and weighs the facts somewhat differently than did the Arbitrator. In light of the above, the Commission finds an award of permanent partial disability of 5% person-as-a-whole to be more in line with the extent of the injuries Petitioner sustained, and modifies the Arbitrator's award accordingly.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed on November 29, 2018, is hereby modified as stated herein and otherwise affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $285.45 per week for a period of 25 weeks, as provided in §8(d)2 of the Act, because the injury sustained caused a 5% disability of the person-as-a-whole.

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

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

No bond is required for removal of this cause to the Circuit Court. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: JUN 17 2019

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mp/mcp
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Marc Parker

Barbara N. Flores

DISSENTING OPINION

I respectfully dissent from the Decision of the majority. The Commission modified the Decision of the Arbitrator by increasing the permanent partial disability award from loss of 2% of the person-as-a-whole to loss of 5% of the person-as-a-whole. I would have affirmed and adopted the Decision of the Arbitrator.

Petitioner sustained an injury to his lower back while lifting a recycling bin on April 15, 2015. He was diagnosed with a lumbar sprain/strain. He began treating with Dr. Mary Chow on May 4, 2015. He also began treating with Dr. Zozzaro, a Chiropractor, on May 11, 2015. Dr. Chow initially released to full duty and from treatment on May 29th, noting he was going to continue chiropractic treatment. Dr. Zozzaro released him to work without restrictions and released him from care on June 12, 2015 noting that his condition was "excellent."

Petitioner returned to Dr. Chow asking for a referral to a back specialist. On September 15, 2015 Petitioner saw Dr. Patrick Tracy, a neurosurgeon, for consultation. Dr. Tracy noted that he had been working full duty for 3 months. Currently, he reported 0/10 pain, 2/10 if he sit/stands too long, and up to 4/10 with heavy physical exertion. Dr. Tracy concluded that Petitioner was much improved with conservative treatment, no further treatment was indicated, and Petitioner needed no limitations or restrictions. Petitioner returned to Dr. Chow on September 28th. Petitioner reported no pain currently and only intermittent low back pain. Dr. Chow's examination indicated there was no need for additional treatment and he was discharged from care.

19IWCC0300

In increasing the permanent partial disability award, the majority relied on Petitioner's testimony regarding his continuing impairments and disability. However, in her decision, the Arbitrator noted that she did "not find Petitioner's testimony regarding his current symptomology to be persuasive as it is not reflected in the medical records entered into evidence at the time of arbitration. Specifically, [she noted] that there is no indication from any medical provider that his condition got worse after he sought treatment despite Petitioner's assertion otherwise." The Act requires the Commission to consider "evidence of disability corroborated by the medical records." In this case, Petitioner's claims of continued disability are not corroborated by the medical records. In my opinion, the Arbitrator was in a better position to determine the credibility of Petitioner regarding his ongoing disability. Accordingly, I would have affirmed and adopted the Decision of the Arbitrator.

For the reasons stated above, I would have affirmed and adopted the Decision of the Arbitrator. Therefore, I respectfully dissent from the majority decision.

Deborah L. Simpson

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

CROW, JASON
Employee/Petitioner

Case# **15WC021035**

ILLINOIS STATE UNIVERSITY
Employer/Respondent

19IWCC0300

On 11/29/2018, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 2.47% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

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

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

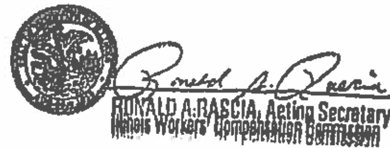
4138 ASSISTANT ATTORNEY GENERAL
WARREN WILKE
500 S SECOND ST
SPRINGFIELD, IL 62706

0903 ILLINOIS STATE UNIVERSITY
1320 ENVIRONMTL HEALTH SAFETY
NORMAL, IL 61790

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

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

NOV 29 2018



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

Jason Crow
Employee/Petitioner

Case # **15** WC **21035**

v.

Consolidated cases: **N/A**

Illinois State University
Employer/Respondent

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Melinda Rowe-Sullivan**, Arbitrator of the Commission, in the city of **Bloomington**, on **October 29, 2018**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

19IWCC0300

FINDINGS

On **April 15, 2015**, Respondent *was* operating under and subject to the provisions of the Act.

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

On this date, 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.

Per the stipulation of the parties, in the year preceding the injury Petitioner earned **$24,734.62**; the average weekly wage was **$475.75**.

On the date of accident, Petitioner was **41** years of age, *married* with **0** dependent children.

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

Respondent shall be given a credit of **$407.80** for TTD, **$0** for TPD, **$0** for maintenance, **$0** in non-occupational indemnity disability benefits and **$0** for other benefits, for a total credit of **$407.80**.

Respondent is entitled to a credit for medical bills paid in the amount of **$ALL AMOUNTS PAID** through its group medical plan for which credit may be allowed under Section 8(j) of the Act.

ORDER

Respondent shall pay for medical services **as set forth in Petitioner's Exhibit 12** as provided in Sections 8(a) and 8.2 of the Act as stipulated to by the parties at the time of arbitration. 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 the provider(s). Respondent shall pay any unpaid, related medical expenses **as set forth in Petitioner's Exhibit 12** according to the fee schedule and shall provide documentation with regard to said fee schedule payment calculations to Petitioner. Respondent is entitled to a credit for all bills paid under its group medical plan for which credit may be allowed under Section 8(j) of the Act.

Respondent shall pay Petitioner permanent partial disability benefits of **$285.45/week** for **10 weeks**, because the injuries sustained caused **2% loss of use of the person-as-a-whole**, as provided in Section 8(d)2 of the Act.

Respondent shall be given a credit of **$407.80** for TTD, **$0** for TPD, **$0** for maintenance, **$0** in non-occupational indemnity disability benefits and **$0** for other benefits, for a total credit of **$407.80**.

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

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

Melinda M. Rowe-Sullivan
Signature of Arbitrator

11/27/18
Date

NOV 29 2018

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Jason Crow
Employee/Petitioner

Case # **15** WC **21035**

v.

Consolidated cases: **N/A**

Illinois State University
Employer/Respondent

19IWCC0300

MEMORANDUM OF DECISION OF ARBITRATOR

FINDINGS OF FACT

Petitioner, a 41-year-old Building Service Worker for Respondent, sustained an accidental injury that arose out of and in the course of his employment by Respondent on April 15, 2015 when he was lifting a recycling container weighing approximately 60-70 pounds. Petitioner testified that when lifting the container, he experienced an immediate sharp shooting pain into his low back and left hip area. He testified that he completed his shift, but that he took it easy the remainder of the shift. He described his pain level as being a 5-6/10. He testified that he continued to work the week after his accident, but that he experienced stiffness in his low back and left hip with ongoing pain.

Petitioner testified that after having been seen at Advocate on May 4, 2015, he spoke to Doug Saxton, the Workers' Compensation Coordinator for Respondent, after his appointment and that he referred him to Dr. Chow at OSF Occupational Health. After describing the treatment recommendations made by Dr. Chow, Petitioner testified that Respondent did not have work within the restrictions issued by Dr. Chow. The Arbitrator notes that the parties stipulated that Petitioner was temporarily totally disabled from May 5, 2015 through May 13, 2015 and that Petitioner received the appropriate temporary total disability benefits for this timeframe. (AX1).

After having described his medical treatment by both Dr. Chow and Dr. Zozzaro, Petitioner testified that he continued to have ongoing low back and left hip pain which sometimes radiated into his left thigh. He testified that the pain was worse when he was working, especially with mopping and sweeping. He testified at arbitration that he was surprised that Dr. Chow released him given his ongoing symptoms.

Petitioner testified that he continued to work performing his normal custodial duties, but that he noticed increased low back and left hip pain, especially while mopping, sweeping, and lifting. He testified that he again treated with Dr. Zozzaro in 2016 because his symptoms did not abate, but the Arbitrator notes that no such corresponding medical records were entered into evidence at the time of arbitration documenting such additional chiropractic treatment.

Petitioner testified that his primary care physician has continued to fill out FMLA forms for his back. He testified that since his work accident, he regularly uses FMLA and misses work because of intermittent increased back and left hip pain. He testified that sometimes he will miss up to 3-4 days per month because of increased back pain. He testified that there are times that he has used up all his sick and vacation time, and that he does not get paid for his lost time due to his back injury. The Arbitrator notes that no such supporting records from his primary care physician, however, were included in the record.

Petitioner testified that prior to his April 15, 2015 accident, he did not have any back, left hip or left thigh pain. He testified that since his work accident, he has continued to experience pain in his back, left hip and left thigh. He testified that he has increased pain if he stands or sits for any length of time and that he experiences the pain the most at work when he is sweeping, mopping or waxing a floor. He testified that sudden movements or twisting intensifies his low back and left hip pain, as does riding in a car. He testified that since his accident, he gave up golfing and bowling as these aggravate his low back and left hip pain. Petitioner testified that prior to his accident he did some drywalling for profit on the side. Petitioner testified that since his accident, he no longer does any drywalling.

On cross examination, Petitioner testified that he has been able to complete just job duties as assigned since returning to work for Respondent in May 2015. He testified that his average weekly wage has increased since returning. He also testified that he has not been disciplined for an inability to complete his job duties. He further testified that he takes Ibuprofen approximately three times per month when he feels that his back is inflamed.

The report of Dr. Zozzaro dated April 25, 2018 was entered into evidence at the time of arbitration as Petitioner's Exhibit 1. The report reflects that Petitioner treated in Dr. Zozzaro's office from May 11, 2015 through June 12, 2015 for pain in his lower back and right sacroiliac region, that Petitioner's injury occurred while lifting a recycling bin on April 15, 2015, that Petitioner was diagnosed with lumbar sprain/strain, lumbalgia and muscle spasms, and that he opined that there was a causal connection between the injury described, the diagnosis and Petitioner's symptoms. (PX1).

The report of Dr. Zozzaro dated May 11, 2015 was entered into evidence at the time of arbitration as Petitioner's Exhibit 2. The report notes that Petitioner's chief complaint was that of central low back pain radiating into his left sacroiliac region, that his injuries occurred while picking up a recycling bin and that he had felt better the past week after being off work. It was noted that Petitioner's working diagnosis was that of lumbar sprain/strain with associated thoracic and pelvic subluxations and muscle spasms. It was noted that Petitioner's treatment would be three times per week for 10 visits and that his prognosis was expected to be good. (PX2).

The report of Dr. Zozzaro dated July 8, 2016 was entered into evidence at the time of arbitration as Petitioner's Exhibit 3. The report reflects that Petitioner had treated from May 11, 2016 [*sic*] to June 12, 2016 [*sic*] and was released from care, and that his prognosis at the time was good. (PX3).

The FMLA Certification of Dr. Chow dated August 28, 2015 was entered into evidence at the time of arbitration as Petitioner's Exhibit 4. It was noted that Dr. Chow opined that Petitioner's condition would not cause episodic flare-ups periodically preventing him from performing his job functions and that she further opined that it was not medically necessary for Petitioner to be absent from work during the flare-ups. (PX4).

The Lumbar Spine MRI Interpretive Report dated July 15, 2015 was entered into evidence at the time of arbitration as Petitioner's Exhibit 5. It was noted that the films were interpreted as revealing mild degenerative disk disease at L5-S1 level with associated small left paracentral disc herniation at this level encroaching upon the left S1 nerve root sleeve. (PX5).

The FMLA Report of Dr. Chow dated May 5, 2015 was entered into evidence at the time of arbitration as Petitioner's Exhibit 6. It was noted that Dr. Chow opined that Petitioner's condition would not cause episodic flare-ups periodically preventing him from performing his job functions. (PX6).

The medical records of Dr. Zozzaro were entered into evidence at the time of arbitration as Petitioner's Exhibit 7. The records reflect that Petitioner was seen on May 11, 2015, at which time he was noted to be complaining of bilateral low back pain that radiated to the left hip/buttock region. It was noted

that a work injury precipitated or caused the condition and that the symptoms had been present since April 15, 2015. Petitioner was advised to use ice pack therapy at home and to use a moist heating pad or a hot water bottle at home 15-20 minutes per hour. Petitioner was also given a home exercise program. At the time of the May 13, 2015 visit, it was noted that Petitioner's pain felt a little higher in his left low back on that date and that slight improvement was noted since the last treatment. It was noted that Petitioner was progressing as expected. At the time of the May 15, 2015 visit, it was noted that Petitioner's pain felt a little higher in his left low back on that date and that slight improvement was noted since the last treatment. It was noted that Petitioner was having very occasional low back sharp pains with bending and that he had had had one episode of left hamstring pain. It was also noted that a discussion was had regarding lifting and mopping mechanics. (PX7).

The records of Dr. Zozzaro reflect that Petitioner was seen on May 18, 2015, at which time it was noted that his pain felt a little higher in his left low back on that date and that slight improvement was noted since the last treatment. It was noted that Petitioner was progressing as expected and that he had tolerated his work shift well. It was also noted that Petitioner was sore after leaning forward cleaning toilets. At the time of the May 21, 2015 visit, it was noted that Petitioner's pain felt a little higher in his left low back on that date and that slight improvement was noted since the last treatment. It was noted that Petitioner's low back had been tired by the end of his shift from walking, but that overall he was tolerating work well. At the time of the May 27, 2015 visit, it was noted that Petitioner's pain felt a little higher in his left low back on that date, that he had less sacroiliac pain and that slight improvement was noted since the last treatment. It was also noted that Petitioner had left sacroiliac pain after work activities, but that otherwise he had been doing well. At the time of the June 1, 2015 visit, it was noted that Petitioner was complaining of bilateral low back pain and that the pain was not radiating but was more localized in presentation. It was noted that Petitioner reported moderate improvement in severity and frequency of his condition since the last visit. It was also noted that Petitioner had returned to work with no restrictions and had no problems. At the time of the June 10, 2015 visit, it was noted that Petitioner reported slight improvement since the last treatment. It was also noted that Petitioner had some soreness and was stiff after work activities. (PX7).

The records of Dr. Zozzaro reflect that Petitioner was seen on June 11, 2015, at which time it was noted that slight improvement from the last treatment was evident during the assessment of his condition. It was noted that Petitioner was progressing as expected. At the time of the June 12, 2015 visit, it was noted that since his last treatment Petitioner reported moderate improvement. It was noted that it was Dr. Zozzaro's opinion that Petitioner's condition could be considered excellent. Petitioner was released from care and was instructed to return as needed. The report of Dr. Zozzaro dated June 12, 2015 noted that Petitioner had rated his improvement at 80%, that his working diagnosis was that of resolved lumbar sprain/strain with associated thoracic and pelvic subluxations, and that he had reached maximum medical improvement as of June 12, 2015. (PX7).

The medical records of Dr. Tracy were entered into evidence at the time of arbitration as Petitioner's Exhibit 8. The records reflect that Petitioner was seen on September 15, 2015, at which time it was noted that he was seen for back pain. It was noted that Petitioner was at work in April of 2015 emptying a recycling bin when he had an acute onset of left lumbosacral pain and that it would occasionally go into his buttock, but that he had no radicular features. It was noted that Petitioner saw a chiropractor for a while, that he was off work for two weeks, went back to light duty for one month and had been back to full duties for about three or more months, and that he had had an MRI at one point which was interpreted by the radiologist as showing a tiny left L5-S1 disc herniation. It was noted that Petitioner's pain was currently a 0 most of the time, that it was a 2 if he sat or stood too long and that it might be a 4/10 with heavy physical exertion. The assessment was noted to be that of acute low back pain possibly due to a tiny disc herniation, which is already much improved with conservative treatment. It was noted that Dr. Tracy opined that he did not think that Petitioner required any further treatment, that he did not think that he

required any limitations or restrictions and that he would not benefit from either epidural steroid injections or consideration of surgical treatment. (PX8).

The medical records of Dr. Chow were entered into evidence at the time of arbitration as Petitioner's Exhibit 9. The records reflect that Petitioner was seen on May 5, 2015, at which time it was noted that he had hurt his low left back while lifting a recycling container on April 15, 2015. It was noted that Petitioner had been seen at Advocate and was given muscle relaxers and Ibuprofen. It was noted that Petitioner stated that he had seen a chiropractor in the past which had helped. The assessment was noted to be that of low back strain with sacroiliac joint dysfunction and muscle spasm (right). It was noted that a request would be submitted for chiropractic care with Dr. Zozzaro. Petitioner was also given prescriptions for Naprosyn and Norflex and was issued work restrictions. At the time of the May 14, 2015 visit, it was noted that Petitioner stated that he was doing about the same, that he had started chiropractic treatment and that his pain was not constant. Petitioner was recommended to continue chiropractic treatment and to use Biofreeze. Petitioner was issued work restrictions. At the time of the May 29, 2015 visit, it was noted that Petitioner stated that he had less pain and that the chiropractic visits were helping. Petitioner was recommended to finish his chiropractic treatments and to return to work full duty. (PX9).

The records of Dr. Chow reflect that Petitioner was seen on July 2, 2015, at which time it was noted that he presented for a re-check of his back strain. It was noted that Petitioner was worse with activity. It was noted that Petitioner's back pain was still present and still felt out of place, and that he had pain in his left buttock sometimes as well as a twinge in his left thigh sometimes. Petitioner was recommended to undergo an MRI due to his continued back pain. At the time of the July 21, 2015 visit, it was noted that Petitioner stated that his back felt the same, that he stated that the harder he worked the more it ached, and that repetitive bending hurt the most. It was noted that Petitioner had pain traveling into his left buttocks and maybe a "touch" into the top of his left thigh. A discussion was had regarding potential treatment options including chiropractic, physiatry and neurosurgery. At the time of the August 7, 2015 visit, it was noted that Petitioner was doing about the same and had mild pain on that date. It was noted that Petitioner's pain increased after sitting too long. It was noted that Petitioner was requesting a referral to a back specialist and that his pain was worse with sweeping and waxing the floor. It was noted that Petitioner was to be referred to Dr. Tracy, a neurosurgeon, for consultation. (PX9).

The records of Dr. Chow reflect that Petitioner was seen on September 28, 2015, at which time it was noted that he continued to have mild pain and that his pain increased sporadically with no specific motion. It was noted that Petitioner stated that he had no pain and only intermittent low back pain, which varied in time and intensity. It was noted that Petitioner had pain in the left lower back at various times of the day. It was noted that Petitioner reported no new symptoms and no increase in symptoms. It was noted that there was no further treatment to offer per the neurosurgery consultation and that the physical examination performed on that date indicated no further treatment needs. Petitioner was discharged at that time. (PX9).

The Medical Request of Dr. Chow dated August 7, 2015 was entered into evidence at the time of arbitration as Petitioner's Exhibit 10. The record reflects that Petitioner was referred to Dr. Tracy for a one-time consultation only. (PX10).

The Adjuster Response dated August 7, 2015 was entered into evidence at the time of arbitration as Petitioner's Exhibit 11.

The Medical Bills Exhibit was entered into evidence at the time of arbitration as Petitioner's Exhibit 12.

The medical records of Advocate Occupational Health were entered into evidence at the time of arbitration as Petitioner's Exhibit 13. The records reflect that Petitioner was seen on April 21, 2015 for a

chief complaint of a date of injury of April 15, 2015 and that he was lifting up a recycling container and felt pain in his lower back and left hip. It was noted that the assessment was that of low back pain. Petitioner was prescribed Ibuprofen and a muscle relaxant, and was issued work restrictions. At the time of the May 4, 2015 visit, it was noted that Petitioner was seen for an initial visit for a work injury that happened at ISU, that he was a janitor, that he was going to dump a recycling container and squatted down to pick it up and that when he stood up to dump it, he felt a strain in his back, lower middle and lower left. It was noted that Petitioner was requesting to be taken off work to facilitate quicker healing and stronger pain medications. It was noted that Petitioner also reported that his back felt out of alignment. The diagnosis was noted to be that of lumbosacral sprain. Petitioner was given stretching exercises, was instructed to take Ibuprofen and was told to use heat when he had pain. It was noted that x-rays were done for Petitioner's complaints of feeling that his spine was not aligned and that there were no acute findings on the initial reading. The interpretive report for the lumbar spine x-rays performed on May 7, 2015 noted that the films were interpreted as revealing mild osteoarthritis at L5-S1; the interpretive report for the sacroiliac joint x-rays performed on May 5, 2015 noted that the films were interpreted as revealing an unremarkable exam. (PX13).

The Payment Ledger was entered into evidence at the time of arbitration as Respondent's Exhibit 1.

CONCLUSIONS OF LAW

The parties stipulated at the time of hearing that on April 15, 2015, Petitioner sustained an accident that arose out of and in the course of his employment with Respondent. (AX1).

With respect to disputed issue (F) pertaining to causation, the Arbitrator finds that Petitioner has not met his burden of proving that his current condition of ill-being is causally related to the accident of April 15, 2015.

The Arbitrator notes that the only neurosurgeon to review Petitioner's MRI of the lumbar spine, Dr. Tracy, indicated in his medical records that there may not, in fact, have been a disc herniation despite the radiologist's interpretation that there was a tiny left L5-S1 disc herniation. (PX8). When comparing the opinions proffered by Petitioner's treating providers, *i.e.*, those of Dr. Zozzaro and Dr. Tracy, the Arbitrator places significantly greater weight given upon the opinions of Dr. Tracy given the fact that not only is he a neurosurgeon, but also the fact that Dr. Zozzaro, a chiropractor, was not treating Petitioner at the time of the MRI, did not review the MRI and did not see Petitioner either immediately before or after the MRI was performed.

Additionally, the Arbitrator does not find Petitioner's testimony regarding his current symptomatology to be persuasive as it is not reflected in the medical records entered into evidence at the time of arbitration. Specifically, the Arbitrator notes that there is no indication from any medical provider that his condition got worse after he sought treatment despite Petitioner's assertions otherwise. In fact, Dr. Zozzaro described Petitioner's condition as "excellent" at his last treatment and Dr. Tracy noted that Petitioner's condition was much improved and that Petitioner himself described his pain level as 0/10 the majority of the time. (PX7; PX8). Given the record as a whole, the Arbitrator finds that Petitioner sustained an acute low back strain which was resolved as of the visit with Dr. Tracy on September 15, 2015.

Having reviewed and considered the entirety of the medical evidence in this matter, the Arbitrator finds that Petitioner has not met his burden of proving that his current condition of ill-being is causally related to the accident of April 15, 2015.

With respect to disputed issue (J) pertaining to reasonable and necessary medical services, the Arbitrator finds that Respondent shall pay for medical services as set forth in Petitioner's Exhibit 12 as provided in Sections 8(a) and 8.2 of the Act as stipulated to by the parties at the time of arbitration. Respondent is entitled to a credit for all bills paid under its group medical plan for which credit may be allowed under Section 8(j) of the Act.

With respect to disputed issue (L) pertaining to the nature and extent of Petitioner's injury, and consistent with 820 ILCS 305/8.1b, permanent partial disability shall be established using the following criteria: (i) the reported level of impairment pursuant to subsection (a) of Section 8.1b of the Act; (ii) the occupation of the injured employee; (iii) the age of the employee at the time of the injury; (iv) the employee's future earning capacity; and (v) evidence of disability corroborated by the treating medical records. 820 ILCS 305/8.1b. No single enumerated factor shall be the sole determinant of disability. *Id.*

With respect to Subsection (i) of Section 8.1b(b), the Arbitrator notes that no AMA rating was offered by either party in this matter. As a result thereof, the Arbitrator gives no weight to this factor.

With respect to Subsection (ii) of Section 8.1b(b), the Arbitrator notes that Petitioner continues to work in his pre-accident position with Respondent. While Petitioner testified that he is under an FMLA certification and takes 3-4 FMLA days per month, the Arbitrator notes that no such medical records from Petitioner's primary care physician were proffered by Petitioner at the time of arbitration so as to support this assertion. The Arbitrator places lesser weight on this factor when making the permanency determination.

With respect to Subsection (iii) of Section 8.1b(b), Petitioner was 41 years old on his date of accident. Given the age of Petitioner and the fact that his treating providers gave him a full duty/no restriction release, the Arbitrator places greater weight on this factor when making the permanency determination.

With respect to Subsection (iv) of Section 8.1b(b), the Arbitrator notes that Petitioner testified that his current hourly rate is greater than it was on the date of accident, that he was able to resume his position with Respondent in an unrestricted manner and that he has resumed his regular work schedule after having been temporarily totally disabled for a short period of time, *i.e.*, May 5, 2015 through May 13, 2015 in light of Respondent's inability to accommodate his work restrictions. As there was no evidence proffered at arbitration to demonstrate that this work accident has impaired or otherwise affected Petitioner's future earnings capacity beyond his unsupported assertion that he no longer does drywalling on the side (the earnings for which were not established in any form at the time of arbitration), the Arbitrator places lesser weight on this factor when making the permanency determination.

With respect to Subsection (v) of Section 8.1b(b), the Arbitrator notes that Petitioner testified that he has continued to experience pain in his back, left hip and left thigh. Petitioner testified that he has increased pain if he stands or sits for any length of time and that he experiences the pain the most at work when he is sweeping, mopping or waxing a floor. Petitioner testified that sudden movements or twisting intensifies his low back and left hip pain, as does riding in a car. Petitioner testified that since his accident, he gave up golfing and bowling as these aggravate his low back and left hip pain. At the final office visit with Dr. Zozzaro on June 12, 2015, it was noted that since his last treatment Petitioner reported moderate improvement. It was noted that it was Dr. Zozzaro's opinion that Petitioner's condition could be considered excellent. Petitioner was released from care and was instructed to return as needed. (PX7). Furthermore, at the time of the office visit with Dr. Tracy on September 15, 2015, it was noted that Petitioner's pain was currently a 0 most of the time, that it was a 2 if he sat or stood too long and that it might be a 4/10 with heavy physical exertion. The assessment was noted to be that of acute low back pain possibly due to a tiny disc herniation, which is already much improved with conservative treatment. It was noted that Dr. Tracy

opined that he did not think that Petitioner required any further treatment, that he did not think that he required any limitations or restrictions and that he would not benefit from either epidural steroid injections or consideration of surgical treatment. (PX8). The Arbitrator concludes that Petitioner's evidence of disability at the time of arbitration, namely his continued complaints and purported limitations, was only minimally corroborated by his treating records. The Arbitrator accordingly places lesser weight on this factor in determining permanency.

The Arbitrator notes that the determination of permanent partial disability benefits is not simply a calculation, but an evaluation of all of the factors as stated in the Act in which consideration is not given to any single factor as the sole determinant. Based on the above factors and the record in its entirety, the Arbitrator concludes that Petitioner sustained permanent partial disability to the extent of **2% loss of use of the person-as-a-whole** under Section 8(d)2 of the Act.

STATE OF ILLINOIS	)		
	) SS.		
COUNTY OF COOK	)		

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

MIKE MCGANN,

Petitioner,

vs.

NO: 08 WC 52156
10 WC 21559

CITY OF CHICAGO,

Respondent.

19IWCC0301

DECISION AND OPINION ON REMAND

This consolidated matter now comes before the Commission on remand from the Circuit Court of Cook County. The Circuit Court reversed and remanded the Commission's Decision as to causal connection for Petitioner's right hip condition, and as to the Commission's award of temporary total disability (TTD) benefits. The Circuit Court further ordered the Commission to determine whether Petitioner is entitled to additional compensation for his cervical and lumbar spine injuries. In all other respects, the Circuit Court confirmed the remainder of the Commission's Decision relative to claim number 10 WC 21559. The Circuit Court of Cook County took no further action on claim number 08 WC 52156, as will be explained below.

Procedural History / Claim No. 08 WC 52156

The parties proceeded with a Section 19(b) hearing on April 9, 2010, as to claim number 08 WC 52156 only. Arbitrator Gerald Jutila issued his Decision on May 20, 2010. Arbitrator Jutila noted that Petitioner had worked for Respondent for 17 years; one year as a plumber and the last 16 years as a plumbing inspector. Petitioner's job required him to access various work sites,

including roofs, basements, and excavations to inspect service connections; it was also necessary for Petitioner to drive to designated inspection sites and traverse uneven ground surfaces.

In August or September 2008, Petitioner noticed low back and right hip pain while getting in and out of his car and negotiating stairs. Petitioner was diagnosed with a repetitive type injury that required surgery; he denied any previous injury to his right hip. On March 27, 2009, Dr. Benjamin Domb, of Hinsdale Orthopedics, performed an extensive repair of the right hip joint including a capsular release along the rim of the acetabulum, chondroplasty to trim the unstable flap of cartilage, debridement of the ligamentum teres, acetabuloplasty to trim the acetabular rim, labral repair with sutures and five anchors, debridement of the torn cartilage, and osteoplasty to remove the cam lesion.

Petitioner subsequently returned to work for Respondent performing desk work in the plumbing inspections department at City Hall. As of the April 9, 2010 hearing, Petitioner testified to continued pain in his right hip. Arbitrator Jutila found that Petitioner proved accident and causal connection for his right hip, and awarded reasonable and necessary medical expenses as well as temporary total disability (TTD) benefits.

On December 19, 2016, the parties proceeded to a final hearing before Arbitrator Milton Black on claim numbers 08 WC 52156 and 10 WC 21559, as consolidated. As to 08 WC 52156 only, nature and extent was the sole issue in dispute at arbitration; the Arbitrator, in his March 13, 2017 Decision, awarded 20% loss of use of the right leg. On Review, the Commission noted that by the parties' Briefs, no dispute existed relative to the Arbitrator's Decision on permanency in the 2008 claim. The Commission therefore affirmed and adopted the Arbitrator's Decision in 08 WC 52156; the Circuit Court of Cook County took no further action on the 2008 claim.

Procedural History / Claim No. 10 WC 21559

As to Petitioner's second claim, 10 WC 21559, Petitioner testified that after he returned to work for Respondent, he was eventually transferred back to the field to complete job site inspections as he had previously done. (T.45-46). The parties stipulated that on May 11, 2010, Petitioner injured himself after slipping and falling down the stairs of a building he had just inspected. (T.47-48). As Petitioner fell down the stairs, he hit the right side of his body, as well as his "knees, the hip and the shoulder and my head." (T.49-50).

In his March 13, 2017 Decision for claim number 10 WC 21559, Arbitrator Black considered the issues of causal connection, medical expenses, TTD, nature and extent, and penalties and attorney's fees. The Arbitrator found that Petitioner's conditions as to his right shoulder, left knee, and right hip, up through February 16, 2015, were causally related to the May 11, 2010 work accident. As a result of that accident, Petitioner underwent a right hip replacement on May 18, 2011 with Drs. Jason Griffin and Benjamin Domb at Good Samaritan Hospital. (T.55-56; PX8). Thereafter, Dr. Kris Alden performed a right hip total arthroplasty revision on December

4, 2014. (PX8). The Arbitrator found that Petitioner reached maximum medical improvement (MMI) for his right hip condition on February 16, 2015; this was the date Petitioner was released from treatment. (T.88).

Petitioner subsequently developed an infection that led to revision surgery of Petitioner's right hip prosthesis in 2016. The removal and replacement was completed by Dr. Justin LaReau in a two-part surgery that took place at Adventist Hinsdale Hospital on February 25, 2016 and May 18, 2016, respectively. (T.65-66; PX6; PX8). On February 25, 2016, Dr. LaReau proceeded with the removal of components as well as an extended trochanteric osteotomy. Dr. LaReau also implanted antibiotic spacers. (PX8). On May 18, 2016, Dr. LaReau removed the antibiotic spacers and reimplanted the right total hip replacement. (PX6).

The Arbitrator in his Decision stated that Petitioner had sustained a strep infection as a result of dental work performed in November 2015. The Arbitrator denied causal connection for Petitioner's right hip condition after February 16, 2015, due to the lack of evidence as to why an infection spread to the right hip and/or the lack of explanation as to whether the right hip would be more prone to infections as a result of the initial replacement surgery. Specifically, the Arbitrator stated, "There is no opinion in the records supporting the claim that but for the petitioner's hip replacement, he would not have had the infection spread and necessitate two additional surgeries." (Arbitrator's Decision, page 10). The Arbitrator also indicated, "There is no opinion in the records indicating that the strep infection of the right hip was causally related to, or a sequelae of the May 11, 2010 injury." (Arbitrator's Decision, pg. 10).

Additionally, the Arbitrator did not find Petitioner's right knee or seizure conditions to be related to the May 11, 2010 accident. The Arbitrator explained that the contemporaneous medical records did not indicate that Petitioner hit his head or lost consciousness, and any initial treatment to Petitioner's knee, was related to the left knee and not the right knee. Petitioner did not seek treatment for his right knee until a year after the work injury. The Arbitrator further stated that despite Petitioner's claim that he did not have any prior right knee symptoms, the medical records demonstrated that Petitioner had had three prior right knee arthroscopies. The Arbitrator indicated that there was no evidence causally relating the Petitioner's right knee injury, except for Petitioner's inconsistent and non-credible testimony. (Arbitrator's Decision, pg. 9).

On Review before the Commission, Petitioner disputed the Arbitrator's Decision denying causal connection for the infection that Petitioner had developed, and which resulted in revision surgery of his right hip prosthesis in 2016. Petitioner further argued that the Arbitrator erred in denying causal connection for his right knee condition, and that the Arbitrator's Decision was silent as to causal connection for Petitioner's alleged cervical and lumbar spine conditions.

On January 25, 2018, the Commission affirmed and adopted the Arbitrator's Decision in 10 WC 21559, and further wrote to clarify its affirmation. The Commission noted the lack of evidence, by way of testimony or the medical records, to indicate that the bacterial infection that

arose in November/December 2015 was a natural consequence of the right hip prosthesis. The Commission further noted that Petitioner's physicians acknowledged that the etiology of the infection was unclear.

Petitioner appealed the Commission's Decision to the Circuit Court of Cook County. In its August 14, 2018 Opinion and Order, the Circuit Court reversed the Commission's Decision and found that Petitioner's May 11, 2010 work injury played a role in contributing to Petitioner's infection. The Circuit Court stated, "While it is difficult to articulate a precisely when a causal chain is broken, the court does not believe it was broken in this case, and in general would not consider routine medical work to break the causal chain." Simply put, the Circuit Court indicated that, "if Plaintiff did not have a prosthetic hip, there would not have been a prosthesis to become infected." (Circuit Court Opinion and Order, pg. 4). Thus, the Circuit Court found that the Commission erred when it determined that Petitioner's hip infection was not causally related to his work injury.

Therefore, based upon the directive from the Circuit Court, the Commission finds that Petitioner's right hip condition is causally related to the May 11, 2010 accident. The Commission further finds that Petitioner is entitled to all reasonable and necessary medical expenses related to the right hip. Per the parties' Briefs, the only bills in dispute were those related to treatment for Petitioner's right hip after February 16, 2015.

Turning to Petitioner's cervical and lumbar spine injuries, the Circuit Court stated that it could not review the Commission's Decision regarding Petitioner's spinal injuries, "since the decision does not explain the reasons why it decided not to award benefits for these injuries." (Circuit Court Opinion and Order, pg. 7). The Circuit Court has ordered the Commission to determine whether there is a causal connection between Petitioner's work accident and his cervical and lumbar spine injuries, and what specific benefits, if any, Petitioner should receive.

On page 4 of the Commission's Decision for claim number 10 WC 21559, dated January 25, 2018, the Commission wrote the following:

> Petitioner further indicated that the Arbitrator did not address causal connection relative to Petitioner's cervical and lumbar spine. In this instance, causation between an accident and an employee's condition may be found where a chain of events demonstrate "a previous condition of good health, an accident, and a subsequent injury resulting in disability." *Int'l Harvester v. Indus. Comm'n*, 93 Ill. 2d 59, 63-64 (1982).
>
> Petitioner did have complaints to his spine at the onset, and underwent physical therapy. Dr. Michael Zindrick provided a causal connection opinion for Petitioner's cervical spine condition, stating,

> "The patient's symptoms do appear to stem from this work related injury back on May 11th. Although he had some underlying disk degeneration, it was aggravated by this fall." As to the lumbar spine, Dr. Zindrick stated that Petitioner initially had back pain after the May 2010 accident, but that within a month, his back had "started to settle down." Dr. Zindrick opined on July 13, 2010 that Petitioner had suffered aggravation of low back pain secondary to physical therapy for his hip. However, Petitioner was not undergoing physical therapy for the hip at this time. (PX8).
>
> After 2010, there is evidence of sporadic, generalized complaints of neck or back pain, the last of which appears in the September 8, 2011 discharge note from ATI Physical Therapy and the March 21, 2013 Section 12 report of Dr. Levin. There is no evidence to support that Petitioner's current condition of ill-being, if any at all, relative to his cervical and lumbar spine, is causally related to the May 11, 2010 accident. (PX5; RX3). Thus, in light of the foregoing, the Commission denies causal connection for the cervical and lumbar spine.

(Commission Decision for 10 WC 21559, pg. 4).

As to the Circuit Court's directive relative to the cervical and lumbar spine, the Commission reaffirms its January 25, 2018 Decision finding no causal connection between the cervical and lumbar spine for the reasons previously stated in its Decision and quoted above. As the Commission finds no causal connection, no additional benefits are awarded relative to the cervical and lumbar spine.

The Circuit Court also determined that the Commission's denial of causal connection for Petitioner's right knee condition was not against the manifest weight of the evidence. (Circuit Court Opinion and Order, pg. 9).

The issue of TTD has been resolved pursuant to the parties' March 8, 2019 stipulation. Pursuant to the stipulation, the parties agreed that Petitioner is entitled to TTD from May 31, 2012 through August 10, 2012; August 22, 2014 through February 15, 2015; and, December 1, 2015 through December 6, 2016, despite the Circuit Court's order awarding TTD benefits from August 22, 2014 through December 6, 2016.

The Circuit Court confirmed the remainder of the Commission's January 25, 2018 Decision.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $664.72 per week for 43 weeks, as provided in Section 8(e) of the Act, because the injuries sustained on October 2, 2008 (claim number 08 WC 52156), caused 20% loss of use of the right leg.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $664.72 per week for 317.5 weeks, because the injuries sustained on May 11, 2010 (claim number 10 WC 21559), caused 50% loss of use of the left leg (left knee injury), 7% loss of use of the person as a whole (right shoulder injury), and 35% loss of use of the person as a whole (right hip injury) for a job change pursuant to Section 8(d)(2) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Petitioner is entitled to all reasonable and necessary medical expenses relative to the right hip infection, pursuant to Sections 8(a) & 8.2 of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Petitioner is entitled to temporary total disability benefits of $1,198.88 per week for 88-4/7 weeks, commencing May 31, 2012 through August 10, 2012; August 22, 2014 through February 15, 2015; and, December 1, 2015 through December 6, 2016, that being the period of temporary total incapacity for work under Section 8(b) of the Act, and as stipulated to by the parties.

IT IS FURTHER ORDERED BY THE COMMISSION that Petitioner's claim for compensation relative to the cervical and lumbar spine, and right knee is hereby denied.

IT IS FURTHER ORDERED BY THE COMMISSION that Petitioner's claim for a wage differential is hereby denied.

IT IS FURTHER ORDERED BY THE COMMISSION that Petitioner's claim for penalties and attorney's fee under Sections 16, 19(k), and 19(l) is hereby denied.

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

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

No bond is required for the removal of this cause to the Circuit Court. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in the Circuit Court.

19IWCC0301

08 WC 52156
10 WC 21559
Page 7

DATED: JUN 18 2019

DDM/pm
D: 6-5-19
052

D. Douglas McCarthy

Stephen Mathis

L. Elizabeth Coppoletti

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

ALAK ANDREWS,

Petitioner,

vs. NO: 15 WC 32460

MORTON SALT,

19IWCC0302

Respondent.

DECISION AND OPINION ON REVIEW

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

We specifically affirm the Arbitrator's denial of temporary total disability. However, we clarify the Arbitrator's rationale on page 7 of the Decision. In the first paragraph under ISSUE (L), the Arbitrator wrote, "Petitioner has proven by a preponderance of the evidence that he is entitled to temporary total disability benefits for the time he has been off work as a result of his work-related injuries." However, in the second paragraph, the Arbitrator wrote, "The Arbitrator declines to award TTD where Petitioner admitted he worked elsewhere inasmuch as Petitioner was able to and did in fact find work. Therefore, Petitioner's request for TTD benefits is denied." *Dec. at 7.*

The Appellate Court, in *City of Granite City v. IC* stated, "To show entitlement to TTD benefits, claimant must prove not only that he did not work, but that he was unable to work." 279 Ill.App.3d 1087 at 1090 (5th Dist., 1996). Although, as the Arbitrator found, Petitioner was restricted to sedentary work by his treating physicians and was unable to perform his previous job at Respondent, Petitioner continued to work every day as a manager for American Parking, a valet

company that had thirteen locations. *T.20-28.* Petitioner also worked as an Uber driver, which sometimes required him to lift customers' bags and put them in the trunk. *Id.*

Based on the above and the record as a whole, Petitioner failed to prove that he was unable to work and that he did not work. Therefore, his request for temporary total disability is denied. As another point of clarification, if Petitioner wanted to pursue a claim for temporary partial disability (TPD) benefits because he was earning less than he had been at his job with Respondent, he would have needed to introduce, at the time of the hearing, evidence of the amount he earned working for American Parking and Uber to make such a calculation possible. Since Petitioner failed to prove entitlement to TTD or TPD at the hearing on June 20, 2017, any possible future claim for those benefits is limited to the time period after that arbitration hearing.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed August 29, 2017, is hereby affirmed and adopted with the clarification noted above.

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: JUN 18 2019

Maria Elena Portela

Thomas J. Tyrrell

L. Elizabeth Coppoletti

SE/
O: 5/21/19
49

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

ANDREWS, ALAK
Employee/Petitioner

Case# **15WC032460**

MORTON SALT
Employer/Respondent

19IWCC0302

On 8/29/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.11% 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:

1927 HUGHES SOCOL PIERS RESNICK & D
MARK WEINER
70 W MADISON ST SUITE 4000
CHICAGO, IL 60602

1109 GAROFALO SCHREIBER STORM
JAMES CLUNE
55 W WACKER DR 10TH FL
CHICAGO, IL 60601

STATE OF ILLINOIS)

)SS.

~~COUNTY OF COOK)~~

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

ALAK ANDREWS,
Employee/Petitioner

v.

MORTON SALT,
Employer/Respondent

Case # 15 WC 32460

Consolidated cases: N/A

19IWCC0302

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **MARIA S. BOCANEGRA**, Arbitrator of the Commission, in the city of **CHICAGO**, on **JUNE 20, 2017**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. [ ] Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?

B. [ ] Was there an employee-employer relationship?

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

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

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

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

G. [ ] What were Petitioner's earnings?

H. [ ] What was Petitioner's age at the time of the accident?

I. [ ] What was Petitioner's marital status at the time of the accident?

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

K. [x] Is Petitioner entitled to any prospective medical care?

L. [x] What temporary benefits are in dispute?
[ ] TPD [ ] Maintenance [x] TTD

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

N. [ ] Is Respondent due any credit?

O. [ ] Other _____

FINDINGS

On **10/2/2015**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

On this date, 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: **$66,156.48** and the average weekly wage, pursuant to Section 10, was **$1,272.24.**

On the date of accident, Petitioner was **44** years of age, ***married*** with **4** dependent children.

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

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

Respondent shall be given a credit of **$39,378.86** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$39,378.86**. By agreement, Respondent is entitled to a credit under Section 8(j) of the Act for payment of medical services prior to trial.

ORDER

Petitioner's request for TTD is hereby ***denied***.

Respondent shall pay reasonable and necessary medical services of $19,879.84, as provided in Sections 8(a) and 8.2 of the Act. Respondent shall be given a credit for medical benefits that have been paid, and Respondent shall hold Petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act.

Respondent shall pay for and approve the recommended surgical treatment of Dr. Wingate, including any and all incidental care thereto.

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

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

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

Signature of Arbitrator

8/29/2017
Date

AUG 29 2017

FINDINGS OF FACT

Alak Andrews ("Petitioner") alleged injuries to his low back arising out of and in the course of his employment against his employer Morton Salt Company ("Respondent") on October 2, 2015. Ax1, Ax3. On June 20, 2017, the parties proceeded to arbitration on the following disputed issues: causal connection, liability for unpaid medical bills, temporary total disability and prospective medical care/surgery. Ax1. Petitioner filed his 19(b) petition and Respondent filed its response to the 19(b) petition. Ax2-3, Rx3. The following is a recitation of the facts adduced at trial.

Petitioner, formerly a 44-year-old employee for Morton Salt Company, testified that he began working for Respondent in 1997. Petitioner' physically demanding duties included manual labor and operating heavy machinery, including forklifts. In addition, he testified he ran a machine and stacked fifty-pound bags.

On October 2, 2015, Petitioner was clearing planks of wood with the assistance of a forklift at a Morton Salt factory that was being closed. While standing on the pile of wood, about 3 feet above the ground, Petitioner lost his balance and fell, striking the right side of his low back on the metal fork of the forklift. Petiioner said he was advised to go home by his employer. The following morning, Petitioner woke up with pain in his back and blood in his urine. He said this continued for almost two days until he sought medical treatment at Skokie Hospital. Petitioner submitted a photo into evidence depicting bruising along his right side. Px11. It was taken four or five days after the accident.

On October 4, 2015, Petitioner went to Skokie Hospital. Px8. An x-ray of his lumbar spine and pelvis revealed degenerative joint disease of the sacroiliac joints. He was diagnosed with a back injury with hematoma and hematuria (blood in urine) and then discharged to his primary medical doctor.

Petitioner stated that his manager, Chet, called advising Petitioner to go to the company clinic, which tested Petitioner for drugs. The clinic indicated it would not treat Petitioner for his work accident and specifically told Petitioner to go to an emergency room.

The next day, October 5, 2015, Petitioner presented to Rush University Medical Center and informed the doctor at Rush that he fell from a pile of two-by-fours and landed on a forklift. Px6. He reported increasing pain and endorsed low back pain that radiated to the right hip. Petitioner underwent additional diagnostic imaging and laboratory tests which were unremarkable. Petitioner still had blood in his urine. He was discharged home with a prescription for pain medicine and instructions to follow-up with his primary care physician.

On October 6, 2015, Petitioner followed up with Dr. Nadim Ilbawi at NorthShore University HealthSystem, who diagnosed Petitioner with right-sided low back pain with right-sided radiculopathy and a hematoma. Dr. Ilbawi indicated the radicular pain was likely from a new herniated disc. Px4. Petitioner was taken off work and referred to physical therapy.

Petitioner went to Illinois Orthopedic Network ("ION") two days later, on October 8, 2015, where he was treated by Dr. Krishna Chunduri. Px3. Upon review of Petitioner' history and physical exam, Dr. Chunduri diagnosed Petitioner with lumbar contusion and lumbago with right radiculitis. Chunduri prescribed Petitioner with physical therapy three times per week for four weeks and started his medication management and took him off work.

On October 12, 2015, Petitioner began treating conservatively with physical therapy at Northside Medical Center with Thomas Dambrogio, D.C. Px5. n October 14, 2015, MRI revealed grade one retrolisthesis of L4 over L5, Modic type two and plate degenerative changes noted at L4 five, a 2-mm diffuse disc protrusion compressing the fecal sac at L4 five along with spinal canal stenosis. There is disc material and facet hypertrophy causing bilateral neural foraminal stenosis encroaching the left and right L4 exiting nerve roots right greater than left. Px7.

On October 29, 2015, Dr. Chunduri changed Petitioner' work status to no carrying/lifting more than 20 pounds, no pulling/pushing more than 20 pounds, no bending/squatting, no climbing/ladders, no kneeling/crawling and no stairs. Px3. Dr. Chunduri indicated that sedentary work was acceptable. Petitioner said he was able to continue working for Uber and American Parking as he did before his work accident. Petitioner said they were essentially sedentary jobs and that he needed the income.

On November 5, 2015, Petitioner received a left transforaminal epidural steroid injection at L4 and L5 from Dr. Chunduri at ION. Px3. Petitioner reported a 30% improvement from the injection to Dr. Chunduri at a follow-up appointment on November 19, 2015. A repeat injection was ordered.

On December 3, 2015, Petitioner received his second left L4 and L5 transforaminal epidural steroid injection from Dr. Chunduri, however, this injection failed to have any significant improvement. Px3. Overall, the two injections resulted in about a 30-40% improvement. On December 8, 2015, Petitioner underwent nerve conduction studies and an EMG of his lower extremities from Dr. Syed Naveed at Chicago Neuro Diagnostics. Px1. The findings of the EMG nerve conduction studies indicated moderate to severe bilateral L5-S1 radiculopathy.

At a follow-up appointment with Dr. Chunduri on January 14, 2016, Petitioner' diagnoses included lumbar spondylosis with left radiculitis, lumbar contusion and mild globulinuria. On January 21, 2016, Petitioner received his third left transforaminal epidural steroid injection at L5 and S1, from Dr. Chunduri, resulting in a temporary 30% improvement, but the pain returned a few days later.

On February 4, 2016, Petitioner indicated he was experiencing issues with urinary urgency and difficulty with sexual activity, in addition to the constant pain in his lower back with numbness and tingling radiating down his left leg. Px3. Dr. Chunduri opined that the October 2, 2015 work accident was the source of these issues. Dr. Chunduri believed Petitioner was suffering from permanent nerve damage. Petitioner eventually completed physical therapy at Northside Medical Center on March 2, 2016.

As of March 3, 2016, Dr. Chunduri continued to report that Petitioner experienced significant pain and paresthesia due to L5-S1 radiculopathy, and maintains his diagnoses of lumbar spondylosis with left radiculitis, lumbar contusion, and myoglobinuria (blood in urine).

Petitioner' prescriptions consisted of gabapentin, tramadol, and Viagra, and Dr. Chunduri recommended that Petitioner seek a consultation for spine surgery, and a psyche consultation for his depression, which was becoming more prominent. Dr. Chunduri indicated that Petitioner' depression arose from his dissatisfaction with his circumstances, such as his urinary and sexual dysfunction and his constant pain.

On March 4, 2016, Petitioner was referred by Dr. Chunduri to see Dr. Jeffrey Wingate at ION, for an initial evaluation of his low back pain with radicular leg pain, and trouble walking with both legs. Petitioner

~~reported to Dr. Wingate that prior to his work injury on October 2, 2015, he had no related injuries to the back~~ and had an excellent work history with Morton Salt Company. In addition to severe, constant low back pain, heaviness and numbness in the left leg, and difficulty with walking, Petitioner continued to have red-tinged urine, urinary urgency and, for the first time in his life, sexual dysfunction. Dr. Wingate diagnosed Petitioner with transitional lumbosacral segmentation, retrolisthesis at L4-L5, and possible congenital pseudarthrosis at L5-S1 or L5-L6. Dr. Wingate's treatment plan consisted of Petitioner undergoing a full set of x-rays to document and diagnose the exact nature of his anatomy at the lumbosacral junction, evaluation by a urologist, new upright MRI scans with flexion and extension views to see the true dynamic nature of the bulging retrolisthesis disk at the L4-L5 motion segment, and separately evaluating Petitioner' discogenic pain, as well as facetogenic pain that could be greatly helped by facet rhizotomies.

On March 22, 2016, Petitioner had his first appointment with Dr. Neeraj Jain at ION. Dr. Jain performed a provocative diagnostic lumbar discography to definitively demonstrate the pain generator. The lumbar discography revealed discogenic pain at L5-S1 with controlled levels at L3 and L4 and a transitional S1-S2 intervertebral disk space. That same day, following the discography, Petitioner underwent a CT scan at Lakeshore Open MRI which revealed a 3-4mm broad-based subligamentous posterior disk herniated at L5-S1 with mild nucleus pulposus noted to indent the thecal sac with spinal stenosis and mild bilateral neuroforaminal narrowing, probably Dallas classification type III, along with a rudimentary-type transitional S1-S2 intervertebral disk. Petitioner followed up with Dr. Wingate on March 31, 2016, and indicated that Petitioner is probably headed towards surgical management.

On April 7, 2016, Petitioner met with Dr. Chunduri, who started Petitioner on Norco, for better pain control. On April 9, 2016, Petitioner went to Upright MRI for both upright and recumbent MRI scans of the lumbar spine. Px9. Impression was degenerative lumbar spondylosis; large renal cyst on the right; at L4-5, a broad-based disc bulge that abuts the fecal sac and at L5-S1, mild bilateral foraminal stenosis due to broad-based predominately central disc bulge with osteophyte and facet joint hypertrophy.

Two months later, Petitioner followed up with Dr. Wingate on June 8, 2016 to discuss the results of the radiographic tests. Dr. Wingate reports that Petitioner continues to be extremely debilitated in terms of his day-to-day activities. Petitioner reported he was unable to stand, walk around or enjoy playing with his children. Dr. Wingate opined that the injuries he sustained from his work-related accident of October 2, 2015 are causally related to his ongoing need for pain management services, epidural steroid injections, and transforaminal epidural injections, and that Petitioner has failed all available conservative treatments regarding the discogenic pain and the facet arthropathy at the transitional S1-S2 segment. Dr. Wingate recommended spinal fusion of the L5-S1 and S1-S2 segments.

On August 24, 2016, Dr. Wingate wrote Petitioner a Durable Medical Equipment (DME) prescription and letter of medical necessity for an EMS/STIM unit, a lumbar orthosis, and a lumbar-sacral orthosis. Px2. On September 23, 2016, Petitioner underwent urological consultation for his hematuria with Dr. Michael McGuire at NorthShore University HealthSystem. Px4. Dr. McGuire ordered a CT urogram with and without contrast, which showed no obvious cause for his hematuria, and an OP urine dipstick, which was negative. On October 21, 2016, Petitioner returned to Dr. McGuire, and the cause for the hematuria was not found.

Nine months after last seeing Dr. Wingate, on March 17, 2017, Petitioner followed up with the doctor. Px3. Dr. Wingate reports that Petitioner continues to complain of severe, unremitting back pain and bilateral leg pain, both legs and feet are painful (left worse than right), that he walks with an obvious limp, and he cannot sit or stand comfortably. Dr. Wingate also noted that Petitioner's unremitting pain is a result of the ongoing

discogenic syndrome in his lumbar spine. Dr. Wingate recommends lower lumbosacral spinal reconstruction, as this is more likely to lessen his impairment and long-term disability. As of May 10, 2017, Dr. Wingate continues to keep Petitioner off work and still wants to perform surgery.

At trial, Petitioner expressed an interest in pursuing the recommendations of Dr. Wingate. Petitioner said he continues to experience low back pain and symptoms.

CONCLUSION

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

The Arbitrator incorporates the foregoing findings of fact as though fully set forth herein. The Arbitrator has carefully considered the record as a whole and concludes that Petitioner has proven by a preponderance of the evidence that his current condition of ill-being with respect to the lumbar spine is causally related to the work accident. At the time of the hearing, Petitioner has conditions of ill-being to the following body parts: low back and bilateral lower extremities and blood in the urine. Petitioner had no back or bilateral lower extremity problems or urinary problems before the October 2, 2015 work-related injury.

The Arbitrator assigns less weight to Respondent's doctor, Dr. Alexander J. Ghanayem. The doctor's report is a short review of Petitioner's history of accident, treatment and review of the record. In addition, the doctor gave very little useful information regarding his medical opinion on the EMG report and CT discogram. Dr. Ghanayem's opinion was that Petitioner had no herniations or compressive pathology on imaging but this opinion failed to consider later imaging which showed retrolisthesis, compression on the L4 exiting nerve root and annular tear. The doctor also did not consider these subsequent studies along with Petitioner's medical record as a whole.

Instead, the Arbitrator adopts the medical opinions of Drs. Chunduri and Wingate over those of Dr. Ghanayem, as Petitioner treated with these physicians for longer and they are in a much better position to assess, evaluate and make recommendations. Petitioner credibly and consistently explained his mechanism of injury to his providers, his symptoms, difficulties and impairments as well as complaints of pain. These complaints and symptoms appear to be corroborated by objective examinations and by objective testing including but not limited to x-ray, multiple MRI studies, EMG and discography. Further, Dr. Wingate opines a causal relationship between Petitioner's work accident, his need for treatment and his condition of ill-being.

Petitioner' physical therapist, Thomas Dambrogio, D.C. of Northside Medical Center, states that Petitioner' diagnoses of sprain of ligaments of lumbar spine and contusion of lower back and pelvis are causally related to the work-related incident on October 2, 2015. Similarly, it is Dr. Chunduri's opinion, based on a reasonable degree of medical certainty, the symptoms and diagnoses he reports in his initial consultation on October 8, 2015 are causally-related to the October 2, 2015 work injury.

Finally, Petitioner' several MRI scans were reviewed by separate radiologists who all came to similar conclusions: Petitioner's MRI on October 14, 2015, was reviewed by radiologists Dr. Amjad Safvi, who saw, among other things, a 2mm disc herniation; radiologist Dr. George Kuritza performed the CT scan of Petitioner lumbar spine following his lumbar discography on March 22, 2016, and he determined there to be a 3-4mm disk herniation; Petitioner' last MRI scans on April 9, 2016 were performed by radiologist Dr. Amjad Safvi again, who maintained his impression of disk herniations in Petitioner' lumbar spine.

~~Thus, the preponderance of the evidence shows that Petitioner's current condition of ill-being relative to~~ his low back is causally related to his work accident.

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

The Arbitrator incorporates the foregoing findings of fact and conclusions of law as though fully set forth herein. The Arbitrator finds that Petitioner has proven by a preponderance of the evidence that his treatment to date has been reasonable and necessary. The Arbitrator finds that the outstanding balances submitted by Petitioner for G&U Orthopedics, Illinois Orthopedic Network, NorthShore University, Rush University, Upright MRI and Metro Anesthesia are all related to the reasonable and necessary treatment and services in connection with this claim. The Arbitrator finds that Respondent has not yet paid for all reasonable and necessary medical care.

Respondent shall pay, according to the Fee Schedule, G&U Orthopedics $3,585.19 outstanding bill; Illinois Orthopedic Network's $402.25 outstanding bill; NorthShore University HealthSystem's $4,779.40 outstanding bill; Rush University Medical Center's $3,080.22 outstanding bill; Upright MRI $6,000.00 outstanding bill and Metro Anesthesia Consultants' $2,032.78 outstanding medical bill.

ISSUE (L) What temporary benefits are in dispute?

The Arbitrator incorporates the foregoing findings of fact and conclusions of law as though fully set forth herein. The Arbitrator finds that Petitioner has proven by a preponderance of the evidence that he is entitled to temporary total disability benefits for the time he has been off work as a result of his work-related injuries. Petitioner seeks TTD from October 7, 2015 through the date of arbitration hearing, or June 20, 2017, for a total of 88-6/7th weeks.

Petitioner has not worked for Morton Salt Company since October 7, 2015. Petitioner has been taken off work by his treating physicians and allowed to and can do sedentary work. His Morton Salt position involved heavy lifting and much strenuous work. Despite this, Petitioner has continued employment elsewhere, Uber and American Parking, without exceeding the limitations imposed by his injuries or the limits advised by his doctors. Petitioner has done some driving for Uber and has maintained a managing position at American Parking, a valet company. Petitioner has elected to seek TTD benefits without seeking TPD benefits for the difference in any pay between his pre-injury earnings and any earnings from Uber and/or American Parking. The Arbitrator declines to award TTD where Petitioner admitted he worked elsewhere inasmuch as Petitioner was able to and did in fact work. Therefore, Petitioner's request for TTD benefits is denied.

ISSUE (K), (O) Prospective Medical Treatment

The Arbitrator incorporates the foregoing findings of fact and conclusions of law as though fully set forth herein. The Arbitrator finds that Petitioner has proven by a preponderance of the evidence that his lumbar condition has not yet stabilized or reached maximum medical improvement and that he is entitled to further prospective medical treatment.

By June 8, 2016, Petitioner had failed all available conservative treatments: chiropractic treatment/physical therapy, three injections, multiple x-rays/CT scans/ MRI scans, an EMG, and a discography, all of which have failed to resolve his symptoms. Because all available conservative treatments have been exhausted, Dr. Wingate evaluated Petitioner as a great candidate for surgery and recommends spinal fusion of L5-S1 and S1-S2, and lower lumbosacral spinal reconstruction. Consequently, the Arbitrator finds that Petitioner has exhausted all available conservative treatment and is entitled to prospective medical care, including, but not limited to lumbar surgery. Respondent shall pay for and approve the recommended surgical treatment of Dr. Wingate, including any and all incidental care thereto.

Signature of Arbitrator

8/29/2017
Date

STATE OF ILLINOIS)
) ss.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

ANDRZEJ PAWINSKI,)
)
Petitioner,) 13 WC 41281
)
vs.)
) 19IWCC0303
AT&T,)
)
Respondent.)

DECISION AND OPINION ON REMAND

This matter comes before the Commission on remand from the Circuit Court of Cook County, which in its Opinion and Order dated August 31, 2017, ordered:

> The Commission is ordered to provide the necessary basis for its PPD benefits' determination relative to the Plaintiff's left leg and right shoulder.

As background, this case involves Petitioner, a cable splicer for AT&T, who was attacked by an unknown assailant wielding an unknown object. Petitioner was knocked unconscious and discovered lying on the ground by a co-worker. The Arbitrator awarded permanent partial disability in the amount of 35% loss of use of the left leg as provided in §8(e) of the Act, 18% loss of the person as a whole for injuries to the right shoulder area of the body as provided in §8(d)2 of the Act, and 10% loss of the person as a whole for psychological injuries as provided in §8(d)2 of the Act. On September 29, 2016, the Commission modified the Arbitrator's decision, reducing the awards for the left leg to 22.5% loss of use of the left leg and 12.5% loss of the person as a whole for injuries to the right shoulder. The Commission affirmed the award for psychological injuries. On remand, the Commission makes the following clarifications to support its conclusion, pursuant to the Circuit Court order.

We understand Respondent's argument that Dr. Karlsson's A.M.A. impairment rating of 6% of the upper extremity equating to 4% loss of person as a whole, and 0% impairment rating for the left knee was not given an assignment of weight by the Arbitrator. However, we do not agree with the great weight that Respondent wants placed on this rating because to do so would be to disregard the other factors and give them little, if any, weight at all. The Commission gives

the impairment ratings provided by Dr. Karlsson in this case some weight. Section 8.1b of the Act requires the consideration of five factors in determining permanent partial disability:

1) Reported level of impairment;
2) Occupation;
3) Age at time of injury;
4) Future earning capacity;
5) Evidence of disability corroborated by treating medical records.

Section 8.1b also states, "No single factor shall be the sole determinant of disability. In determining the level of disability, the relevance and weight of any factors used in addition to the level of impairment as reported by the physician must be explained in a written order." We initially note that the term "impairment" in relation to the A.M.A. rating is not synonymous with the term "disability" as it relates to the ultimate permanent partial disability award.

Regarding the second factor, we find that Petitioner was employed in a physically demanding occupation. He was a cable slicer at the time he was attacked and knocked unconscious. We find that Petitioner's upper extremity impairment combined with a lower extremity impairment is more significant for a person with Petitioner's heavier job duties than someone with a lighter-duty job and that this supports a finding of increased disability compared to the impairment rating. Following the accident, Petitioner began working full duty as a line man. By Petitioner's description, this position may be even more physically demanding than the position he was working at the time of injury. (T. 12) The Commission gives this factor greater weight.

Regarding the third factor, we find that Petitioner was only 30 years old and will live longer with his disability than someone who is older. However, given that Petitioner was only 30 years old at the time of injury, his potential for complete recovery is also greater than someone who is older. The Commission gives this factor minimal weight.

Regarding future earning capacity, Petitioner testified that he currently works as a line man with the same rate of pay as a cable splicer. Although Petitioner testified as to some problems raising his right arm, it does not seem to have impeded his ability to perform his current job or require additional interventional care. Petitioner's knee problem had resolved, and Petitioner was at maximum medical improvement with no restrictions and there was no testimony that his knee impacted his ability to perform his current job. Additionally, Petitioner did not offer any evidence as to the impact of his injuries on his future earning capacity. We find that Petitioner's future earning capacity has been minimally diminished, if at all, so we only give this factor minimal weight.

As for the fifth factor, evidence of disability corroborated by treating medical records, Petitioner credibly testified as to his ongoing symptoms and his testimony was corroborated by the medical records. Following his injury, Petitioner presented to his doctor on July 16, 2012, with multiple complaints including right shoulder pain, numbness and tingling in his hand, and post-traumatic stress disorder. At that time, Petitioner presented with symptoms consistent with a SLAP tear of his right shoulder and potential shoulder dislocation. Petitioner had full range of motion of both lower extremities. Petitioner underwent surgery to repair his right shoulder injuries in August, 2012. However, in December, 2012, Petitioner presented to his doctor with complaints of left knee pain which were diagnosed as prepatellar bursitis related to the work injury. Petitioner was released at maximum medical improvement with respect to the shoulder in January, 2013. However, his left leg MRI showed a possible ACL tear that appeared chronic in nature. There was no evidence

 19IWCC0303

of a bone bruise pattern to suggest he suffered an acute injury at the time of his work accident. Petitioner underwent left knee surgery in February, 2013, and was released at maximum medical improvement with no restrictions in May, 2013. Petitioner appeared to be a compliant patient. Although he was released to full-duty, Petitioner complains of some residual issues to his shoulder and knee. Petitioner is off all medications and will take over the counter aspirin, as needed, for pain. The Commission gives this factor some weight.

In reviewing the totality of the evidence, the Commission finds that the Arbitrator issued an award for permanency regarding the left knee and right shoulder in amounts higher than supported by the evidence. In regard to the right shoulder injury, based on the testimony and medical records, the Commission awards 12.5% loss of the person as a whole on the basis that following his right shoulder surgical repair surgery in August of 2012, Petitioner was able to return to work full duty in a more demanding position than that previously occupied. Although Petitioner will occasionally take over the counter medications, he exhibits full range of motion and full strength in his shoulder. (Px4 1/17/13 note) As to the left knee, shortly after the accident, Petitioner had full range of motion in his bilateral lower extremities. It was not until December of 2012 that Petitioner presented with left knee pain. Petitioner's prepatellar bursitis was related to the work injury, but the possible ACL tear was not acute and appeared chronic in nature on imaging. Petitioner underwent left knee surgery in February of 2013 and made a full recovery as to his left knee. (Px4 5/13/13 note) There was evidence of only minimal left knee complaints for which he will take over the counter aspirin and use ice.

Based on the above, when considering the five factors, the Commission modifies the Arbitrator's Decision, to decrease Petitioner's partial disability award from 18% loss of use of the person as a whole as a result of his right shoulder, to 12.5% loss of use of the person as a whole as a result of his right shoulder injury; 35% loss of use of the left leg to 22.5% loss of use of the left leg, and affirms the award for 10% loss of use of the person as a result of the psychological injuries pursuant to Sections 8(d)2 and 8(e) of the Act. Although Petitioner suffered multiple, significant injuries, Petitioner has essentially recovered from his physical injuries and has been working a physically demanding, full-duty job since 2013.

All else is affirmed and adopted.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $712.55 per week for a period of 48.375 weeks, as provided in §8(e)(12) of the Act, for the reason that the injuries sustained caused the 22.5% loss of use of the left leg.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $712.55 per week for a period of 62.5 weeks, as provided in §8(d)(2) of the Act, for the reason that the injuries sustained to the right shoulder caused the 12.5% loss of the person as a whole.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $712.55 per week for a period of 50 weeks, as provided in §8(d)(2) of the Act, for the reason that the injuries sustained caused the 10% loss of the person as a whole for psychological injuries.

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

19IWCC0303

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: JUN 18 2019

MEP/dmm
O: 61119
49

Maria E. Portela

Thomas J. Tyrrell

Deborah L Simpson

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

JOANNE FABRE-AUSTIN,
Petitioner,

vs. NO: 12 WC 29360

AMERICAN AIRLINES,
Respondent,

19IWCC0304

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of causation, medical expenses, prospective medical treatment, temporary total disability and permanent partial disability, and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof, but makes clerical corrections to the Decision as outlined below.

The Commission hereby notes and corrects clerical errors in the Decision. On page 3, paragraph 5 of the Decision, the date of the addendum to the medical record is corrected from October 27, 2014 to January 29, 2015. On pages 1 and 7 of the Decision, the duration of temporary total disability is corrected to begin on September 1, 2015, instead of September 17, 2015. On page 6, the first sentence of paragraph 3 the Decision is hereby corrected to read August 26, 2014, instead of November 15, 2013.

All else is affirmed and adopted.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed April 28, 2015 is hereby affirmed and adopted.

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

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

19IWCC0304

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: JUN 18 2019

Maria E. Portela

Thomas J. Tyrrell

L. Elizabeth Coppoletti

MEP/dmm
O:052119
49

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

FABRE-AUSTIN, JOANIE
Employee/Petitioner

Case# **12WC029360**

AMERICAN AIRLINES
Employer/Respondent

19IWCC0304

On 4/28/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.95% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

4128 RUBENS AND KRESS
FRANK D KRESS
134 N LASALLE ST SUITE 444
CHICAGO, IL 60602

1109 GAROFALO SCHREIBER HART ETAL
DANIEL GRANT
55 W WACKER DR 10TH FL
CHICAGO, IL 60601

STATE OF ILLINOIS)

)SS.

COUNTY OF **Cook**)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Joanie Fabre-Ausitn
Employee/Petitioner

v.

American Airlines
Employer/Respondent

Case # **12** WC **29360**

Consolidated cases: ____

19IWCC0304

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Frank Soto**, Arbitrator of the Commission, in the city of **Chicago**, on **March 16, 2017**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **5/7/2012**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**50,541.92**; the average weekly wage was $**971.92**.

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

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

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

Respondent shall be given a credit of $**118,754.07** for TTD, $**0** for TPD, $**0** for maintenance, and $**0** for other benefits, for a total credit of $**118,754.07**.

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 **$647.95** per week for **183 2/7** weeks, commencing **7/7/2012 through 7/15/2015 and 9/1/2015 through 2/24/2016**, as provided in Section 8(b) of the Act.

Respondent shall be given a credit of **$118,754.07** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for non-occupational indemnity disability benefits, for a total credit of **$118,754.07**.

Respondent shall pay Petitioner permanent partial disability benefits of **$583.18** per week for **150** weeks, because the injuries sustained caused the **30%** loss of the person as a whole, as provided in Section 8(d)2 of the Act.

Respondent shall pay Petitioner compensation that has accrued from May 7, 2012 through March 16, 2017, and shall pay the remainder of the award, if any, in weekly payments.

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

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

Signature of Arbitrator

4/28/2017
Date

APR 2 8 2017

FINDINGS OF FACT

The parties stipulated that on May 7, 2012, Petitioner, Joanie Fabre-Austin, sustained an accident that arose out of and in the course of her employment with Respondent, American Airlines. The parties further stipulated Petitioner's conditions of bilateral rotator cuff tears were causally related to Petitioner's work accident of May 7, 2012 and Petitioner was paid temporary total disability (TTD) benefits of $647.95 per week from July 7, 2012 through July 17, 2015 and from September 17, 2015 through February 24, 2016. The issues in dispute involve whether or not Petitioner's work accident caused or aggravated a condition involving Petitioner's cervical spine and Respondent's responsibility to pay for medical care and TTD related to the Petitioner's cervical spine condition.

The Petitioner, who was 52 years old at the time of the accident, was a ramp crew chief for Respondent. Petitioner was responsible for the loading and unloading aircraft including the replenishing the water on outbound aircraft. On May 7, 2012, Petitioner was refilling an aircraft water supply when she sustained a work injury while attempting to remove a water hose from the plane. Petitioner testified that as she injured while pulling the water hose and she felt immediate pain in her right shoulder and her back.

On May 11, 2012, Petitioner reported to CareNow, a company that provides healthcare services for Respondent. On June 27, 2012, Petitioner was referred to Dr. Levy of Texas Sports Medicine and Orthopedic Group.

On July 5, 2012, Petitioner was examined by Dr. Levy. The history provided to Dr. Levy indicates Petitioner injured both shoulders but her right shoulder was worse than her left. Petitioner reported she had been experiencing symptoms in both shoulders for about a year. Dr. Levy determined Petitioner had sustained right shoulder impingement syndrome and a supraspinatus tear. Dr. Levy performed a neurologic examination which found normal reflexes, no motor or sensory deficits and Petitioner's light touch was intact and Petitioner's neck was found to be normal. Dr. Levy recommended surgery to repair the right shoulder. (PX 1).

On September 26, 2012, Dr. Levy performed arthroscopic surgery consisting of glenohumeral debridement, synovectomy, subacromial decompression and bursectomy and repair of the right rotator cuff. The tear was found to be moderate to high-grade partial-thickness tear of the distal supraspinatus with about 60% avulsed from the articular surface. (PX 1)

On October 2, 2012, Petitioner returned to Dr. Levy. At that time Dr. Levy found Petitioner was not suffering from any physical problems from the surgery and Petitioner was not experiencing any numbness or tingling. On October 18, 2012, Petitioner returned to Dr. Levy. Petitioner was fund to have normal reflexes and gait without any motor or sensory deficits and she her light touch was intact. Dr. Levy's exam also found that Petitioner was not suffering any numbness or tingling. (PX 1)

On December 6, 2012, Dr. Levy re-evaluated Petitioner and felt it was appropriate for her to begin physical therapy. Petitioner underwent physical therapy at Source One Rehabilitation in Plano, Texas (PX. 4).

On February 21, 2013, Dr. Levy recommended Petitioner undergo a functional capacity examination which occurred on March 5, 2013. During the FCE, Petitioner consistently complained of left shoulder pain during the assessment. The FCE report noted that Petitioner's right shoulder was the focus of the treatment and the left shoulder because the left shoulder was not treated. The FCE report recommended work conditioning. (PX 4) Petitioner began work conditioning on March 6, 2013. (PX 4).

On March 20, 2013, Petitioner underwent a second functional capacity evaluation at Source One Rehabilitation. The FCE report shows that Petitioner demonstrated a lack of effort with testing involving her left shoulder and she was unable to register a valid reading for most of the static NIOSH lifts. The FCE recommended a health and behavioral assessment to rule out symptom magnification, secondary gain and or psychological impeding Petitioner's progress. (PX 4).

On April 16, 2013, Petitioner returned to Dr. Levy for a follow up examination. At that time, Dr. Levy requested an MRI of the left shoulder and proscribed a health and behavioral assessment.

Petitioner had a left shoulder MRI at Baylor Healthcare which showed a full thickness tear of the left rotator cuff. (PX 1) Petitioner returned to Dr. Levy on September 10, 2013. At that time, Dr. Levy recommended surgery. Petitioner had arthroscopic surgery on November 13, 2013 which consisted of glenohumeral debridement, glenohumeral synovectomy, subacromial decompression and bursectomy, distal clavicle resection, and rotator cuff repair. A full-thickness tear involving the supraspinatus and infraspinatus tendon was found and Petitioner also needed a complete synovectomy and 1 cm resection of the distal clavicle bone.

On November 15, 2013, Petitioner followed up with Dr. Levy. The medical records show that Petitioner was not experiencing numbness or tingling at that time. Petitioner returned to Dr. Levy on January 6, 2014. At that time, Dr. Levy records show that he was pleased with Petitioner's progress. During the neurologic portion of his examination, Dr. Levy found Petitioner has normal reflexes and balance and she was not experiencing any motor of sensory deficits and her light touch was intact. Dr. Levy made the same neurologic findings after examining Petitioner on February 10, 2014, March 25, 2014, April 22, 2014 and June 10, 2014. (PX 1)

On August 26, 2014, Dr. Levy re-evaluated Petitioner. At that time, Petitioner complained of having neck pain, numbness and tingling. Dr. Levy recommended a MRI of the cervical spine. On October 27, 2014, Petitioner underwent a MRI which showed mild loss of vertebral body height at C2 through C6, straightening of the cervical spine with loss of normal expected cervical lordosis. The radiologist's impression of the MRI was multilevel degenerative changes of the cervical spine. (PX 1)

On October 30, 2014, Dr. Levy recommended epidural steroid injections and referred Petitioner to Dr. Kevin James of Advanced Spine and Orthopedics. On December 2, 2014, Petitioner was examined by Dr. James. At that time, Petitioner said she had been experiencing frequent neck pain for two years. Petitioner also stated her left wrist was swollen and felt like it was placed in dry ice. (PX 2) Dr. James reviewed the October 27, 2014 MRI and found that the MRI showed Petitioner had significant disc herniations at C3-4 and C4-C5 which deformed the anterior surface of the spinal cord. Dr. James further found Petitioner's work related injury caused neck pain that radiated down the shoulders and into the arms consistent with radiculopathy. Dr. James recommended physical therapy and epidural steroid injections.

On December 16, 2014, Petitioner returned to Dr. James. At that time, Petitioner told Dr. James she had pain for the past two years that begins at the base of her neck and radiates to the front lobe of her head. Dr. James diagnosed Petitioner as sustaining herniated discs at C3-C4 and C4-C5, foraminal stenosis at C5-C and C6-C7, occipital headaches, and cervical radiculopathy progressively worsening with numbness and weakness.

Dr. James recommended another functional capacity evaluation, physical therapy, epidural steroid injections and took Petitioner off of work. Dr. James also requested a different radiologist review the October 27, 2014 MRI. (PX 2)

Petitioner returned to Dr. James on January 29, 2015. The medical records indicate Petitioner told Dr. James she has an IME coming up and she needed information to help her with her case. The medical records show Petitioner was complained of neck pain, left occipital headache pain and a burning pain in her left arm. Petitioner said the burning pain had existed since her surgery. (PX 2)

On April 6, 2015, attended a Section 12 examination with Dr. Kern Singh, associate Professor, Department of Orthopaedic Surgery at rush University Medical Center. Petitioner told Dr. Singh she had been experiencing neck pain. Petitioner rated the pain at a level of 10 out of 10. Petitioner denied having any arm pain. Petitioner said her pain increases with sitting, bending forward and it decreases with cold. Dr. Singh found Petitioner was able to sit, stand and walk for 30 minutes at a time. (RX 1) Dr. Singh further found Petitioner was self-limits her range of motion to 5 degrees of flexion, extension and axial rotation and had a positive Waddell finding. Dr. Singh said the monofilament testing of both upper extremities was symmetric and equal without any sensory loss.

Dr. Singh reviewed the October 27, 2014 MRI films. Dr. Singh said the MRI showed diffused cervical spondylosis extending from C2 to C7 with minimal evidence of central or foraminal stenosis. Dr. Singh determined that the Petitioner had cervical spondylosis that was pre-existing and Petitioner may have had a soft tissue muscular strain that resolved but Petitioner could return to work full duty without restrictions. (RX 1)

On October 27, 2014, Dr. James added an addendum to his medical records showing he secured a re-reading of the October 27, 2014 MRI. The new reading of the MRI showed a 4 mm herniation at C3-4 and C4-5 that moderately contacted the thecal sack and spinal cord.

On November 30, 2015, Petitioner attended physical therapy at Riata Therapy Specialists of Southlake. At that time, Petitioner provided a history of intermittent neck pain that was not present every day. Petitioner said her neck pain was exacerbated by certain cervical motions and UE exercises. Petitioner said she has similar symptoms in her shoulders which radiates to her head. Petitioner denied having symptoms of radiculopathy. (PX 5).

Petitioner attended physical therapy from November 30, 2015 through March 14, 2016. Each time Petitioner attended physical therapy she completed a questionnaire. On the questionnaire Petitioner stated she could lift heavy weights and she was able perform recreational activities and she could perform her usual work activities. On February 15, 2016, Petitioner was re-evaluated at Riata Therapy Specialists. At that time, Petitioner said she was experiencing intermittent neck pain and she had improved overall. Petitioner reporting having frequent headaches she thought was due to her sinuses.

On March 14, 2016, Petitioner retuned to Riata Therapy Specialist. At that time, Petitioner said her neck pain had diminished but she still was experiencing pain in her shoulders at the anterior GH joint. Petitioner said she continues to experience headaches on the left side which occur when the weather is cold and rainy. Petitioner denied experiencing numbness or tingling. (PX 5)

On March 15, 2016, Petitioner returned to Dr. James. At that time, Petitioner said she was experiencing mild cervical pain. Petitioner said she has been experiencing cervical pain for an unknown period of time. Petitioner further said the cervical pain was the result of an unknown injury. Dr. James diagnosed Petitioner as having C3-C7 herniated nucleus pulposus

with radiculopathy and neck pain with radiculopathy. Dr. James medical records states that Petitioner does not wish to have cervical surgery.

On May 10, 2016, Petitioner was reexamined by Dr. James. Petitioner said she was going back to work because workers comp was stopping her salary compensation. Petitioner told Dr. James she was having a work comp hearing on May 18th for reconsideration as to whether the cervical spine was part of her compensable on-the-job injury. Petitioner reported having cervical pain at a pain level of 7 out of 10 and the pain started as the result of an unknown injury. Petitioner reported that her neck pain was radiating to the left side of her neck and shoulders. (PX 2)

On January 27, 2016, Dr. James was deposed. Dr. James testified he believes the term herniation to be interchangeable with other terms such as bulge, protrusion or extrusion. (PX 3, pg. 7) Dr. James said the October 27, 2014 MRI showed significant herniations which were deforming the interior surface of the spinal cord. The deformation, he said, was worse at C5-5. Dr. James also testified that Petitioner sustained herniations at C5-6 and C6-7 with complete loss of disc space height at those levels which was caused some foraminal stenosis.

Dr. James opined the disc herniations were secondary to Petitioner's work-related injury. Dr. James testified the major basis for his opinion was that Petitioner did not have symptoms prior to her work accident and she had been working prior to her work accident and she did not have any prior injuries. (PX 3, pg 15) On cross-examination, Dr. James testified he did not review any of Petitioner's medical records or physical therapy notes prior to December 2, 2014 other than the MRI. Dr. James testified his opinion that Petitioner's cervical radiculopathy was progressively worsening with numbness and weakness was based upon his interview with Petitioner. (PX 3, pg 21)

On December 7, 2016, Dr. Singh was deposed. Dr. Singh testified he reviewed the October 27, 2014 MRI and found that Petitioner had degenerative changes which extended from C2 to C7 had caused the changes in the discs and the facet joint. Dr. Singh testified the MRI did not show evidence of any nerve root compression or spinal cord compression. (RX 3, pg. 10) Dr. Singh testified Petitioner did not have any disc herniations rather Petitioner had degenerative disk osteophytes or bulges that had calcified. Dr. Singh agreed with Dr. James that the MRI showed disk protrusions and calcifications that had contacted the thecal sac but, he said, the thecal sac just holds the fluid and Petitioner did not have any herniations compressing on the spinal cord. Dr. Singh testified his opinion were also consistent with the radiologist's report which found disk osteophyte that had just touched the sac and no spinal cord compression. (PX 3, pg.11)

Dr. Singh testified if Petitioner had spinal cord compression, she would have had cervical myelopathy and Petitioner would have had C5 nerve root involvement. If Petitioner had C5 nerve root involvement, she should have had certain symptoms for findings such as deltoid weakness, inability to raise her arms up, biceps weakness, loss of her biceps reflex, and loss of sensation into her forearm. Dr. Singh testified Petitioner did not have any of those symptoms or findings. (PX 3, pg. 12-13) Dr. Singh further testified that if Petitioner had spinal cord compression, she should have had a positive Hoffmann sign and inverted brachioradialis reflexes. Petitioner had negative findings for these.

Dr. Singh testified one could not have a traumatic disk herniation at three, four, five levels, as alleged by Dr. James, because the energy would have imparted to a particular level or two and that energy would have cause a vertebral body to fracture and, in that situation, you

would not see calcifications. Dr. Singh said Petitioner's disk protrusions were very symmetric and equal at every level which shows a systemic ongoing process. (RX 3, pg. 14)

Dr. Singh opined Petitioner's neck complaints were not causally related to her work accident. Dr. Sign testified the MRI showed degenerative changes with no coexisting or concomitant neurological changes and Petitioner's neck pain could not be objectified either based upon her imaging studies or examination. Dr. Singh testified had Petitioner experienced two years of spinal cord compression, she should have symptoms or findings of weakness in her arm in the C5 distribution, biceps weakness, sensation loss, spinal cord reflex changes, Hoffmann sign, inverted brachioradialis reflex or dermatomal distribution in her arms. Dr. Singh testified Petitioner had none of these symptoms or findings. Dr. Singh testified that Petitioner did not have any of thy symptoms which correlate with an existing spinal cord compression. (PX 3, pg. 16)

Respondent submitted a Utilization Review into evidence. The UR did not recommend cervical fusion surgery. (RX 2) Because Petitioner testified she was not seeking surgery for her neck the Arbitrator will not comment further on the UR findings.

Petitioner testified that she is currently earning more money for Respondent than she was at time of her injury. Petitioner testified that she has pin but if she takes Lyrica she feels ok and if she lifts heavy things she feels pain. She testified of having difficulties lifting a bag weighing 70 pounds the other day and she experiences pain in cold weather. Petitioner testified she avoids lifting really heavy things. On cross-examination, Petitioner acknowledged being released to work full duty and she does not have any restrictions regarding her shoulders. Petitioner does have restrictions regarding her neck.

Conclusions of Law

The Arbitrator adopts the above Findings of Fact in support of the Conclusions of Law set forth below.

To obtain compensation under the Act, Petitioner has the burden of proving, by a preponderance of the evidence, all of the elements of his claim (*O'Dette v. Industrial Commission*, 79 Ill.2d 249, 253 (1980)) including that the accidental injury both arose out of and occurred in the course of his employment (*Horath v. Industrial Commission*, 96 Ill 2d 349 (1983)) and that there is some causal relationship between his employment and his injury. *Caterpillar Tractor Co. v. Industrial Commission*, 129 Ill. 2d 52, 63 (1998). Decisions of an arbitrator shall be based exclusively on the evidence in the record of the proceeding and material that has been officially noticed. 820 ILCS 305/1.1(e).

WITH RESPECT TO ISSUE (F), IS THE PETITIONER'S PRESENT CONDITION OF ILL-BEING CAUSALLY RELATED TO THE INJURY, THE ARBITRATOR FINDS AS FOLLOWS:

The parties further stipulated Petitioner's conditions of bilateral rotator cuff tears were causally related to Petitioner's work accident of May 7, 2012 and, therefore, the remaining issue

involves whether or not Petitioner sustained an aggravation or acceleration to her preexisting cervical condition that was causally related to her work injury of May 7, 2012.

In preexisting conditions cases, recovery will depend on the employee's ability to show that a work-related accidental injury aggravated or accelerated the preexisting disease such that the employee's current condition of ill-being can be said to have been casually-connected to the work-related injury and not simply the result of a normal degenerative process of the preexisting condition. *Caterpillar Tractor Co. v. Industrial Comm'n*, 92 Ill2d 30, 36-37.

The Arbitrator has carefully reviewed and considered all medical evidence along with all testimony. The Arbitrator finds that Petitioner has not proven by a preponderance of the credible evidence that her cervical condition was causally related to her work injury as set forth more fully below.

In so finding, the Arbitrator notes the long gap between Petitioner's work accident of May 7, 2012 and complaints of numbness and tingling which did not appear, in the medical records, until November 15, 2013. The Arbitrator further notes inconstancy of the complaints of numbness and tingling. On March 5, 2013, Petitioner had a FCE and she did not make any complaints of numbness and tingling. In November of 2015 and March of 2016, while attending therapy at Riata Therapy Specialist, Petitioner denied having symptoms of radiculopathy. (PX 5). The Arbitrator notes that Petitioner did not testify that she continues to experience numbness or tingling at the time of the trial.

The Arbitrator finds the testimony of Dr. Singh to be more persuasive than the testimony of Dr. James. Dr. Singh testified Petitioner's neck pain could not be objectified either upon MRI imaging or findings during various medical examinations. Dr. Singh testified had Petitioner experienced two years of spinal cord compression, she should have weakness in her arm in the C5 distribution, biceps weakness; sensation loss; spinal cord reflex changes, Hoffmann sign, inverted brachioradialis reflex or developed a dermatomal distribution in her arms. Dr. Singh testified Petitioner did not have any of thy symptoms which correlate with an existing spinal cord compression. (PX 3, pg. 16) The Arbitrator notes Dr. Levy's examinations did not reveal signs of nerve root compression. On January 6, 2014, Dr. Levy's neurologic examination found that Petitioner had normal reflexes and balance and she was not experiencing any motor of sensory deficits and her light touch was intact. Dr. Levy made these same neurologic findings on February 10, 2014, March 25, 2014, April 22, 2014 and June 10, 2014. (PX 1)

It was Dr. Singh's opinion Petitioner's neck complaints were not causally related to her work accident. Petitioner had degenerative changes in the disks and facet joints which extended from C2 to C7. Dr. Singh testified his opinions were consistent with the MRI findings because the MRI showed degenerative changes and no disk herniations, nerve root compression or spinal cord compression.

The Arbitrator does not find the opinions of Dr. James to be reliable. Dr. James testified he did not review Petitioner's medical records or physical therapy records from the accident date of May 7, 2012 through December of 2014, with the exception of an MRI. Dr. James also testified that his opinion of Petitioner had radicular symptoms and those symptoms had been present since the date of the accident were based upon the history provided by Petitioner. The Arbitrator finds Petitioner provided various medical providers inconstant dates regarding the onset of radicular symptoms, the nature of the cervical complaints and the origin of the symptoms

Based upon the findings of Dr. Singh, testimony of Petitioner and medical records, the Arbitrator concludes Petitioner did not suffer any nerve root compression or injury to her

cervical spine requiring medical treatment that was causally related to her work injury of May 7, 2012.

WITH RESPECT TO ISSUE (K), WHAT AMOUNT OF COMPENSATION IS DUE FOR TEMPORARY TOTAL DISABILITY, TEMPORARY PARTIAL DISABILITY AND/OR MAINTENANCE, THE ARBITRATOR FINDS AS FOLLOWS:

To be entitled to receive TTD the claimant must show not only that he or she did not work but also that he was unable to work. *Interstate Scaffolding, Inc. v. The Illinois Workers' Compensation Commission,* 236 Ill.2d 132, 923 N.E.2d 266, 337 Ill.Dec. 707 (2010). The parties stipulated that Petitioner was paid temporary total disability (TTD) benefits of $647.95 per week from July 7, 2012 through July 17, 2015 and from September 17, 2015 through February 24, 2016 representing 183 2/7 weeks. Petitioner is seeking additional TTD benefits while she was off of work due to her cervical spine condition from February 25, 2016 through April 30, 2016 for an additional 9 3/7 weeks.

As stated above, the Arbitrator found Petitioner's cervical spine condition was not causally related to her work injury of May 7, 2012 and, therefore, Petitioner has failed to prove by the preponderance of the evidence that she is entitled to receive TTD from February 25, 2016 through April 30, 2016. Petitioner was released from care for her shoulder conditions and was working for Respondent when she was taken off of work for her cervical spine condition. Therefore, Petitioner's claim for additional TTD benefits is denied.

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

Pursuant to §8.1b of the Act, the following criteria and factors must be weighed in determining the level of permanent partial disability for accidental injuries occurring on or after September 1, 2011:

(a) A physician licensed to practice medicine in all of its branches preparing a permanent partial disability impairment report shall report the level of impairment in writing. The report shall include an evaluation of medically defined and professionally appropriate measurements of impairment that include, but are not limited to: loss of range of motion; loss of strength; measured atrophy of tissue mass consistent with the injury; and any other measurements that establish the nature and extent of the impairment. The most current edition of the American Medical Association's "Guides to the Evaluation of Permanent Impairment" shall be used by the physician in determining the level of impairment.

(b) In determining the level of permanent partial disability, the Commission shall base its determination on the following factors;

(i) the reported level of impairment pursuant to subsection (a);
(ii) the occupation of the injured employee;
(iii) the age of the employee at the time of the injury;
(iv) the employee's future earning capacity; and
(v) evidence of disability corroborated by the treating medical records. No single enumerated factor shall be the sole determinant of disability. In determining the level of disability, the relevance and weight of any factors

used in addition to the level of impairment as reported by the physician must be explained in a written order.

With regard to subsection (i) of §8.1b(b), the Arbitrator notes that no permanent partial disability impairment report and/or opinion was submitted into evidence. Therefore, this factor is given no weight in determining permanent partial disability.

With regard to subsection (ii) of §8.1b(b), the Arbitrator notes at the time of the accident Petitioner was employed as a ramp crew chief and her job was considered a heavy physical demand occupation. Petitioner was unable to go back to her pre-injury occupation and had to accept a different position that is considered a medium physical demand occupation. Although Petitioner continues to work for Respondent in a less physical demanding position, she still is at a greater risk for suffering disability than someone with a light duty job. Her current position is physically more demanding than other occupations. Therefore, the Arbitrator gives this factor significant weight in determining permanent partial disability.

With regards to subsection (iii) of Section 8.1b(b), the Arbitrator notes that at the time of her injury Petitioner was 52 years old. Petitioner would be required to live with this disability than someone who is older. The Arbitrator gives this factor some weight in determining permanent partial disability.

With regards to subsection (iv) of Section 8.1b(b), the employee's future earing capacity, the Arbitrator notes that Petitioner continues to work for Respondent and she testified that she had not experienced any loss of future earning capacity as a result of her disability. Therefore, the Arbitrator gives this factor little weight in determining permanent partial disability.

With regards to subsection (v) of Section 8.1b(b), the Arbitrator notes the medical records reveal Petitioner underwent a bilateral surgical intervention to repair her shoulders. Petitioner had left shoulder arthroscopic surgery consisting of glenohumeral debridement, glenohumeral synovectomy, subacromial decompression and bursectomy, distal clavicle resection, and rotator cuff repair. A full-thickness tear involving the supraspinatus and infraspinatus tendon was found and Petitioner also needed a complete synovectomy and 1 cm resection of the distal clavicle bone. Petitioner had arthroscopic surgery on her right shoulder consisting of glenohumeral debridement, synovectomy, subacromial decompression and bursectomy and repair of the right rotator cuff. The tear was found to be moderate to high-grade partial-thickness tear of the distal supraspinatus with about 60% avulsed from the articular surface. (PX 1)

Considering the above, for the bilateral rotator cuff injuries, the Arbitrator finds the Petitioner has sustained 30% loss to the person as a whole and, accordingly, the Arbitrator awards 150 weeks of permanent partial disability benefits pursuant to Section 8(d)2 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

JOHN M. LUCCHESI,

Petitioner,

vs.

NO: 17 WC 1840

CITY OF SPRINGFIELD,

Respondent.

19IWCC0305

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 and permanent partial disability (PPD), and being advised of the facts and law, modifies the Decision of the Arbitrator only as to the PPD award, 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 the Commission, we have considered the record in its entirety. We have reviewed the facts of the matter, both from a legal and a medical/legal perspective. The Commission has considered all the testimony, exhibits, pleadings, and arguments submitted by the parties. The Commission is not bound by the Arbitrator's findings. Our Supreme Court has long held that it is the Commission's province "to assess the credibility of witnesses, resolve conflicts in the evidence, assign weight to be accorded the evidence, and draw reasonable inferences from the evidence." *City of Springfield v. Indus. Comm'n*, 291 Ill. App. 3d 734, 740 (1997) (citing *Kirkwood v. Indus. Comm'n*, 84 Ill. 2d 14, 20 (1981)). Interpretation of medical testimony is particularly within the province of the Commission. *A. O. Smith Corp. v. Indus. Comm'n,* 51 Ill. 2d 533, 536-37 (1972).

The Arbitrator considered the five factors under Section 8.1b of the Act, and found that Petitioner sustained five-percent (5%) loss of use of the person as a whole as a result of his right shoulder condition. The Commission, however, having reviewed and reweighed the evidence in

this matter, finds the PPD award to be excessive, and instead finds that Petitioner is entitled to three-and-a-half percent (3.5%) loss of use of the person as a whole. The Commission weighed the five factors listed under Section 8.1b of the Act as follows:

(i) Impairment Rating: The Commission gives no weight to this factor as neither party offered any evidence or opinion relative to impairment.

(ii) Occupation of Injured Employee: The Commission gives no weight to this factor. As noted by the Arbitrator, there is no evidence in the record that Petitioner's occupation had any effect on the level of permanent partial disability as Petitioner had retired on December 1, 2016, and removed himself from the workforce.

(iii) Petitioner's Age: Petitioner was 59 years old on the accident date; the Commission gives this factor no weight as there is no evidence in the record that Petitioner's age had any effect on the level of permanent partial disability.

(iv) Petitioner's Future Earning Capacity: There is no evidence in the record as to reduced earning capacity. Therefore, the Commission gives no weight to this factor.

(v) Evidence of Disability: The Arbitrator found that as a result of the April 12, 2016 accident, Petitioner aggravated his pre-existing right shoulder proximal biceps tendinitis. Petitioner underwent physical therapy and had three right shoulder injections in order to alleviate his condition. Petitioner's treating physician, Dr. Christopher Maender had also recommended surgery, but Petitioner decided not to proceed with it.

At the time of Petitioner's discharge from treatment on March 15, 2017, the Commission notes that Petitioner had reported a pain level of zero, his motion and strength were deemed excellent, and his exam was normal. The Arbitrator had further noted that Petitioner was able to sleep through the night, and had very little trouble with various activities of daily living. Nonetheless, Petitioner testified at arbitration that he still experienced pain that interfered with his activities of daily living. Petitioner also testified to having difficulty throwing a baseball, casting a fishing rod, changing the oil, and scratching his back.

In light of the foregoing, with no single enumerated factor being the sole determinant of disability, the Commission finds that a PPD award of three-and-a-half percent (3.5%) loss of use of the person as a whole is more appropriate and in line with the totality of the evidence in this case.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator, filed August 20, 2018, 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 $755.22 per week for a period of 17.5 weeks, as provided in Section 8(d)2 of the Act, for the reason that the injuries sustained caused 3.5% loss of use of the person as a whole.

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

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

No bond is required for the removal of this cause to the Circuit Court. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in the Circuit Court.

DATED: JUN 18 2019

DDM/pm
O: 6-4-19
052

D. Douglas McCarthy

Stephen Mathis

L. Elizabeth Coppoletti

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

LUCCHESI, JOHN M
Employee/Petitioner

Case# **17WC001840**

CITY OF SPRINGFIELD
Employer/Respondent

19IWCC0305

On 8/20/2018, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 2.18% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

1157 DELANO LAW OFFICES LLC
CHARLES H DELANO IV
1 SE OLD STATE CAPITOL PLZ
SPRINGFIELD, IL 62705

0332 LIVINGSTONE MUELLER ET AL
L ROBERT MUELLER
620 E EDWARDS PO BOX 335
SPRINGFIELD, IL 62705

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

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

JOHN M.LUCCHESI,
Employee/Petitioner

Case # **17** WC **1840**

v.

Consolidated cases: _____

CITY OF SPRINGFIELD,
Employer/Respondent

19IWCC0305

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Maureen Pulia**, Arbitrator of the Commission, in the city of **Springfield**, on **7/25/18**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **4/12/16**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

On this date, 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 $**71,774.54**; the average weekly wage was $**1,380.28**.

On the date of accident, Petitioner was **59** years of age, ***married*** with **no** dependent children.

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

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

Respondent shall be given a credit of $**00.00** for TTD, $**00.00** for TPD, $**00.00** for maintenance, and $**00.00** for other benefits, for a total credit of $**00.00**.

Respondent is entitled to a credit of $**00.00** under Section 8(j) of the Act.

ORDER

Respondent shall pay Petitioner permanent partial disability benefits of $755.22/week for 25 weeks, because the injuries sustained caused the 5% loss of petitioner's 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.

Maureen H Pulia

Signature of Arbitrator

8/10/18
Date

AUG 20 2018

ICArbDec p. 2

THE ARBITRATOR HEREBY MAKES THE FOLLOWING FINDINGS OF FACT:

Petitioner, a 59 year old division manager of unsafe and dangerous structures, sustained an accidental injury to his right shoulder that arose out of and in the course of his employment by respondent on 4/12/16. Petitioner's duties include sending out notices of demolition after inspection, getting a judgment in court, getting utilities disconnected, hiring contractors, and conducting demolitions. Petitioner's job required on-site visits to the structures that are being demolished.

Prior to 4/12/16 petitioner had presented to Dr. Wottowa's Physician's Assistant David Purves on 11/25/15 for right shoulder pain around the anterior aspect of the shoulder, without numbness and tingling. Petitioner's pain was in the impingement zone. He had tenderness to palpation directly over the proximal biceps tendon. Impingement signs were positive. An MRI was performed that showed no evidence of a full thickness tear of the rotator cuff. There was some mild fluid seen throughout. It showed type 2 acromion, and degenerative changes were seen at the AC joint. There was a lot of fluid around the proximal biceps tendon. Dr. Wottowa diagnosed right shoulder proximal biceps tendinitis. Dr. Wottowa showed petitioner some supraspinatus strengthening and shoulder strengthening exercises. Dr. Wottowa and petitioner talked about an injection, but petitioner wanted to hold off awhile. Dr. Wottowa told petitioner to give it 4-6 weeks and if not better, he could perform the injection. Petitioner did not return to Dr. Wottowa because his shoulder was better. Petitioner reported normal strength and full motion with his right shoulder, and no problems with his right shoulder before the injury on 4/12/16.

On 4/12/16 petitioner went to a demolition site and was standing preparing to inspect a sewer cap location in the basement. As he was looking down into the basement cavity he took a step on some loose bricks and fell into the basement cavity of the demolition site injuring his right shoulder. He fell 7 feet down onto his right side and rolled over. Petitioner had immediate pain in his right shoulder. Following the injury he reported the injury to Brad O'Neil.

On 4/14/16 The Supervisor Notification of Possible Injury was completed. It described the injury as "attempt to locate sewer cap in basement cavity of demolition. While descending into the open cavity the ground gave way and I fell forward down the hill into the hole." Body parts affected were right shoulder and biceps.

On 4/18/16 petitioner completed a City of Springfield Employee Accident Report. Petitioner provided a consistent history of the accident and described the nature of his injury as "strained or dislocated shoulder and arm (right side)".

~~On 4/25/16 petitioner presented to Dr. Maender at the request of Brad O'Neil, for his right shoulder pain.~~ He reported that he has had aching pain with his right shoulder since November of 2015 and had an MRI in November of 2015. Petitioner provided a consistent history of the accident. He denied any numbness, tingling, or hearing a pop when he fell. He reported that the other night his wife indicated he turned over in bed and she heard a pop and he woke up screaming in pain. He tried some massaging for the pain and had temporary relief of his pain. He has tried Aleve and ice, both of which have helped minimally. He described his pain as "aching" with rest and 6/10 with movement.

Dr. Maender reviewed the MRI from November of 2015 and noted that it showed a biceps tendinopathy with fluid around it, and mild changes of the superior scapularis. No other rotator cuff pathology at the supraspinatus or infraspinatus was noted. X-rays performed 4/25/16 showed mild AC joint arthritis. Dr. Maender was of the opinion that petitioner's right shoulder pain was most consistent with long head of biceps tendinopathy, with no evidence of a rupture. Dr. Maender noted that petitioner had increased pain in his right arm since the injury. Dr. Maender injected the right biceps tendon sheath and told petitioner to take over the counter medications. On 4/29/16 Dr. Maender restricted petitioner from any overhead use of the right arm/shoulder.

Petitioner followed up with Dr. Maender on 5/25/16. He reported that his right shoulder pain had improved with the injection along the biceps sheath. He still reported soreness in the area, but noted that it was improved. He also reported ongoing stiffness of the shoulder, that was much improved. He reported trouble sleeping at night. Dr. Maender recommended a course of physical therapy.

Petitioner underwent physical therapy at Midwest Rehabilitation from 6/8/16 through 7/5/16.

On 6/29/16 petitioner followed-up with Dr. Maender. He reported that his shoulder was improving slowly, but he had certain exercises that increase his pain on a regular basis. The pain was located across the anterior and anterolateral shoulder. Since petitioner still had significant symptoms, Dr. Maender recommended an MRI of the right shoulder.

On 7/25/16 petitioner underwent an MRI of his right shoulder. The impression was severe long head biceps tendinosis with tenosynovitis; subscapularis tendinosis with articular sided fraying and minimal interstitial tearing; and mild infraspinatus tendinosis.

On 8/5/16 petitioner returned to Dr. Maender. Petitioner only reported pain across the anterior shoulder in the area of the biceps tendon. He denied any recent popping. Petitioner reported that his pain improved with decreased activity. Petitioner wanted to continue non-operative treatment. Dr. Maender recommended that

~~petitioner resume regular activities and continue his exercises he learned in therapy. He noted that if petitioner's~~ pain increases, then he is going to require a right shoulder arthroscopy with biceps tenodesis and evaluation of his rotator cuff and treatment as needed.

On 9/2/16 petitioner followed-up with Dr. Maender. He reported that his shoulder was bothersome, but not as much as before. He stated that he was planning on retiring in 3 months. Dr. Maender recommended surgical intervention. Petitioner wanted to wait until retirement before considering surgery.

On 9/19/16 petitioner presented to Dr. Wottowa for a 2nd opinion. Petitioner had previously seen Dr. Wottowa in November 2015 for his right shoulder pain. He noted that petitioner had a fall in March (sic) and his right shoulder pain increased quite a bit. Petitioner reported more pain over the anterior aspect of his shoulder down his arm. He noted that it bothers him with moving away from his body and sleeping at night. Dr. Wottowa reviewed the MRI of 7/25/16 and was of the opinion that it showed tendinosis without full thickness tearing of his rotator cuff. Dr. Wottowa compared this MRI to the one in November 2015 and was of the opinion that there was no full thickness tear from the fall, but the fall made the symptoms worse. An examination revealed positive impingement signs. Dr. Wottowa thought petitioner's main problem was rotator cuff tendonitis. He recommended a repeat injection and exercises. Dr. Wottowa performed another subacromial space injection which provided petitioner with relief. Dr. Wottowa taught him supraspinatus strengthening exercises.

On 10/31/16 petitioner returned to Dr. Wottowa. Petitioner reported that the injection had helped and he had excellent strength and motion. Dr. Wottowa wondered if he could maintain his progress, and where he would be in January of 2017, since he had been there before. Petitioner had a negative impingement sign.

On 12/1/16 petitioner retired.

On 1/16/17 petitioner followed-up to Dr. Wottowa. He reported up and down course with his shoulder. He noted good and bad days. He reported pain and stiffness. He reported primary discomfort at end range, and sometimes sleeping. Petitioner was very tender over the biceps tendon itself, and had increased pain with impingement testing. He had excellent range of motion and strength. Dr. Wottowa noted that he had improvement with the injections, but only until they wear off. Dr. Wottowa thought petitioner would benefit from either a biceps tenotomy or tenodesis, and a subacromial decompression. Petitioner stated that he was not yet ready for surgery. He wanted another injection. Dr. Wottowa performed the third injection to his right shoulder. Petitioner had less rotational pain with the injection, which was a good sign.

~~On 1/19/17 petitioner's Application for Adjustment of Claim was filed with the Commission. He alleged~~ injuries to his right shoulder and biceps. He alleged this injury occurred when he lost footing on loose bricks as he was descending demolition site and fell head-first into the basement cavity.

On 3/15/17 petitioner returned to Dr. Wottowa. He reported that he was doing well. He stated that the 3rd injection seemed to do the trick. He reported that his pain had gone down to basically 0. His motion and strength were excellent, and he was able to sleep through the night. Dr. Wottowa reinforced petitioner's exercises for his supraspinatus. He released petitioner on an as needed basis.

Petitioner's Oxford Shoulder Score on 3/15/17 was 33. Petitioner reported the worst pain from his shoulder as unbearable. He reported little trouble dressing, and very little trouble getting in and out of car or using public transportation. He can easily use a knife and fork, and brush/comb his hair with his right arm. He can do household shopping, carry a tray containing a plate of food across the room, hang his clothes up, and dry himself under both arms with little difficulty. He described his pain from his right shoulder as moderate. He reported that his pain from his shoulder interfered with his work a little bit. Petitioner testified that he interpreted work to be his daily activities since he was retired when he completed the questionnaire. He reported pain from his shoulder at night for 1 or 2 days in the past 4 weeks.

Petitioner testified that the injection he received on 1/16/17 has worn off. He testified that he cannot throw a baseball, change oil, cast a fishing pole, or scratch his back.

F. IS PETITIONER'S CURRENT CONDITION OF ILL-BEING CAUSALLY RELATED TO THE INJURY?

It is unrebutted that petitioner presented for treatment to Dr. Wottowa's office on 11/25/15 for right shoulder pain. An MRI was performed that showed no evidence of a full thickness tear of the rotator cuff. There was some mild fluid seen throughout; type 2 acromion; degenerative changes at the AC joint; and a lot of fluid around the proximal biceps tendon. Petitioner was assessed with right shoulder proximal biceps tendinitis. An injection was offered, but petitioner declined. Dr. Wottowa told petitioner to return in 4-6 weeks if not improved. Petitioner did not return because his shoulder was better. Petitioner reported that he had normal strength and full motion of the right shoulder before 4/12/16.

Following his fall into the basement cavity of a demolition, petitioner had increased pain in his right shoulder. Petitioner first treated with Dr. Maender. He did report some aching with his right shoulder since November of 2015. He complained of "aching" pain, and rated his pain at a 6/10. Following a review of the November 2015 MRI and x-rays of the right shoulder, Dr. Maender was of the opinion that petitioner's right shoulder pain was most consistent with long head of biceps tendinopathy, with no evidence of a rupture. He

~~also noted that petitioner had increased pain in his right arm since the injury. When petitioner saw Dr. Wottowa~~ for a 2nd opinion, Dr. Wottowa was also of the opinion that the fall on 4/12/16 made petitioner's symptoms worse.

Based on the above, as well as the credible evidence, the arbitrator adopts the opinions of Dr. Maender and Dr. Wottowa and finds the accident on 4/12/16 aggravated petitioner's preexisting condition in his right shoulder. The arbitrator finds the petitioner's current condition of ill-being as it relates to his right shoulder is causally related to the injury he sustained on 4/12/16.

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

With regard to subsection (i) of §8.1b(b), the Arbitrator notes that no permanent partial disability impairment report and/or opinion was submitted into evidence. The Arbitrator therefore gives no weight to this factor.

With regard to subsection (ii) of §8.1b(b), the occupation of the employee, the Arbitrator notes that the petitioner was a division manager of unsafe and dangerous structures at the time of the injury. After the injury petitioner reported that the pain from his shoulder interfered with his work a little bit. However, on 12/1/16 petitioner retired and removed himself from the workforce. The Arbitrator therefore gives lesser weight to this factor.

With regard to subsection (iii) of §8.1b(b), the Arbitrator notes that Petitioner was 59 years old at the time of the accident. Following his release from care by Dr. Wottowa, petitioner has continued to experience moderate pain in his right shoulder. He also complained of pain in his right shoulder at night. Although petitioner is retired he will continue to experience pain in his right arm with certain activities and at night. Being 59 years old, petitioner may experience these problems for the remainder of his life. Therefore, the arbitrator gives greater weight to this factor.

With regard to subsection (iv) of §8.1b(b), Petitioner's future earnings capacity, the arbitrator notes that the petitioner offered no evidence regarding his future earnings capacity. The arbitrator further notes that petitioner retired on 12/1/16, and took himself out of the labor market. Therefore, the arbitrator gives lesser weight to this factor.

With regard to subsection (v) of §8.1b(b), evidence of disability corroborated by the treating medical records, the Arbitrator finds petitioner was discharged from care by Dr. Wottowa on 3/15/17. At that time petitioner reported that the injection seemed to do the trick and he had basically no pain. His motion and strength were excellent and he was able to sleep throughout the night. When petitioner completed his Oxford

Shoulder Questionnaire he reported little trouble dressing; very little trouble getting in and out of car or using public transportation; easy use of a knife and fork; ability to brush/comb his hair with his right arm, do household shopping, carry a tray containing a plate of food across the room ,hang his clothes up, and dry himself under both arms with little difficulty. He described his pain from his right shoulder as moderate. He reported that his pain from his shoulder interferes with his work (aka daily activities) a little bit. He also reported right shoulder pain at night 1-2 nights a week. Petitioner testified that after the injection of 1/16/17 wore off he could not throw a baseball, change the oil in his car, cast a fishing pole or scratch his back.

The Arbitrator therefore gives greater weight to this factor.

Based on the above factors, and the record taken as a whole, the Arbitrator finds that petitioner sustained a permanent partial disability to the extent of 5% loss of use of his person as a whole pursuant to Section 8(d)2 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 ROCK ISLAND	)	☐ Reverse	☐ Second Injury Fund (§8(e)18)
			☐ PTD/Fatal denied
		☒ Modify	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

RODNEY WEST,

Petitioner,

vs. NO: 14 WC 5913

NAPA AUTO PARTS d/b/a L & L Sterling,

Respondent.

19IWCC0306

DECISION AND OPINION ON REMAND

This matter now comes before the Commission on remand from the Circuit Court of Knox County. In its April 23, 2018 Order, the Circuit Court reversed and remanded the Commission's Decision as to whether Petitioner's injury on December 28, 2013 "arose out of" his employment. The Circuit Court found that Petitioner's injury arose out of and in the course of his employment with Respondent.

The Circuit Court further denied Respondent's cross-appeal on the issue of whether Petitioner was "in the course of" his employment when the accident occurred. The Circuit Court confirmed the Commission's Decision in this regard, finding that Petitioner was in the course of his employment when the accident occurred.

The Circuit Court remanded the claim to the Commission for further proceedings and factual determinations consistent with its Order. Specifically, the Commission was to make further findings on the issues of notice, causation, temporary total disability (TTD), medical expenses, and prospective medical care.

Procedurally, the parties proceeded with a Section 19(b) hearing on March 2, 2016 before Arbitrator Maria Bocanegra. The Arbitrator noted that Petitioner was working as a store manager for Respondent's store in Galesburg, Illinois. Respondent was in the business of providing automobile parts, including windshield wiper blades. Petitioner had testified at arbitration that he had injured his low back while installing a wiper blade on a customer's car on December 28, 2013. Petitioner explained that while installing the wiper blade, he had twisted and lifted his body, and felt a pop in his low back and shooting pain down his left leg.

In the Arbitrator's May 2, 2016 Decision, the Arbitrator found that while Petitioner's injuries occurred in the course of his employment, Petitioner's injuries did not arise out of the employment. The Arbitrator found that Petitioner failed to prove the issue of accident on the basis that the risk he had encountered was a neutral risk, or an activity of daily life to which all members of the public are equally exposed to. The Arbitrator stated that turning or twisting was an activity of everyday life. The Arbitrator did not find that Petitioner encountered any employment-related risk. As the Arbitrator denied accident, she considered the remaining issues of notice, causal connection, TTD, medical expenses, and prospective medical moot and did not address them in her Decision. On October 2, 2017, the Commission affirmed and adopted the Arbitrator's Decision in its entirety.

On April 23, 2018, Judge Scott Shipplett, of the Circuit Court of Knox County, issued his Order on Judicial Review. Relative to the issue of accident, the Circuit Court reversed the Commission's Decision as to the "arising out of" requirement, and confirmed the Commission's Decision as to the "in the course of" requirement. The Circuit Court found that it was Respondent's policy that if a customer purchased windshield wipers, then Respondent would have an employee install them for no additional charge. Therefore, the Circuit Court held that Petitioner's changing of wiper blades was a job duty "directly and distinctly associated with employment, and as such, does not require any additional analysis." The Circuit Court remanded the claim back to the Commission for further findings.

Therefore, based upon the directive from the Circuit Court, the Commission finds that Petitioner sustained an accident arising out of and in the course of his employment on December 28, 2013.

Turning to the next issue of notice, the Commission finds that Petitioner established appropriate notice pursuant to the Act. Respondent advanced no argument against notice. Respondent, through the testimony of its office manager, Elizabeth Jane Jacobs, confirmed that on or about February 10, 2014, Petitioner notified them of his work injury. (T.125-126; T.128-130; RX4C). This is 44 days from the December 28, 2013 accident date, and meets the statutory deadline for notice under the Act. 820 ILCS 305/6(c). Ms. Jacob's testimony was further corroborated by proof of the email communication on February 10, 2014. (RX4C).

Relative to causal connection, it is well-established that an accident need not be the sole or primary cause—as long as employment is a cause—of a claimant's condition. *Schroeder v. Ill.*

Workers' Comp. Comm'n, 2017 IL App (4th) 160192WC, ¶ 28; citing *Sisbro, Inc. v. Indus. Comm'n*, 207 Ill. 2d 193, 205 (2003). Furthermore, an employer takes its employees as it finds them. *Id.*; citing *St. Elizabeth's Hosp. v. Ill. Workers' Comp. Comm'n*, 371 Ill. App. 3d 882, 888 (5th Dist. 2007). A claimant with a preexisting condition may recover where employment aggravates or accelerates that condition. *Id.*; citing *Caterpillar Tractor Co. v. Indus. Comm'n*, 92 Ill. 2d 30, 36 (1982). In other words, an accident need only be *a* cause of a condition of ill-being for a claimant to recover under the Act and, correlatively, a preexisting condition will not prevent recovery. *Id.* at 29; citing *Sisbro, Inc.*, 207 Ill. 2d at 205; *Caterpillar Tractor Co.*, 92 Ill. 2d at 36. *Schroeder* further instructs, "The salient factor is not the precise previous condition; it is the resulting deterioration from whatever the previous condition had been." *Id.* at 26.

In this claim, there is no question that Petitioner had long-standing treatment for his back. Petitioner testified to his pre-existing back condition, stating that he had received chiropractic treatment for his back, on and off since 2007, but that the treatment consisted of regular adjustments. (T.28-29; T.64-65). Petitioner further testified that he had never experienced pain or numbness traveling down his legs into his feet prior to December 28, 2013. (T.29; T.49-50).

The medical records in evidence reveal that Petitioner had injured his back in January 2000 – nearly 14 years prior to the December 28, 2013 injury. Petitioner was treated conservatively with chiropractic therapy for this injury. By February 4, 2000, Petitioner was reporting no pain in his back. He was discharged from chiropractic care on February 9, 2000. (RX8). Thereafter, beginning in January 2007, Petitioner began treating with Dr. Alan Phillips for his cervical, thoracic, and lumbar spine. Petitioner testified that his last appointment with Dr. Phillips, prior to December 28, 2013, was on December 20, 2013. (T.65). In reviewing these prior records, there were no complaints of either pain or radiating pain to the lower extremities in Dr. Phillips' records until June 2009, wherein the assessment stated, "thoracic or lumbosacral neuritis or radiculitis." There was no further description or explanation other than that written assessment. This assessment was included in each office visit note until August 2012. (RX7).

Further prior history reveals that Petitioner was involved in a collision with a semi-truck in January 2010. Although he complained to Dr. Phillips of right sacroiliac and lower back tenderness with stiffness and soreness; his main injury from this accident was a fractured collarbone which was surgically repaired. (RX7; RX8).

Respondent's Section 12 examiner, Dr. Donald deGrange, examined Petitioner approximately four months after the December 28, 2013 injury. He reviewed Petitioner's x-rays of December 29, 2013 and the MRI films of January 10, 2014, and diagnosed Petitioner with L4-5 herniated nucleolus pulposis and lumbar spine degenerative disc disease. (RX11, pg. 18). However, he did not find Petitioner's condition causally related to the December 28, 2013 accident and characterized his findings as degenerative in nature. (RX11, pg. 19; 22). Dr. deGrange further opined that Petitioner's surgery at L4-5, on January 24, 2014, was appropriate, but also not causally related to the December 28, 2013 accident. (PX2, pg. 8; PX13; PX17). However, on cross-examination, Dr. deGrange testified that Petitioner had significant pre-existing disc degeneration,

and it was possible that bending and twisting could result in a disc herniation or aggravate a herniated disc. (RX11, pg. 36; 44). Dr. deGrange did not review any additional medical records after his May 15, 2014 Section 12 examination. (RX11, pg. 40).

As our case law directs: Prior to December 28, 2013, Petitioner had on and off treatment (sometimes with a significant gap of several years) for his back, and was able to manage his prior condition using only conservative measures. Evidence of radiating pain to the lower extremities or lumbar radiculopathy appeared for approximately two and half weeks in January 2000, and then no complaints until June 2009; and, to be clear, there were no specific complaints of radiculopathy in 2009, but simply a note under "assessment" in Dr. Phillips' medical records. That assessment changed in August 2012, and there were no further indications of radiating pain until the December 28, 2013 injury.

Following the December 28, 2013 accident, Petitioner's physician visits increased and treatment for his low back became more aggressive. For the first time, Petitioner received recommendations for cortisone injections and underwent two surgeries: a left hemilaminectomy and partial facetectomy and foraminotomy at L4-5 on January 24, 2014, and an instrumented spinal fusion and interbody fusion lumbar at L4-5 with a revision decompression at that same level on January 8, 2015. (PX2, pg. 8; PX12; PX13; PX17). Dr. Daniel Mulconrey, Petitioner's treating spine surgeon, opined that,

> The relationship between his two surgeries and the December 28 date are related via patient's history. The patient's history indicated to my office that on December 28 was the origin of his pain. Based on his history that's correlated with the MRI finding of acute disc herniation on the left at L4-5 which led to his first surgery, which due to the condition of his disc, his body, eventually led to the second surgery that occurred in 2015. (PX2, pgs. 20-21).

Now, according to Dr. Mulconrey, Petitioner is in need of an instrumented spinal fusion at L3-4 and L5-S1, with a laminectomy of L3-4 and L5-S1. (PX2A, pg. 42). As to this recommendation, Dr. Mulconrey opined,

> It's my opinion that Mr. West had these underlying degenerative conditions at L3-4 and L5-S1. It appears through his history and repeated examinations by myself that they became more symptomatic after the fusion procedure. Because of his continued symptoms, his inability to return to work, the surgical procedure is reasonable treatment for Mr. West and would be related to the, in layman's terms, stiffening or the fusion procedure at L4-5, which I believe in the previous deposition I related to the reported work injury that occurred in 2013. (PX2A, pg. 50).

Dr. Mulconrey reiterated that the mechanism of twisting one's body while installing wiper blades on a car could cause the herniation identified in the initial January 10, 2014 MRI. (PX2, pg. 21; PX8; PX13). Dr. Mulconrey also stated on cross-examination that it was unlikely that the extruded disc fragment was degenerative in nature. (PX2, pg. 25). "That finding is more an acute finding rather than a chronic finding." (PX2, pg. 26). With that said, Dr. Mulconrey testified that he was not aware of any prior history as it related to Petitioner's back. (PX2, pgs. 23-24).

The Commission further notes that following the December 28, 2013 injury, Petitioner's work ability was also considerably restricted, per doctor's orders; and, despite evidence of a couple of subsequent falls, neither party claimed any intervening injury that would sever causal connection in this claim.

Thus, based on the totality of the evidence, the Commission finds that Petitioner's low back condition is causally related to the December 28, 2013 accident.

Relative to medical benefits, the Commission finds that Petitioner is entitled to medical benefits, including prospective medical care as recommended by Dr. Mulconrey. Dr. Mulconrey, stated that the treatment he had rendered to Petitioner was reasonable, necessary, and causally related to the December 28, 2013 accident. (PX2, pg. 22). Dr. Mulconrey further opined that the recommended instrumented spinal fusion at L3-4 and L5-S1, with a laminectomy of L3-4 and L5-S1, was appropriate, reasonable, as well as causally related to the December 28, 2013 injury. (PX2A, pg. 53).

Respondent's Section 12 examiner, Dr. deGrange, had opined that Petitioner's surgery at L4-5 on January 24, 2014 was appropriate, although not causally related to the December 28, 2013 injury. (RX11, pg. 23; 28). The Commission finds Dr. Mulconrey more persuasive than Dr. deGrange on the issue of causal connection. Additionally, Dr. deGrange predicted that Petitioner would require further treatment for his back, including a revision discectomy. (RX11, pg. 26).

In light of the foregoing, the Commission awards reasonable and necessary medical expenses, including the pending recommendation for surgery by Dr. Mulconrey.

Finally, the Commission finds that Petitioner is entitled to TTD benefits from December 29, 2013 through March 2, 2016, the date of arbitration. Petitioner testified that since December 29, 2013, he had not returned to work and had not received any TTD benefits. (T.37; T.51). The record shows that the emergency room physicians at Galesburg Cottage Hospital ordered Petitioner off work on December 29, 2013. (T.37-38; PX11; RX8). Petitioner continued to stay off work following his first back surgery in January 2014. By March 12, 2014, Dr. Mulconrey allowed Petitioner to return to work with restrictions. (T.41; PX2, pgs. 10-11; PX13; RX9). Petitioner testified that he had reached out to Respondent, specifically, the owner and Mr. Donahue, but he did not receive a response from them as to whether they could accommodate his restrictions or not. (T.42). By May 2014, Petitioner was no longer employed by Respondent; he found out after receiving a COBRA letter in the mail. (T.44).

Respondent advanced no argument relative to TTD. Its Section 12 examiner, Dr. deGrange, had opined that Petitioner was at maximum medical improvement (MMI) and could return to full duty work as of the May 15, 2014 Section 12 examination. (RX11, pg. 24). Dr. deGrange did not examine Petitioner or review any additional medical records after his May 15, 2014 Section 12 examination. Based on the totality of the evidence and the Commission's finding of causal connection for Petitioner's current condition of ill-being as it relates to Petitioner's lumbar spine, the Commission does not find Dr. deGrange's opinion persuasive, and instead finds that Petitioner is entitled to TTD from December 29, 2013 through the date of arbitration, or March 2, 2016. (RX11, pg. 40).

IT IS THEREFORE ORDERED BY THE COMMISSION that Petitioner is entitled to all reasonable and necessary medical expenses totaling $198,373.52, as detailed in Petitioner's Exhibit 18, and pursuant to Sections 8(a) & 8.2 of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Petitioner is entitled to prospective medical care, including the lumbar fusion surgery and related treatment, as recommended by Dr. Mulconrey.

IT IS FURTHER ORDERED BY THE COMMISSION that Petitioner is entitled to temporary total disability benefits of $543.27 per week for 113 4/7 weeks, commencing December 29, 2013 through March 2, 2016, 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 interest under §19(n) of the Act, if any.

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

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

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $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 the Circuit Court.

DATED: JUN 18 2019

D. Douglas McCarthy

19IWCC0306

DDM/pm
D: 6-5-19
052

Stephen Mathis

L. Elizabeth Coppoletti

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 COLES	)	[ ] Reverse	[ ] Second Injury Fund (§8(e)18)
			[ ] PTD/Fatal denied
		[ ] Modify	[X] None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

RONALD SINDE,

Petitioner,

vs.

NO: 10 WC 33190
11 WC 4724

NICHOLS SIDING & WINDOWS,

19IWCC0307

Respondent.

DECISION AND OPINION ON REMAND

This matter comes before the Commission on remand from the Circuit Court of the Fifth Judicial Circuit, Coles County. Per the remand order, dated July 24, 2017, Honorable James Glenn confirmed the Commission's November 21, 2016 Decision relative to causation, medical expenses, prospective medical, travel expenses and temporary total disability benefits (TTD). The Court set aside the Commission's Decision relative to the issues of Section 8(j) credit and penalties. The Court remanded the matter for further proceedings to determine "in light of the finding that Respondent has not made payments under Section 8(j), whether Petitioner is entitled to penalties and attorney's fees."

Procedurally, this matter was tried before Arbitrator William Gallagher on November 20, 2015. The Petitioner, Ronald Sinde, alleged two dates of injury. The first, on June 22, 2009 (11 WC 4724), involved an injury to Petitioner's left shoulder and left foot. Petitioner did not seek any medical treatment following the injury and did not miss any time from work. The claim was denied and is not the subject of this remand order. The second, on August 4, 2010 (10 WC 33190), involved an injury to Petitioner's left foot and cervical spine. The Arbitrator found that Petitioner's

left foot was causally related to the August 4, 2010 accident, but that his alleged neck and cervical spine condition was not causally related to said accident.

In support of his Decision, the Arbitrator adopted the opinion of Dr. Richard Lehman over the opinion of Dr. Samuel Chmell. Specifically, the Arbitrator noted that Dr. Lehman found that the mechanics of Petitioner's fainting episode on August 10, 2010 could have aggravated the underlying spine condition. Whereas Dr. Chmell was never informed that Petitioner fainted on August 10, 2010. The Arbitrator further noted that Dr. Chmell testified that the August 4, 2010 ER record made no mention of neck or left shoulder pain, but left trapezius tenderness, and Petitioner denied any spine pain. The August 10, 2014 medical record further noted that Petitioner had been cutting plywood at his friend's home when he fainted. The Arbitrator was not persuaded by Petitioner's testimony that he was only providing direction to his friend on how to cut the plywood.

The Arbitrator found that Respondent was not responsible for medical bills or for reimbursement of the travel expenses as the treatment to Petitioner's cervical spine was not related to the August 4, 2010 accident. The Arbitrator awarded Petitioner TTD benefits from August 5, 2010 through September 24, 2010, representing 7-2/7 weeks of disability for his ankle sprain. The Respondent was entitled to a credit of $12,944.61 for payments made. Penalties were denied.

The Commission, in its November 21, 2016 Decision, modified the Arbitrator's Decision relative to the average weekly wage (AWW) only and affirmed and adopted all else.

The Circuit Court confirmed the Commission's Decision relative to causation, medical expenses, prospective medical, travel expenses and TTD. The court set aside the Commission's Decision relative to the issue of the Section 8(j) credit and penalties. The Court remanded the matter for further proceedings to determine "in light of the finding that Respondent has not made payments under Section 8(j), whether Petitioner is entitled to penalties and attorney's fees."

The Petitioner argued, through its Circuit Court brief, that penalties should be awarded as TTD for August 4, 2010 through September 1, 2010 was not paid until March 31, 2011, or 239 days after the first day of lost time. Respondent then did not pay additional TTD until several weeks later and payments continued to be intermittent thereafter. Petitioner asked that penalties pursuant to Sections 19(l), 19(k), and 16 be assessed against the Respondent.

The Commission declines to award penalties in this matter. This case involves two injuries: one to the ankle and the second to the neck. The Arbitrator found the left ankle compensable but denied the neck claim. The Respondent paid $12,944.61 in TTD benefits and PPD advancements, and $76,664.23 in medical expenses. The $76,664.23 was claimed as an 8(j) credit on the Request for Hearing form. The Circuit Court, however, set aside the Commission's Decision relative to the Section 8(j) credit.

The evidence establishes that Petitioner incurred medical bills for treatment to the left ankle and the neck. The medical bills relating to the left ankle were minimal. Respondent paid the bills, including the medical bills relating to the neck. However, as the alleged neck injury was found not compensable (a finding that was confirmed by the Circuit Court), Respondent is not liable for the medical bills or alleged period of TTD for the neck injury. Therefore, the Commission finds that penalties are not appropriate relative to the alleged neck injury.

The Commission further finds that penalties are not appropriate relative to the left ankle injury. The evidence establishes that Petitioner sought the following medical treatment following his August 4, 2010 injury:

Petitioner was seen by Dr. Joseph Burton of Sarah Bush ER on August 4, 2010 after hurting his foot and ankle. Petitioner reported that he stepped off a stool located just off the back of a trailer and turned his left ankle. He reported that he "kind of rolled his ankle." He had minimal tenderness in the left trapezius area. He denied any spine pain, distal paresthesias, or numbness. His blood pressure was 190/128. X-ray of the left foot was negative. His left lower extremity was intact on the neurovascular examination. The impression was acute left ankle/foot sprain. The addendum noted that Petitioner's blood pressure during the recheck was 238/127. He denied any chest pains, headaches or shortness of breath. An added diagnosis of acute hypertension was added. It was also noted in the triage assessment that his foot slipped off the stool, "this is an old injury." PX.4.

Petitioner testified that his neck, shoulder and ankle were bothering him, and he had a knot in his head while he was at the hospital on August 4, 2010. T.27. He was told to stay off work for 3 days. T.41.

Petitioner testified that the following day Mr. Nichols, the owner of Nichols Siding & Windows, came to his house and told him he could resign or be fired. T.42. He refused to resign so he was fired. He has not worked since. T.44.

Petitioner presented to Sarah Bush Hospital on August 10, 2010 following a syncopal event. Per the ER report, Petitioner was out in the yard working with a buddy for an hour. He ate lunch and was staying well hydrated. He did not feel fatigued while outside. He then came in and had the syncopal event. He denied alcohol or drug use and indicated that he smoked a half pack of cigarettes per day. His neck was supple with no jugular venous distention. He had good range of motion in all four extremities. The assessment was syncope, atypical chest pain, and acute renal failure. PX.11.

Per the ER record from August 10, 2010, Petitioner was outside for about an hour helping some friends cut plywood. He went back home and drank some water. He went to stand up and broke into a sweat and went down to the floor. He reported being out for about 30 seconds. He was trying to quit smoking but smoked about a pack and a half of cigarettes per day since he was

a teenager. He occasionally smoked marijuana. Examination of the neck revealed no adenopathy or thyromegaly, and no palpable thyroid nodules. PX.11.

Petitioner presented to Sarah Bush Occupational Health on August 18, 2010. Petitioner reported stepping off a trailer and onto a stool, twisting his ankle. He fell onto his left side and bumped his head on the ground. He denied loss of consciousness. He had good range of motion of the left ankle with some mild swelling on the lateral aspect of the left ankle. He had tenderness to palpation of the distal lateral malleolus and ATFL of the left ankle. X-ray of the left ankle revealed no acute bony abnormality. The diagnoses included: left ankle sprain, trapezius strain, and left anterior chest wall strain. He could work full duty. PX.11.

Petitioner presented to Sarah Bush on September 1, 2010 for his ankle pain. Petitioner reported that his ankle pain had decreased somewhat. He had full range of motion of the left ankle. He was returned to work full duty. PX.12.

Petitioner was seen at Sarah Bush Occupational on September 24, 2010 for continued neck and ankle pain with certain activities. He denied swelling of the ankle and any radiation of pain in his neck. He denied numbness and tingling. Examination revealed full range of motion of the left ankle. He could work full duty without restriction. PX.12.

Section 19(l) provides, in part:

> 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. A delay in payment of 14 days or more shall create a rebuttable presumption of unreasonable delay. 820 ILCS 305/19(l).

Penalties under Section 19(l) are in the nature of a late fee. *Mechanical Devices v. Indus. Comm'n*, 344 Ill. App. 3d 752, 763 (2003). In addition, the assessment of a penalty under Section 19(l) is mandatory "[i]f the payment is late, for whatever reason, and the employer or its carrier cannot show an adequate justification for the delay." *McMahan v. Indus. Comm'n*, 183 Ill. 2d 499, 515 (1998). The standard for determining whether an employer has good and just cause for a delay in payment is defined in terms of reasonableness. *Mechanical Devices*, 344 Ill. App. 3d at 763. The employer has the burden of justifying the delay, and the employer's justification for the delay is sufficient only if a reasonable person in the employer's position would have believed that the delay was justified. *Board of Education of the City of Chicago v. Indus. Comm'n*, 93 Ill. 2d 1, 9-10 (1982). The Commission's evaluation of the reasonableness of the employer's delay is a

question of fact that will not be disturbed unless it is contrary to the manifest weight of the evidence. *Crockett v. Indus. Comm'n*, 218 Ill. App. 3d 116, 121 (1991).

As to Section 19(l) penalties, the Commission finds that Respondent's delay in paying TTD benefits was reasonable based on the medical records. Following the August 4, 2010 accident, Petitioner began treating for his ankle injury and was diagnosed with an ankle sprain. Petitioner then fainted on August 10, 2010 prompting a visit to the emergency room. Thereafter, Petitioner began treating for neck issues in addition to his left ankle. Petitioner was then returned to work full duty on August 18, 2010. Petitioner's medical treatment then focused on his neck, which was found not compensable. There is no indication that Respondent unreasonably delayed in the payment of benefits given it had a good faith objection to liability regarding the neck injury. Despite its good faith objection to liability, Respondent paid medical expenses and TTD benefits. Therefore, the Commission declines to award Section 19(l) penalties as the Respondent's conduct was not unreasonable.

The standard for awarding penalties under Section 19(k) is higher than the standard under 19(l). Section 19(k) of the Act provides:

> 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 the Act equal to 50% of the amount payable at the time of such award. 820 ILCS 305/19(k).

Section 16 of the Act provides for an award of attorney fees when an award of additional compensation under Section 19(k) is appropriate. 820 ILCS 305/16. "The amount of [attorney] fees to be assessed is a matter committed to the discretion of the Commission." *Williams v. Indus. Comm'n*, 336 Ill. App. 3d 513, 516 (2003).

An award of penalties and attorney fees pursuant to Sections 19(k) and 16 are "intended to promote the prompt payment of compensation where due and to deter those occasional employers or insurance carriers who might withhold payment from other than legitimate motives." *McMahan v. Indus. Comm'n*, 289 Ill. App. 3d 1090, 1093 (1997), *aff'd*, 183 Ill. 2d 499 (1998).

The standard for awarding penalties and attorney fees under Sections 19(k) and 16 of the Act is higher than the standard for awarding penalties under Section 19(l) because Sections 19(k) and 16 require more than an "unreasonable delay" in payment of an award. *McMahan v. Indus. Comm'n*, 183 Ill. 2d 499, 514-15 (1998). It is not enough for the claimant to show that the employer simply failed, neglected, or refused to make payment or unreasonably delayed payment without

good and just cause. *McMahan*, 183 Ill. 2d at 515. Instead, Section 19(k) penalties and Section 16 fees are "intended to address situations where there is not only a delay, but the delay is deliberate or the result of bad faith or improper purpose." *McMahan*, 183 Ill. 2d at 515. In addition, while Section 19(l) penalties are mandatory, the imposition of penalties and attorney fees under Section 19(k) and Section 16 fees is discretionary. *Id.*

The Commission finds no justification for the imposition of Section 19(k) penalties or attorney fee's pursuant to Section 16. The Petitioner sought minimal treatment to his left ankle and the record reveals that he was returned to work full duty on August 18, 2010. Thereafter, his treatment focused primarily on his neck, which was found not compensable. His TTD benefits were paid in March 2011. The Respondent also paid his medical expenses even though the alleged neck injury was not compensable. There is no indication that payment of the medical expenses or TTD benefits relative to the left ankle were unreasonably delayed. As such, the Commission finds no evidence that there was an unreasonable or vexatious delay in payment of the TTD benefits or medical expenses. Thus, the imposition of penalties pursuant to Section 19(k) and Section 16 is not warranted.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent shall pay to the Petitioner the sum of $350.58 per week for a period of 7-2/7 weeks, August 5, 2010 – September 24, 2010, that being the period of temporary total incapacity for work under §8(b), and that as provided in §19(b) of the Act, this award in no instance shall be a bar to a further hearing and determination of a further amount of temporary total compensation or of compensation for permanent disability, if any.

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

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

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

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

DATED: JUN 18 2019

D. Douglas McCarthy

Douglas McCarthy

19IWCC0307

DMM/tdm
d: 6/4/19
052

Elizabeth.Coppoletti

Stephen Mathis

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

EDDIE ANDREWS,

Petitioner,

vs. NO: 13 WC 24044

AGENCY FOR COMMUNITY TRANSIT,

Respondent.

19IWCC0308

DECISION AND OPINION ON REMAND

This matter comes before the Commission pursuant to remand from the Circuit Court of St. Clair County. This matter was consolidated at Arbitration with two separate decisions having been issued; one for Respondent, Cerro Copper (07 WC 51356) and the second for Respondent, Agency for Community Transit (ACT) (13 WC 24044). The facts of both cases have been set forth in the Circuit Court's January 3, 2017 Order. A separate Decision and Opinion on Remand has been issued for Cerro Copper.

Procedurally, Petitioner alleged injury on January 7, 2008 while working for Cerro Copper. The Arbitrator awarded certain medical expenses and 8.5% loss of use of the right hand and 6.5% loss of use of the left hand. No award for temporary total disability (TTD) was made.

The Commission affirmed the Arbitrator's finding that Petitioner's bilateral carpal tunnel syndrome arose out of and in the course of his employment with Cerro Copper. The Commission further affirmed the Arbitrator's award of medical expenses and the permanent partial disability (PPD) award of 8.5% loss of use of the right hand and 6.5% loss of use of the left hand. The Commission, however, modified the Arbitrator's Decision and found Cerro Copper liable for TTD

benefits from May 13, 2014 through June 2, 2014 and July 3, 2014 through July 21, 2014, representing the period Petitioner was off work for his bilateral upper extremity surgeries.

Relative to ACT, Petitioner alleged injury on June 13, 2014 while working for ACT. The Arbitrator awarded medical expenses and TTD benefits from May 13, 2014 through June 2, 2014 and July 3, 2014 through July 21, 2014, representing 5-3/7 weeks. The Arbitrator awarded 13% loss of use of the right arm, 12% loss of use of the left arm, 6.5% loss of use of the right hand (15% minus the credit of 8.5% from claim 07 WC 51356), and 6% loss of use of the left hand (12.5% minus the credit of 6.5% from claim 07 WC 51356).

The Commission reversed the Arbitrator's Decision relative to the claim against ACT and found that Petitioner failed to prove that his job duties with ACT were repetitive in nature. The Commission adopted the opinion of Dr. Evan Crandall who opined that driving a bus would not cause carpal tunnel or ulnar neuropathy.

As to Cerro Copper, the Circuit Court confirmed the Commission's Decision as to its findings relative to the manifestation date and notice. The Court further confirmed the award of TTD benefits from May 13, 2014 through June 2, 2014 and July 3, 2014 through July 21, 2014. However, the Decision with respect to the PPD award was against the manifest weight of the evidence and, therefore, reversed.

With respect to ACT, the Circuit Court found that the Commission's Decision reversing the Arbitrator's Decision was against the manifest weight of the evidence, and that the Commission's reliance on Dr. Crandall's opinion was in error. The Court found that the evidence supported Dr. Nathan Mall's opinion that Petitioner's duties with ACT were causally related to his condition and his need for surgery. The Circuit Court reversed the Commission's Decision reversing the Arbitrator's finding that Petitioner's claim against ACT was compensable.

The Decision relative to ACT has been reversed as against the manifest weight of the evidence. The Court found the opinion of Dr. Mall more persuasive than the opinion of Dr. Crandall. Dr. Mall opined that the Petitioner's duties with ACT were causally related to his condition and his need for surgery. The Court noted that the evidence supported that Petitioner's condition worsened substantially while working for ACT; therefore, the evidence supported the Arbitrator's finding.

Based on the directive from the Circuit Court, the Commission reinstates, in part, the Arbitrator's original Decision. The Commission awards Petitioner the following reasonable and necessary medical services as contained in Petitioner's exhibit 15: Dr. Mall/Regeneration Orthopedics; NEI of St. Louis; Mercy Imaging; Kansas Brace Systems; Timberlake Surgery Center; Premier Anesthesia; KS Medical; Injured Workers Pharmacy; and, ProRehab, as provided in Sections 8(a) and 8.2 of the Act. The Commission further awards Petitioner TTD benefits from May 13, 2014 through June 2, 2014, and July 3, 2014 through July 21, 2014, representing 5-3/7 weeks. Furthermore, the Commission awards Petitioner 13% loss of use of the right arm and 12%

loss of use of the left arm for his bilateral cubital tunnel surgeries. The Commission further finds that Petitioner is entitled to 15% loss of use of the right hand (with Respondent entitled to a credit of 15% loss of use of the right hand from claim 07 WC 51356), and 12.5% loss of use of the left hand (with Respondent entitled to a credit of 12.5% loss of use of the left hand from claim 07 WC 51356) for his bilateral carpal tunnel surgeries.

IT IS THEREFORE ORDERED BY THE COMMISSION, that the Arbitrator's Decision (13 WC 24044) dated January 5, 2015, is hereby reinstated, in part.

IT IS FURTHER ORDERED BY THE COMMISSION, that Respondent shall pay the reasonable and necessary medical services listed in Petitioner's exhibit 15 of Dr. Mall/Regeneration Orthopedics, NEI of St. Louis, Mercy Imaging, Kansas Brace System, Timberlake Surgery Center, Premier Anesthesia, KS Medical, Injured Workers Pharmacy, and ProRehab, as provided in Sections 8(a) and 8.2 of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION, that Respondent shall pay Petitioner temporary total benefits of $319.00 per week from May 13, 2014 through June 2, 2014, and July 3, 2014 through July 21, 2014, representing 5-3/7 weeks.

IT IS FURTHER ORDERED BY THE COMMISSION, that Respondent shall pay Petitioner permanent partial disability benefits of $319.00 per week for 63.25 weeks, as the injuries sustained caused the 13% loss of use of the right arm and 12% loss of use of the left arm, as provided in Section 8(e).

IT IS FURTHER ORDERED BY THE COMMISSION, that Respondent shall pay Petitioner permanent partial disability benefits of $319.00 per week for 56.375 weeks, as the injuries sustained caused the 15% loss of use of the right hand (with Respondent entitled to a credit of 15% loss of use of the right hand from claim 07 WC 51356), and 12.5% loss of use of the left hand (with Respondent entitled to a credit of 12.5% loss of use of the left hand from claim 07 WC 51356), as provided in Section 8(e).

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 the Circuit Court.

DATED: JUN 18 2019

D. Douglas McCarthy

D: DDM/tdm
d: 6/5/19
052

L. Elizabeth Coppoletti

Stephen J. Mathis

Stephen Mathis

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

EDDIE ANDREWS,

Petitioner,

vs. NO: 07 WC 51356

CERRO COPPER,

Respondent.

19IWCC0309

DECISION AND OPINION ON REMAND

This matter comes before the Commission pursuant to remand from the Circuit Court of St. Clair County. This matter was consolidated at Arbitration with two separate decisions having been issued: one for Respondent, Cerro Copper (07 WC 51356) and the second for Respondent, Agency for Community Transit (ACT) (13 WC 24044). The facts of both cases have been set forth in the Circuit Court's January 3, 2017 Order. A separate Decision and Opinion on Remand has been issued for ACT.

Procedurally, Petitioner alleged injury on January 7, 2008 while working for Cerro Copper. The Arbitrator awarded certain medical expenses and 8.5% loss of use of the right hand and 6.5% loss of use of the left hand. No award for temporary total disability (TTD) was made.

The Commission affirmed the Arbitrator's finding that Petitioner's bilateral carpal tunnel syndrome arose out of and in the course of his employment with Cerro Copper. The Commission further affirmed the Arbitrator's award of medical expenses and the permanent partial disability (PPD) award of 8.5% loss of use of the right hand and 6.5% loss of use of the left hand. The Commission, however, modified the Arbitrator's Decision and found Cerro Copper liable for TTD

benefits from May 13, 2014 through June 2, 2014 and July 3, 2014 through July 21, 2014, representing the period Petitioner was off work for his bilateral upper extremity surgeries.

Relative to ACT, Petitioner alleged injury on June 13, 2014 while working for ACT. The Arbitrator awarded medical expenses and TTD benefits from May 13, 2014 through June 2, 2014 and July 3, 2014 through July 21, 2014, representing 5-3/7 weeks. The Arbitrator awarded 13% loss of use of the right arm, 12% loss of use of the left arm, 6.5% loss of use of the right hand (15% minus the credit of 8.5% from claim 07 WC 51356), and 6% loss of use of the left hand (12.5% minus the credit of 6.5% from claim 07 WC 51356).

The Commission reversed the Arbitrator's Decision relative to the claim against ACT and found that Petitioner failed to prove that his job duties with ACT were repetitive in nature. The Commission adopted the opinion of Dr. Evan Crandall who opined that driving a bus would not cause carpal tunnel or ulnar neuropathy.

As to Cerro Copper, the Circuit Court confirmed the Commission's Decision as to its findings relative to the manifestation date and notice. The Court further confirmed the award of TTD benefits from May 13, 2014 through June 2, 2014 and July 3, 2014 through July 21, 2014. However, the Decision with respect to the PPD award was against the manifest weight of the evidence and, therefore, reversed.

With respect to ACT, the Circuit Court found that the Commission's Decision reversing the Arbitrator's Decision was against the manifest weight of the evidence, and that the Commission's reliance on Dr. Crandall's opinion was in error. The Court found that the evidence supported Dr. Nathan Mall's opinion that Petitioner's duties with ACT were causally related to his condition and his need for surgery. The Circuit Court reversed the Commission's Decision reversing the Arbitrator's finding that Petitioner's claim against ACT was compensable.

The Decision relative to ACT has been reversed as against the manifest weight of the evidence. The Court found the opinion of Dr. Mall more persuasive than the opinion of Dr. Crandall. Dr. Mall opined that the Petitioner's duties with ACT were causally related to his condition and his need for surgery. The Court noted that the evidence supported that Petitioner's condition worsened substantially while working for ACT; therefore, the evidence supported the Arbitrator's finding

As to the Decision relative to Cerro Copper, the Commission hereby reinstates, in part, the Arbitrator's original Decision relative to medical expenses and TTD. The Commission finds that Petitioner is entitled to the following reasonable and necessary medical services as contained in Petitioner's exhibit 15: Dr. Eckert/Chambers Medical; Dr. Glogovac; Midwest Occupational; Dr. Hillard Scott; Christian Hospital; and, St. Louis Neurological Institute, as provided in Sections 8(a) and 8.2 of the Act. The Commission further finds that Petitioner is not entitled to TTD benefits as against Cerro Copper. The Commission, however, awards Petitioner 15% loss of use of the right hand and 12.5% loss of use of the left hand for his bilateral carpal tunnel surgeries.

IT IS THEREFORE ORDERED BY THE COMMISSION, that the Arbitrator's Decision (07 WC 51356) dated January 5, 2015, is hereby reinstated, in part.

IT IS FURTHER ORDERED BY THE COMMISSION, that Respondent shall pay the reasonable and necessary medical services contained in Petitioner's exhibit 15: Dr. Eckert/Chambers Medical; Dr. Glogovac; Midwest Occupational; Dr. Hillard Scott; Christian Hospital; and, St. Louis Neurological Institute, as provided in Sections 8(a) and 8.2 of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $424.93 per week for a period of 56.375 weeks, as provided in §8(e) of the Act, for the reason that the injuries sustained caused 15 percent loss of use of the right hand and 12.5 percent loss of use of the left hand.

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

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

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $27,900.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in the Circuit Court.

DATED: JUN 18 2019

DDM/tdm
d: 6/5/19
052

D. Douglas McCarthy

L. Elizabeth Coppoletti

Stephen Mathis

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Luis Merced,

Petitioner,

vs. NO: 16 WC 17120

Edler Company, Inc.,

19IWCC0310

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Respondent and Petitioner herein and notice given to all parties, the Commission, after considering the issues of causation, earnings, prospective medical treatment and temporary partial disability benefits, and being advised of the facts and law, modifies the Decision of the Arbitrator as stated below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof. The Commission further remands this case to the Arbitrator for further proceedings for a determination of a further amount of temporary total compensation or of compensation for permanent disability, if any, pursuant to *Thomas v. Industrial Comm'n*, 78 Ill.2d 327, 399 N.E.2d 1322, 35 Ill.Dec. 794 (1980).

The Commission notes that §8(a) of the Act provides, in pertinent part, that "[t]emporary partial disability benefits shall be equal to two-thirds the difference between the average amount that the employee would be able to earn in the full performance of his or her duties in the occupation in which he or she was engaged at the time of the accident and the gross amount which he or she is earning in the modified job provided to the employee by the employer or in any other job that the employee is working."

In the present case, Petitioner credibly testified that after his benefits were cut off he worked as an Uber driver. (T.48). He noted that this job was not regular and continuous, and that

he would drive "... probably like three to four hours" a day during a given week and "[n]o more than 16 hours probably. Probably 16 to 20 hours [a week]. My best, I have never even completed a week of Uber drive. I have done maybe three days out of a week at the most." (T.51-52). He noted that on "... average I was making probably like $17 an hour, $16 an hour. Sometimes less, sometimes more. I mean, Uber fluctuates. It depends on if there is a rush going on. I came to find out that the weekends you would earn more money than the weekdays." (T.52). Based on these figures, Petitioner agreed that a fair estimate for the amount of wages that he would earn as an Uber driver on a weekly basis would range from $272.00 to $340.00. (T.52-52).

In arriving at his temporary partial disability ("TPD") rate, the Arbitrator, without explanation, based his award on the highest amount in the aforementioned range, or $340.00. The Commission believes that a fairer reflection of the amount Petitioner earned as an Uber driver during this period would be based on the average amount he estimated he would make on a weekly basis, or $306.00 ([$272.00 + $340.00] ÷ 2). Thus, Petitioner would be entitled to $407.67 per week in TPD benefits, based on 2/3rds of the difference between the stipulated AWW ($917.50) and the average amount Petitioner earned as an Uber driver ($306.00).

Furthermore, by way of clarification, the Commission notes that the parties agreed Petitioner had been paid TTD through 8/17/17, and that Petitioner was seeking TTD from 8/18/17, the alleged MMI date, through 1/5/18, the hearing date at arbitration. (T.10,28). The Arbitrator found that Petitioner failed to prove his entitlement to TTD benefits given that he worked during the period in question, albeit not on a continuous, full-time basis. Thus, the Arbitrator found that "Petitioner is entitled to TPD benefits as of September 1, 2017, the date Petitioner acknowledged that he was driving for Uber, through the date of the hearing, except for the period Petitioner worked for CR Express, from December 7, 2018 [*sic*] through December 18, 2017. As such, the Arbitrator finds Petitioner is entitled to 18 3/7 weeks of TPD benefits of $385.00 per week." (Arb.Dec.[Addendum], p.12). To avoid any possible confusion, the Commission hereby clarifies the Arbitrator's decision to show that Petitioner was entitled to TPD benefits from 9/1/17 through 12/6/17 [13-6/7 weeks] and from 12/19/17 through 1/5/18 [2-4/7 weeks], for a period of 16-3/7 weeks.

All else is otherwise affirmed and adopted.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Arbitrator's decision dated 2/22/18 is modified as stated herein.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to the Petitioner the sum of $407.67 per week from 9/1/17 through 12/6/17 and from 12/19/17 through 1/5/18, for a period of 16-3/7 weeks, that being the period of temporary partial disability under §8(a) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall authorize and pay for prospective medical treatment in the form of the L4-L5, L5-S1 laminectomy and fusion recommended by Dr. Kern Singh, pursuant to §8(a) and §8.2 of the Act.

19IWCC0310

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 $10,000.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: JUN 18 2019
o:4/23/19
TJT/pmo
51

Thomas J. Tyrrell

Maria E. Portela

Deborah L. Simpson

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

MERCED, LUIS
Employee/Petitioner

Case# **16WC017120**

EDLER COMPANY INC
Employer/Respondent

19IWCC0310

On 2/22/2018, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.82% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

4325 MAYER & MARSH
MICHAEL V MARSH
123 W MADISON ST SUITE 700
CHICAGO, IL 60602

0766 HENNESSY & ROACH PC
PETER J PUCHALSKI
140 S DEARBORN ST SUITE 700
CHICAGO, IL 60603

19IWCC0310

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

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
AMENDED ARBITRATION DECISION
19(b)

Luis Merced
Employee/Petitioner

v.

Edler Company, Inc.
Employer/Respondent

Case # **16** WC **17120**

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 **Frank Soto**, Arbitrator of the Commission, in the city of **Chicago**, on **January 5, 2018**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. [ ] Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?

B. [ ] Was there an employee-employer relationship?

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

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

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

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

G. [ ] What were Petitioner's earnings?

H. [ ] What was Petitioner's age at the time of the accident?

I. [ ] What was Petitioner's marital status at the time of the accident?

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

K. [x] Is Petitioner entitled to any prospective medical care?

L. [x] What temporary benefits are in dispute?
[ ] TPD [ ] Maintenance [x] TTD

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

N. [ ] Is Respondent due any credit?

O. [ ] Other ______

FINDINGS

On the date of accident, **May 11, 2016**, Respondent *was* operating under and subject to the provisions of the Act.

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

On this date, 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 **$47,710.00**; the average weekly wage was **$917.50**.

On the date of accident, Petitioner was **38** years of age, *single* with **2** dependent children.

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

Respondent shall be given a credit of **$42,505.23** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$42,505.23**.

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

ORDER

Petitioner has proven by a preponderance of the credible evidence that his current condition of ill-being is causally related to his work injury of May 11, 2016.

Petitioner is entitled to 18 3/7 weeks of TPD benefits as set forth in the Conclusions of Law attached herein.

Respondent shall authorize and pay for the L4-L5, L5-S1 laminectomy and fusion surgery recommended by Dr. Kern Singh as set forth in the Conclusion of law attached herein.

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

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

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

Signature of Arbitrator

2/21/2018
Date

FEB 22 2018

Procedural History

This matter was tried before Arbitrator Frank Soto on October 16, 2017 pursuant to Sections 19(b) and 8(a) of the Act. The disputed issues are whether Petitioner's current condition of ill-being is causally connected to his injury, what temporary benefits are due Petitioner, if any, and whether or not Respondent liable for a laminectomy and fusion surgery recommended by Petitioner's treating physician.

Findings of Facts

Luis Merced (hereinafter referred to as "Petitioner") was employed by Edler Company, Inc., (hereinafter referred to as "Respondent") as a transporter and spotter. Petitioner was 38 years old, single with two dependent children. (Arb. Ex. 1)

On May 11, 2016, Petitioner was dropping of a trailer turning a crank when he felt a pop in his low back. Petitioner testified that he fell to the ground and it felt as a knife was in his back. Petitioner called his boss for assistance and a co-worker picked him up and took Petitioner to his car. Petitioner drove home and went to bed. Petitioner testified that later that night he went to the emergency room at Lutheran General Hospital due to back pain. Petitioner was subsequently discharged only to return the follow day. At that time, Petitioner was admitted into the hospital. While at Lutheran General Hospital Petitioner had a CT-scan and MRI of his lumbar spine, which showed spondylolysis at L4-L5 and a disc herniation at L2-L3. On May 21, 2016, Petitioner returned, again, to Lutheran General Hospital's emergency room with back pain. (PX 4)

On May 23, 2016, Petitioner began treating with Dr. Thomas Gleason of Illinois Bone and Joint Institute. Petitioner was diagnosed with a left L2-L3 disc herniation, lumbar radiculopathy with pain going into the left leg and spondylolysis at L4-L5. Petitioner was proscribed pain medication, epidural steroid injections, physical therapy and home exercise. After Petitioner did not respond to the treatment, Dr. Gleason recommended an L2-L3 laminectomy and disc excision. (RX 6)

On August 31, 2016, Petitioner sought a second opinion from Dr. Bovis, at Dr. Gleason's

request. Dr. Bovis diagnosed a small left L1-L2 and a moderate size left L2-L3 disc herniation and preexisting congenitally narrow lumbar spinal canal. Dr. Bovis recommended a L1-L3 laminectomy, discectomy with possible instrumented fusion. (RX 8), (PX3).

On July 25, 2016, Petitioner was examined by Dr. Wellington Hue, pursuant to Section 12 of the Act. Dr. Hsu diagnosed a left-sided L2-3 disc herniation, congenital lumbar stenosis and bilateral L4 and L5 spondylolysis. Dr. Hsu opined that Petitioner's left lower extremity and low back pain were causally related to the work-related accident of May 11, 2016 and were caused by the left-sided L2-3 disc herniation. Dr. Hsu believed that Petitioner's pre-existing congenital stenosis and lumbar spondylolysis had no bearing upon Petitioner's current symptoms. Dr. Hsu recommended a L2-3 left-sided microdiscectomy. (RX 4)

On October 24, 2016, Respondent sent Petitioner to Dr. Kern Singh, of Midwest Orthopedics at RUSH, for a second opinion. Dr. Singh agreed that Petitioner should have the two-level lumbar fusion surgery because of Petitioner's lower extremity weakness, spondylolysis defects and symptoms being refractory to physical therapy.

On November 4, 2016, Dr. Singh reevaluated his surgical recommendation in a letter to a medical management case manager. In his letter, Dr. Singh agreed to proceed with the microscopic discectomy previously recommended by Dr. Hsu and Dr. Gleason. Dr. Singh testified that he reevaluated his recommendation because the other doctors believed Petitioner's primary pain generator was from the L2-L3 disc herniation. Dr. Singh agreed Petitioner had left lower extremity complaints but there was an overlap of symptoms between the disk herniation and the L4-L5 spondylolysis defects. (PX 3)

On December 14, 2016, Dr. Singh performed the left L2-L3 microscopic discectomy. Following the surgery, Petitioner continued to complain of lower back pain, numbness and tingling extending down his left lower extremity into his foot.

Petitioner attended work conditioning ATI Physical Therapy, Petitioner was discharged on May 19, 2017 at a medium physical demand level. The discharge report states that Petitioner reported pain and numbness/tingling in his left leg and tailbone pain while riding a bike and that Petitioner was unable to tolerate sitting on a bike or a chair for more than 10 minutes. The discharge report indicated that Petitioner's participation exceeded expectations and

recommended that Petitioner received further testing and treatment for his continued low back pain and radicular symptoms. The discharge report further recommended functional capacity examination (hereinafter referred as "FCE").

On April 13, 2017, Petitioner attended an FCE. The FCE report states that Petitioner experienced increased pain with lifting tasks below waist level and decreased pain levels with lifting tasks above the waist level and that Petitioner reported pain levels of 10/10. The report found the FCE to be invalid based upon Petitioner's scored of 58% which was suggestive of a poor effort. (RX 1)

On May 22, 2017, Petitioner returned to Dr. Singh complaining of low back pain shooting down his legs with certain positions. At that time, Dr. Singh renewed his recommendation for fusion surgery and restricted Petitioner from working. Regarding his surgical recommendation, in a letter dated May 26, 2017, Dr. Singh wrote:

> "*Mr. Merced is 5 months from a left-sided L2-3 microdiskectomy where he continues to report of significant lower back pain down both legs. In my opinion, I believe the patient is continuing to have pain from the spondylolysis at L4-L5 and L5-S1. In light of this, I have recommended an L4-5, L5-S1 laminectomy, TLIF, instrumented posterior spinal fusion at both levels.*" Dr. Singh further wrote, "*I reemphasize that Mr. Merced has been suffering from a spondylosis defect...for which I had recommended a 2-level lumbar fusion. He has persistent back and leg pain in an L4-L5 and L5 distribution, consistent with spondylosis defects. Furthermore, he has objective findings of a tibialis anterior and EHL weakness consistent with L4-L5 weakness that, once again, would be consistent with his spondylosis defects. I reemphasize my position that the patient sustained an aggravation of his underlying degenerative condition at the L4 and L5 levels as a result of his date of injury, worsening his spondylosis, and that he requires a 2-level lumbar fusion to address his spondylosis defects.* (PX 3)

On July 28, 2017, Petitioner was sent to Dr. Hsu for an examination, pursuant to Section 12 of the Act. Dr. Hsu diagnosed a fully resolved left-sided L2-3 microdiskectomy, congenital lumbar stenosis, and bilateral L4 and L5 spondylolysis. Dr. Hsu opined that Petitioner's continued left lower extremity and low back pain was not related to his L4 and L5 spondylolysis nor related to Petitioner's work injury of May 11, 2016. Dr. Hsu further opined that Petitioner was at MMI and capable of returning to full duty work. Dr. Hsu did not believe Petitioner was a candidate for an L4-5, L5-S1 laminectomy and fusion surgery because Petitioner exhibited

"narcotic additive behavior," and had an "invalid" functional capacity evaluation. (RX 5)

Testimony of Dr. Wellington Hsu

Dr. Wellington Hsu testified examined Petitioner on July 25, 2016. At that time, Dr. Hsu diagnosed Petitioner with a left-sided L2-3 disc herniation, congenital lumbar stenosis, and bilateral L4 and L5 spondylolysis. Dr. Hsu testified Petitioner's left lower extremity and low back pain was caused by a left-sided L2-3 disc herniation, which was causally related to Petitioner's work-related accident of May 11, 2016. Dr. Hsu opined that Petitioner was a candidate for an L2-3 left-sided microdiscectomy.

Dr. Hsu reexamination of Petitioner July 28, 2017. Dr. Hsu, again, diagnosed left-sided L2-3 disc herniation and continued congenital lumbar stenosis and bilateral L4 and L5 spondylolysis. Dr. Hsu opined that Petitioner's bilateral L4-L5 spondylolysis was not, in any way, related to Petitioner's work accident of May 11, 2016. Dr. Hsu testified that he based his opinion, in part, upon the April 13, 2017 MRI which showed the bilateral L4-5 spondylolysis was not irritating a nerve root. Dr. Hsu testified Petitioner was lying down for the April 13, 2017 MRI was in a supine position. Dr. Hsu's opined that Petitioner's spondylolysis at L4 and L5 had not progressed to spondylolisthesis.

Dr. Hsu acknowledged that symptomatic L4-L5 spondylolysis would show localized low back pain that would be made worse with hyperextension and rotation to the affected side. Dr. Hsu further acknowledged that Petitioner reported to Dr. Singh back pain radiating into the left lower extremity and into the dorsum of the left foot. However, Dr. Hsu testified that Petitioner did not report pain radiating into the left lower extremity during his examination.

Dr. Hsu opined Petitioner reached MMI on April 13, 2017, the date of the FCE, because Petitioner completed conservative surgical management, proper post-operative physical care and the FCE was found not to be valid on that date. Dr. Hsu also opined that Petitioner could return to work full duty and that Petitioner was a poor candidate for fusion surgery because Petitioner failed the FCE and had narcotic addictive behavior postoperatively.

On cross examination, Dr. Hsu testified that Petitioner's mechanism of injury could have aggravated a pre-existing spondylolysis condition and that Petitioner's left lower extremity pain

was worse after the microdiscectomy. Dr. Hsu testified he was unaware that Dr. Singh disregarded Petitioner's failed FCE because Petitioner successfully completed a work conditioning program and that Petitioner exceeded the participation expectations and that Dr. Singh found that Petitioner had rectified narcotic-addictive issues and Petitioner had complied with Dr. Singh's narcotic drug requirements. Dr. Hsu also testified that he was not aware Dr. Singh had not released Petitioner to return to work and Dr. Singh maintained Petitioner's work restriction. (RX 7)

Testimony of Dr. Kern Singh

Dr. Kern Singh testified he is a full professor of orthopedic surgery at Rush University Medical Center and he treats between 150-200 patients per week and performs between 400-500 spinal surgeries per year.

Dr. Singh testified he first saw Petitioner on October 24, 2016. At that time, Petitioner reported low back pain that radiated into his left lower extremity and foot after feeling a pop in his low back while turning a crank at work. Dr. Singh diagnosed L4-L5 and L5-S1 spondylolysis and a disc herniation at L2-L3. Dr. Singh testified that Petitioner's pain, weakness, tingling and numbness in the left foot indicated an L4-L5 etiology. Dr. Singh opined that Petitioner's L4 and L5 spondylolysis was aggravated by his work accident requiring the two-level fusion surgery at L4-L5, L5-S1.

Dr. Singh testified he subsequently reevaluated his initial surgical recommendation because the other doctors believed Petitioner's primary pain generator was the L2-3 disc herniation. Dr. Singh decided to proceed with the L2-3 left-sided microdiscectomy recommended by Dr. Hsu. Dr. Singh testified that an overlap of symptoms existed between Petitioner's L2-L3 disc herniation and Petitioner's L4 and L5 spondylolysis.

On December 14, 2016, Dr. Singh performed the L2-3 microscopic discectomy. Dr. Singh testified over the next five months, Petitioner continued to complain of significant lower back pain, numbness and tingling extending down the left lower extremity into the foot which was consistent with the L4-L5, L5-S1 nerve root pathology. Dr. Singh subsequently recommend Petitioner undergo the L4-5, L5-S1 laminectomy and fusion surgery originally recommended.

Dr. Singh testified a MRI would not show nerve root compression in patients with spondylolysis because, when they lay down for the MRI, the spondylolysis corrects itself and no longer compresses the nerve roots while the patient is lying down. Dr. Singh further testified:

Q. In the fusion that you're recommending, is it being offered to address the spondylolysis defects at L4 and L5 solely or is it being recommended to address any other degenerative condition?

A. No, it's to address the stress fracture at L4 and L5, the spondylolysis.

Q. So there's nothing about the presence of stenosis, be it congenital or not, that is factoring into your surgical recommendation?

A. No. If you really think about this, you asked me some questions about whether Mr. Merced has high-grade stenosis, I said absolutely not. Spondylolysis defect is a discontinuity of the front and the back of the spine. So when someone stands, when they weight bear, the spine, the front part, shifts forward and the back part stays and the nerve root gets pinched and irritated.

When they get their MRI, it reduces, so connects again. That's why the radiologist first missed the spondylolysis defect on the MRI, because it reduces. So when he lays down, you don't see it, and it says "no high-grade stenosis," absolutely. But when he stands, when he goes into a bike in a flexed position and he sits which increases the disc pressure, it splays apart and he gets the irritation.

So to answer your question, it's not about his disc degeneration, it's not about his stenosis, it's about his movement from his stress fracture that has been there before the time point of his injury that I believe was aggravated as a result of the injury.

* * *

Q. And are you going to see -- assuming that you have a symptomatic pars defect, are you going to see on advanced imaging studies cord compression, abutment of a nerve root, are you going to be able to visualize the condition that is actually manifesting in a radicular type symptom?

A. No, because when he lays down, the stress fracture reduces. That's why I get a flexion/extension radiograph which shows the bending forward, bending backward and you see it on an X-ray, because an MRI and CT scan are obtained with him laying down in a reduced position. (PX 5)

Dr. Singh testified that he did not believe Petitioner's "narcotic addictive behavior" or "failed FCE" would make him less of a candidate for a two-level fusion surgery. Dr. Singh said, after raising the issue, Petitioner rectified the behavior, was off narcotics, and was completely compliant, and did not exhibit narcotic dependence or addictive behavior.

Dr. Singh further testified that since Petitioner gave a valid effort during his work conditioning program, his "invalid" FCE results did not diminish Petitioner's candidacy for the surgery. Dr. Singh testified Petitioner was not at MM. Dr. Singh further testified as follows:

Q. If you refer back to Dr. Hsu's report that you've got in front of you, I believe it's under paragraph three, would you agree with Dr. Hsu's opinion that Mr. Merced has reached his maximum medical improvement level on April 13th of 2017 after he exhausted conservative treatment and surgical management fo the L2-L3 left-sided disc herniation?

A. I don't believe that he's at MMI.

Q. Why do you feel that way?

A. He still traces out an L5 radiculopathy with weakness in the L5 distribution and a CT and MRI document no more of a disc herniation at L2-3 is resolved and persistence of his spondylolysis defects, these stress fractures at the L4 and L5 levels which would correlate with his pain complaints and his weakness.

Q. And with that date in mind, do you agree with Dr. Hsu's opinion that any treatment of Mr. Merced -- any treatment that Mr. Merced requires after April 13th, 2017, which presumably would include the L4-L5, L5-S1 laminectomy and fusion surgery that you recommended would be nowhere related to his work accident of May 11th, 2016?

A. I would disagree for the reason I mentioned above, the patient has no disc herniation present, but yet has a radiculopathy in L5 distribution and radiographic studies that correlate.

Q. And do you agree with Dr. Hsu's opinion that Mr. Merced is capable of returning to work on a full-duty basis at that time?

A. I believe he's capable of returning to work in a light/medium category as delineated in his work conditioning program, but I don't believe that he meets his job requirements currently.

Q. And what is the basis of your opinion in that regard?

A. His work conditioning doesn't -- he meets a level right below his level of requirements, and he has a persistent radiculopathy with motor weakness which would explain his deficit. (PX 5)

Dr. Singh opined that Petitioner's symptoms were consistent with the results of an MRI taken on March 13, 2017 and were related to Petitioner's spondylolysis at L4-L5 and L5-S1, which was aggravated by Petitioner's work accident. Dr. Singh further testified Petitioner's work accident aggravated the underlying spondylolysis at L4-L5 and L5-S1 which manifested in sensory loss and motor weakness in the L4 and L5 distribution which also correlated with Petitioner's repeated radiographic studies which reveal the presence of a spondylolysis defect with no disc herniation at the L3-L3 after the microdiscectomy. Dr. Singh testified the mechanism of Petitioner's injury was consistent with his pain complaints in the L4 and L5 distribution which also correlated with Petitioner's repeated radiographic studies

Petitioner testified that Dr. Singh's "narcotic additive behavior" admonishment was based upon an incident in January of 2017 when he attempted to fill his prescription at a CVS after Walgreens was unable to his prescription and directed him to fill the prescription at CVS. Petitioner testified after Dr. Singh's admonishment he discontinued taking the medication and has not taken it since. Petitioner further testified he would like to proceed with the surgery recommended by Dr. Singh and that he is still experiencing significant pain and he is unable to perform many of his everyday activities.

Petitioner testified that he had not been released to return to work but after his TTD benefits were cut-off he tried to earn money to support his family by taking out a loan, use of credit cards and working sporadic jobs. Petitioner testified he worked for a friend painting for a week in October of 2017. Petitioner testified that in September of 2017 he started driving for Uber. During the first week, he drove between 2-3 hours a day and, after buying a pillow to sit on, he started driving 3-4 hours a day. Petitioner testified he earns between $272.00 to $340.00 per week, working 16-20 hours per week and earning between $16.00- $17.00 per hour. Petitioner continues to drive for Uber.

Petitioner also testified from December 7, 2016 through December 18, 2017 he worked for CR Express as a truck driver. During that period, Petitioner earned between $1,600.00 and

$1,700.00. Petitioner testified he stopped working at CR Express because he was not physically able to perform the job.

The Arbitrator found the testimony of Petitioner to be credible.

Conclusions of Law

The Arbitrator adopts the above Findings of Fact in support of the Conclusions of Law set forth below. To obtain compensation under the Act, Petitioner has the burden of proving, by a preponderance of the evidence, all of the elements of his claim. *O'Dette v. Industrial Commission*, 79 Ill.2d 249, 253 (1980) including that there is some causal relationship between his employment and his injury. *Caterpillar Tractor Co. v. Industrial Commission*, 129 Ill. 2d 52, 63 (1998).

Decisions of an arbitrator shall be based exclusively on the evidence in the record of the proceeding and material that has been officially noticed. 820 ILCS 305/1.1(e). 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).

With regard to the issue (F) whether Petitioner's current condition of ill-being is causal related to his injury, the Arbitrator finds as follows:

When a workers' physical structures, diseased or not, give way under the stress of their usual tasks, the law views it as an accident arising out of and in the course of employment. *General Electric Co. v. Industrial Comm'n*, 89 Ill.2d 432, 60 Ill. Dec. 629, 433 N.E.2d 671 (1982). If a claimant is in a certain condition, and accident occurs, and following the accident, the Claimant's condition has deteriorated, it is inferable that the intervening accident caused the deterioration and the salient factor is not the precise previous condition, it is the resulting deterioration from whatever from that previous condition. *Natette Schroeder v. Illinois Workers' compensation Comm'n*, 217 IL. App (4th) 106192WC. In preexisting conditions cases, recovery will depend on the employee's ability to show that a work-related accidental injury aggravated or accelerated the preexisting disease such that the employee's current condition of ill-being can be

said to have been casually-connected to the work-related injury and not simply the result of a normal degenerative process of the preexisting condition. *Caterpillar Tractor Co. v. Industrial Comm'n*, 129 Ill.2d, 52, 133 Ill. Dec. 454, 541 N.E.2d 665 (1989). Even though an employee has a preexisting condition which may make him more vulnerable to injury, recovery for an accidental injury will not be denied as long as it can be shown that the employment was also a causative factor. *Caterpillar Tractor Co. v. Industrial Comm'n*, 129 Ill.2d, 52, 133 Ill.Dec. 454, 541 N.E.2d 665 (1989).

The Arbitrator has carefully reviewed and considered all medical evidence along with all testimony. The Arbitrator concludes that Petitioner has proven by a preponderance of the credible evidence that Petitioner's current condition of ill-being is causally related to his work injury of May 11, 2016, as more fully set forth below.

Prior to May 11, 2016, Petitioner could fully perform his job duties until his work-related accidental injury of May 11, 2016. Following the accident Petitioner's condition continued to deteriorate even after the microdiscectomy.

Dr. Singh testified that the microdiscectomy only addressed the symptoms associated with Petitioner's L2-L3 disc herniation and did not resolved the symptoms associated with the L4 and L5 spondylolysis which was aggravated by Petitioner's work accident of May 11, 2016. Dr. Singh testified Petitioner was suffering from two pathologies after his work accident. Dr. Singh testified the pain, weakness, tingling and numbness in Petitioner's left foot indicated an L4-L5 etiology while the symptoms associated with the L2-3 disc herniation were resolved by the discectomy. Dr. Singh testified the majority of Petitioner's symptoms were explained by the L4-5 and L5-S1 distribution pattern and a percentage of Petitioner's symptoms were related to the L2-L3 level, Petitioner has two different pathologies.

Dr. Singh testified Petitioner's work accident aggravated Petitioner's underlying spondylolysis at L4-L5 and L5-S1 which manifested in sensory loss and motor weakness in the L4 and L5 distribution which was consistent with Petitioner's pain complaints, repeated radiographic studies and mechanism of Petitioner's injury.

The Arbitrator finds the opinions of Dr. Singh to be more reliable than the opinions of Dr. Hsu. Petitioner was complaining of weakness, tingling and numbness in his left foot since his

work accident of May 11, 2016. The symptoms were not symptomatic prior to Petitioner's work accident of May 11, 2016.

Originally, the doctors may have disagreed upon the type of surgery to perform or whether Petitioner's lower extremity symptoms would be resolved by the microdiscectomy but the doctors all agreed that Petitioner had lower extremity symptoms, Petitioner needed surgery and the need for the microdiscectomy was caused by Petitioner's work accident and Petitioner's lower extremity symptoms remained after the microdiscectomy. Following the microdiscectomy a portion of Petitioner's symptoms resolved but the symptoms emanating from the L3 and L4 distribution remained.

After the microdiscectomy Petitioner's condition continued to deteriorate. Dr. Singh opined that Petitioner's work accident aggravated his underlying spondylolysis at L4-L5 and L5-S1, and manifested in an L5 radiculopathy based upon the complaints of pain subjectively and objectively based upon Petitioner's motor weakness and sensory loss. The Arbitrator finds that Petitioner's work accident of May 11, 2016 caused the deterioration of Petitioner's condition.

With respect to issue (K), is Petitioner Entitled to Receive TTD, Maintenance or TPD Benefits, the Arbitrator finds as follows:

Once a claimant has reached MMI, an injury has become permanent and he is no longer eligible for TTD benefits. *Nascote Industries v. Industrial Comm'n*, 353 Ill. App. 3d. 1067, 1072 (5th Dist. 2004) (*citing Archer Daniels Midland Co. v. Industrial Comm'n*, 138 Ill.2d 107, 118 (1990)). To be entitled to receive TTD, the claimant must also show not only that he or she did not work but also that he or she was unable to work. *Interstate Scaffolding, Inc. v. The Illinois Workers' Compensation Commission*, 236 Ill.2d 132, 923 N.E.2d 266, 337 Ill. Dec. 707 (2010).

Petitioner claims he is entitled to received TTD benefits from August 18, 2017 through the date of the hearing. The Arbitrator finds that Petitioner's condition has not stabilized. However, the Petitioner must show he did not work and he was unable to work.

Petitioner testified he started driving for Uber driver about a week after finding out his TTD benefits were terminated. Petitioner was unable to provide the exact date he started driving for Uber. Petitioner testified he continues to drive for Uber earning between $272.00 and

$340.00 per week and driving between 16-18 hours per week. Petitioner testified he makes between $16.00 and $20.00 per hour driving for Uber.

Petitioner also testified that he worked driving a truck from December 7, 2017 to December 18, 2017 for CR Express. Petitioner testified he stopped working for CR Express because he was unable to physically perform the job. Petitioner testified during the week and a half he worked for CR Express he worked fulltime earing approximately $1,600.00. Petitioner testified to also working for a friend painting and earning $400.00.

The Arbitrator finds that Petitioner failed to prove by the preponderance of the evidence that he is entitled to receive TTD benefits because he worked. However, under Section 8(a) of the Act, when an employee is working light duty on a part-time basis or full-time basis and earns less than he would be earning if employed in the full capacity of his job, the employee shall be entitled to temporary partial disability benefits equal to two-thirds of the difference between the average amount that the employee would be able to earn in the full performance of his duties and the gross amount which he or she is earing in in the modified job.

The Arbitrator finds that Petitioner is entitled to receive TPD benefits pursuant to Section 8(a) of Act. The parties stipulated that Petitioner's average weekly wage was $917.50 and Petitioner testified to earning $340.00 per week as an Uber driver. Because Petitioner could not provide the exact date he started, the Arbitrator finds that Petitioner is entitled to TPD benefits as of September 1, 2017, the date Petitioner acknowledged that he was driving for Uber, through the date of the hearing, except for the period Petitioner worked for CR Express, from December 7, 2018 through December 18, 2017. As such, the Arbitrator finds Petitioner is entitled to 18 3/7 weeks of TPD benefits of $385.00 per week.

The Arbitrator further finds that the work Petitioner performed painting for a friend qualifies as occasional wages not precluding an award of benefits pursuant to *Zenith Co. v. Industrial Comm'n*, 91 Ill.2d 278, 437 N.E.2d 628, 62 Ill. Dec. 940 (1982).

With regard to the issue (K) whether or not the Petitioner is entitled to prospective medical care, the Arbitrator finds as follows:

The Arbitrator has carefully reviewed and considered all the medical evidence and all of the testimony and finds that Petitioner is entitled to prospective medical care consisting

of the L4-L5, L5-S1 laminectomy and fusion surgery recommended by Dr. Singh. The Arbitrator found that Petitioner's current condition of ill-being was causally related to his work accident of May 11, 2016. Dr. Singh testified the laminectomy and fusion surgery was necessary and causally related to Petitioner's work accident of May 11, 2016. Petitioner testified he would like to proceed with the surgery recommended by Dr. Singh. The Arbitrator finds the opinions of dr. Singh to be more reliable than the opinions of Dr. Hsu regarding prospective medical care. Accordingly, Respondent shall authorize and pay for the L4-L5, L5-S1 laminectomy and fusion as recommended by Dr. Singh.

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Shari Moore,

Petitioner,

vs. NO: 14 WC 18677

Christopher & Banks Corp., **19IWCC0311**

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, causation, medical expenses, temporary total disability and nature and extent, and being advised of the facts and law, affirms the Decision of the Arbitrator with changes as stated below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

The Commission notes that the Arbitrator made several apparently inconsistent findings in his decision. To wit, the Arbitrator found that "... Petitioner did not sustain an accidental injury arising out of and in the course of her employment for Respondent on May 19, 2014." (Arb.Dec.[Addendum], p.2). However, the Arbitrator proceeded to find that "Petitioner's accident occurred while she was in the course of her employment for Respondent because she was performing a task associated with her job, taking Respondent's deposit to the bank." (Id., p.3). The Arbitrator then essentially found that Petitioner failed to prove that her injuries arose out of her employment on the date in question by noting that "[t]he area where Petitioner sustained the accident was wet and there were some cracks in the surface of the parking lot; however, this did not subject Petitioner to any risk of injury greater than that of the general public (citing *Dukich v. Ill. Workers' Comp. Comm'n*, 2017 Ill.App. [2d] 160351 WC)." (Id.).

19IWCC0311

Furthermore, the Arbitrator noted that he made no conclusions as to causation, medical services, TTD and nature and extent, and that those issues "… are rendered moot because of the Arbitrator's conclusion of law in disputed issue (C)", accident. (Arb.Dec.[Addendum], p.3). However, in the "Findings" section of the Form decision, the Arbitrator found that "Petitioner's current condition of ill-being is not causally related to the accident." (Arb.Dec.[Form], p.2).

The Commission hereby corrects these inconsistencies and clarifies the Arbitrator's decision to show that Petitioner was in the course of her employment at the time of the alleged accident on 5/19/14, but that she failed to prove by the preponderance of the credible evidence that she sustained accidental injuries arising out of her employment or that her right knee condition was causally related to said incident. More to the point, the Commission notes that while Petitioner testified the parking lot in question was "damp" and had "cracks" in it, she failed to present evidence, testimonial or otherwise, that any such hazard was the actual cause of her injury. Instead, she simply stated that she "twisted" her knee as she was walking across the parking lot, and her testimony is noticeably lacking in any mention of slipping on the supposedly "damp" pavement or stumbling on a so-called "crack."

Furthermore, the Commission is unwilling to find that Petitioner was a traveling employee at the time of the accident for the simple reason that the court in *Metropolitan Water Reclamation District of Greater Chicago v. Ill. Workers' Comp. Comm'n*, 407 Ill. App. 3d 1010, 944 N.E.2d 800, 348 Ill.Dec. 559 (1st Dist. 2011) refrained from doing so under a similar scenario involving an employee on her way to make a bank deposit for her employer. The Commission also finds that *Metropolitan Water Reclamation District of Greater Chicago*, supra, is distinguishable on its facts in that the evidence in that case clearly showed that the "street risk" in question (i.e. a "dip" in a driveway) caused the claimant's injury, whereas there was no allegation in the present case that the condition of the parking lot directly influenced the "twisting" of Petitioner's right knee.

All else is otherwise affirmed and adopted.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed 1/30/18, with corrections, is hereby affirmed and adopted, and Petitioner's claim for compensation is hereby denied.

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

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

19IWCC0311

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

DATED: JUN 18 2019
o: 05/07/19
TJT/pmo
51

Thomas J. Tyrrell

Maria E. Portela

Deborah L. Simpson

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

MOORE, SHARI Case# **14WC018677**

Employee/Petitioner

19IWCC0311

CHRISTOPHER & BANKS CORP

Employer/Respondent

On 1/30/2018, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.62% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

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

2284 COZZI & GOGGIN-WARD LAW OFFICE
SHARI GOGGIN
27201 BELLA VISTA PARKWAY
WARRENVILLE, IL 60555

STATE OF ILLINOIS)
)SS.
COUNTY OF MC LEAN)

- [ ] 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

Shari Moore
Employee/Petitioner

v.

Christopher & Banks Corp.
Employer/Respondent

Case # 14 WC 18677

Consolidated cases: n/a

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable William R. Gallagher, Arbitrator of the Commission, in the city of Bloomington, on December 28 2017. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On May 19, 2014, Respondent was operating under and subject to the provisions of the Act.

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

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

Timely notice of this accident was given to Respondent.

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

In the year preceding the injury, Petitioner earned $26,000.00; the average weekly wage was $433.63.

On the date of accident, Petitioner was 55 years of age, married with 0 dependent child(ren).

Petitioner has received all reasonable and necessary medical services.

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

Respondent shall be given a credit of $0.00 for TTD, $0.00 for TPD, $0.00 for maintenance, and $4,162.85 for other benefits, for a total credit of $4,162.85.

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

ORDER

Based upon the Arbitrator's Conclusions of Law attached hereto, claim for compensation is denied.

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

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

William R. Gallagher, Arbitrator
ICArbDec p. 2

January 23, 2018
Date

JAN 3 0 2018

Findings of Fact

Petitioner filed an Application for Adjustment of Claim which alleged she sustained an accidental injury arising out of and in the course of her employment for Respondent on May 19, 2014. According to the Application, Petitioner "twisted knee" and sustained an injury to the "right knee, leg and other parts of the body" (Arbitrator's Exhibit 2). Respondent disputed liability on the basis of accident and causal relationship (Arbitrator's Exhibit 1).

Petitioner worked for Respondent as an Assistant Manager at its retail store located in the Eastland Mall in Bloomington. Petitioner testified that she sustained a slip/fall in the parking lot and injured her right leg/knee. Petitioner stated she left work that morning to go make a deposit for Respondent at PNC Bank. Petitioner was still on the clock and was walking to her car which she intended to drive to the bank because it was several blocks away. Petitioner said that the surface of the parking lot was wet and also had some cracks. At the time Petitioner sustained the slip/fall, she was able to break her fall by grabbing a sign adjacent to a handicap parking spot.

Petitioner testified that she had to park in a designated area of the lot for Respondent's employees. However, Petitioner also stated she was not given a specific assigned spot.

Petitioner reported the accident to Respondent shortly after it occurred and completed and signed a statement regarding same. The statement noted that Petitioner was "Walking to my car, knee popped and lost strength in my knee, handicapped parking sign was there for me to grab onto or I would have fallen." (Petitioner's Exhibit 3). There was nothing in the statement about the surface of the parking lot being wet or having cracks.

Respondent tendered into evidence the First Report of Injury. This report noted that Petitioner injured her knee while in the parking lot going to the bank and her right knee "popped" and her leg went out from under her, but she was able to grab a sign so she did not fall. There was no reference to the surface of the parking lot being wet or having cracks (Respondent's Exhibit A).

Respondent also tendered into evidence a Supervisor Injury Investigation Form which was completed and signed by Ellen Griffith, Petitioner's supervisor. This report noted that Petitioner was walking to her car in the parking lot and her right knee "popped" and Petitioner grabbed a sign to keep herself from falling when her leg went out from under her. Again, there was no reference to the surface of the parking lot being wet or having cracks (Respondent's Exhibit A).

On cross-examination, Petitioner was questioned about the history of the accident contained in the First Report of Injury. Petitioner agreed that the description of the accident contained in the First Report was not completely accurate. Petitioner's explanation was that she was experiencing significant pain at the time the First Report of Injury was completed. Petitioner also stated she remained at work for a few hours after the accident.

Marilee Meyer testified for Respondent at trial. Meyer was Respondent's District Manager and would oversee a group of stores, including the store that employed Petitioner. Meyer testified that the First Report of Injury was completed based on information provided by Petitioner.

In regard to where Petitioner parked her car, Meyer testified that Respondent did not designate an area for employees to park, but that this was designated by the mall. The area where Petitioner parked her car was also available for use by the public. On cross-examination, Meyer agreed that the mall management would communicate the directive of where employees were to park to Respondent's store manager. The manager would then communicate this to the employees.

Respondent tendered into evidence of photographs of the area where Petitioner sustained the accident. In three of the photographs tendered by Respondent, Petitioner agreed that they fairly and accurately depicted the area where she sustained the accident. Petitioner drew circles around the sign adjacent to the handicap parking area and some cracks on the parking lot surface adjacent to it (Respondent's Exhibits D1, D2 and D3). Petitioner stated she fell because of the fact that the surface of the parking lot was wet and she walked on the cracks in the surface.

Subsequent to the accident, Petitioner was treated by Dr. Lawrence Li, an orthopedic surgeon, who initially saw her on May 19, 2014. According to Dr. Li's record of that date, Petitioner was walking on the parking lot at work and on a rough patch of ground. Petitioner then twisted her right knee and fell with excruciating pain (Petitioner's Exhibit 2).

Dr. Li ordered an MRI scan which was performed on May 21, 2014. The MRI revealed a tear of the posterior horn of the medial meniscus, degeneration of the lateral meniscus, patellofemoral compartment degenerative joint disease, joint effusion and a Baker's cyst (Petitioner's Exhibit 4).

Dr. Li performed arthroscopic surgery on June 6, 2014. The surgery consisted of a partial medial and lateral meniscectomy and chondroplasty of the medial femoral condyle, patella and femoral trachea (Petitioner's Exhibit 5).

Following surgery, Dr. Li ordered physical therapy which Petitioner received from September 9, 2014, through October 7, 2014. When Dr. Li saw Petitioner on October 7, 2014, he authorized her to return to work (Petitioner's Exhibits 7 and 8).

Petitioner was able to return to work for Respondent; however, Petitioner subsequently resigned her position with Respondent on October 31, 2014. Petitioner agreed that her resignation had nothing to do with her knee injury. At trial, Petitioner testified she obtained a job as a daycare provider.

At trial, Petitioner stated she still has right knee complaints. Petitioner stated she has difficulty standing for long periods of time and avoids climbing ladders.

Conclusions of Law

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

The Arbitrator concludes that Petitioner did not sustain an accidental injury arising out of and in the course of her employment for Respondent on May 19, 2014.

In support of this conclusion the Arbitrator notes the following:

At trial, Petitioner testified that she sustained the fall on May 19, 2014, because of the fact that the surface of the parking lot where the accident occurred was wet and had cracks. However, in the statement completed and signed by Petitioner, the First Report of Injury and the Supervisor Injury Investigation Form, the accident was described as occurring when Petitioner's right knee "popped." There was no reference to the surface of the parking lot being wet or having cracks.

On cross-examination, Petitioner agreed that the description of the accident contained in the First Report of Injury was not completely accurate. Petitioner's explanation for these omissions was that she was experiencing significant pain at the time the First Report of Injury was prepared.

Even if Petitioner's version of how the accident occurred was, in fact, accurate, the Arbitrator concludes that while the accident occurred under circumstances in the course of Petitioner's employment for Respondent, it did not occur under circumstances arising out of Petitioner's employment for Respondent.

Petitioner's accident occurred while she was in the course of her employment for Respondent because she was performing a task associated with her job, taking Respondent's deposit to the bank.

However, for Petitioner's accident to arise out of her employment for Respondent, she had the burden of proving that she was exposed to a greater risk of injury than the general public because of her employment. Caterpillar Tractor Co v. Industrial Commission, 541 N.E.2d 665 (Ill. 1989).

In this case, Petitioner was walking in a parking lot that was neither controlled nor owned by Respondent. The parking lot was adjacent to a shopping mall and was available for use by the general public. While Petitioner was walking to her car to an area designated for employee parking, that same area was also available for use by the public.

The area where Petitioner sustained the accident was wet and there were some cracks in the surface of the parking lot; however, this did not subject Petitioner to any risk of injury greater than that of the general public.

The fact that Petitioner was walking on a surface that was wet because of rain did not subject Petitioner to any risk of injury greater than that of the public. Dukich v. Illinois Workers' Compensation Commission, 2017 Ill.App. (2d) 160351 WC.

In regard to disputed issues (F), (J), (K) and (L) the Arbitrator makes no conclusions of law as these issues are rendered moot because of the Arbitrator's conclusion of law in disputed issue (C).

William R. Gallagher, Arbitrator

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Douglas Halbert,

Petitioner,

vs. NO. 15WC 19118

Cardinal All Hour Towing,

Respondent.

19IWCC0312

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed November 14, 2018 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. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: JUN 19 2019
SJM/sj
o-6/5/2019
44

Stephen J. Mathis

Douglas McCarthy

L. Elizabeth Coppoletti

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

HALBERT, DOUGLAS
Employee/Petitioner

Case# **15WC019118**

CARDINAL ALL HOUR TOWING
Employer/Respondent

19IWCC0312

On 11/14/2018, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 2.46% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

4890 ANDREW H MARTY PC
5500 MEXICO RD
SUITE 200
ST PETERS, MO 63376

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

19IWCC0312

STATE OF ILLINOIS)
)SS.
COUNTY OF WILLIAMSON)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

Douglas Halbert
Employee/Petitioner

Case # **15** WC **019118**

v.

Consolidated cases: **None**

Cardinal All Hour Towing
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 **Herrin**, on **September 20, 2018**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. [ ] Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?

B. [ ] Was there an employee-employer relationship?

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

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

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

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

G. [ ] What were Petitioner's earnings?

H. [ ] What was Petitioner's age at the time of the accident?

I. [ ] What was Petitioner's marital status at the time of the accident?

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

K. [x] Is Petitioner entitled to any prospective medical care?

L. [ ] What temporary benefits are in dispute?
[ ] TPD [ ] Maintenance [ ] TTD

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

N. [ ] Is Respondent due any credit?

O. [ ] Other ______

FINDINGS

On the date of accident, **April 28, 2014**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

Petitioner's current condition of ill-being in his cervical spine ***is not*** causally related to the accident. Petitioner's current condition of ill-being in his left shoulder ***is*** causally related to the accident.

In the year preceding the injury, Petitioner earned $**31,060.76**; the average weekly wage was $**597.13**.

On the date of accident, Petitioner was **40** years of age, ***married*** with **1** dependent child.

Petitioner was entitled to temporary total disability benefits from **2/18/15** through **5/19/15**, a period of **13 weeks**. Respondent shall be given a credit of $**6,260.93** for TTD, $**0** for TPD, $**0** for maintenance, and $**0** for other benefits, for a total credit of $**6,260.93.**

Respondent ***is*** entitled to a credit of $**0** for any medical bills paid by its group medical plan for which credit is allowed under Section 8(j) of the Act.

ORDER

Petitioner failed to prove that his current condition of ill-being in his cervical spine is causally related to his April 28, 2014 accident. As such, Petitioner's request for an award of prospective medical treatment, in the form of cervical spine surgery, is denied. No benefits are awarded.

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

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

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

Nancy Lindsay
Signature of Arbitrator

November 12, 2018
Date

ICArbDec19(b)

NOV 14 2018

FINDINGS OF FACT AND CONCLUSIONS OF LAW

The parties stipulated that Petitioner sustained an accident arising out of and in the course of his employment with Respondent on April 28, 2014. Respondent further stipulated that Petitioner injured his left shoulder at the time of the accident. However, Respondent disputes that Petitioner also sustained an injury to his neck at the time of the accident.

The Arbitrator finds:

Petitioner began treating for left shoulder problems in 2012. He underwent surgery to the left shoulder on March 22, 2013. (PX G, PX C; RX 1, 2) He was released from care to follow up as needed on September 3, 2013. (PX G)

On November 26, 2013 a settlement contract was approved in case # 13 WC 004502, "Douglas Halbert v. Cardinal All Hour." Petitioner received 15% MAW for right shoulder and disputed left shoulder injuries. (PX F)

The parties stipulated that on April 28, 2014 Petitioner sustained an accident that arose out of and in the course of his employment with Respondent. (AX 1)

Petitioner presented to Dr. Frisella, the surgeon who had treated him in 2012 and 2013 for his shoulder injuries, on May 28, 2014. Petitioner advised that he was holding a trailer with another employee and the employee unexpectedly dropped the trailer, pulling Petitioner's arm forward with immediate excruciating pain and difficulty lifting his arm thereafter. This had occurred a month earlier and he had undergone no treatment in the interim. Petitioner reported persistent shoulder pain. Dr. Frisella suspected a re-tear of the rotator cuff or labrum or a shoulder strain. Petitioner acknowledged some persistent shoulder pain after his 2013 surgery. An MRI of Petitioner's left shoulder was ordered. (PX G)

The MRI was performed on June 9, 2014. It showed a suspected biceps tear with tendon visualized only to the level of the subscapularis tendon, an age indeterminate anterior superior labral tear, and evidence of prior left shoulder surgery with complete history of the intervention not available. (PX G)

Petitioner followed up with Dr. Frisella on June 11, 2014. Petitioner's shoulder still hurt and the doctor, who personally reviewed the MRI, advised Petitioner that it showed no evidence of an acute injury. Dr. Frisella recommended an injection and four weeks of physical therapy. (PX G)

Petitioner presented for physical therapy on June 20, 2014. According to the report Petitioner reported a traumatic onset of left shoulder pain on April 28, 2014. He described symptoms in the acromio-clavicular region and denied any present numbness or tingling. He reported some sleep disturbance a couple of times nightly if lying on his left side. (PX G)

Petitioner continued with physical therapy through July 7, 2014. At the time of that visit he was working full-time regular duty. His overall anterior shoulder discomfort was a 4-5. He described only temporary relief regarding his symptoms. (PX G)

Petitioner followed up with Dr. Frisella on July 8, 2014 reporting ongoing minimal shoulder pain. Petitioner was placed at maximum medical improvement and released to full duty without restrictions. (PX G)

Petitioner underwent no medical treatment between July 8, 2014 and October 3, 2014. Petitioner worked full duty during this time.

Petitioner returned to see Dr. Frisella on October 3, 2014. At that time he reported persistent anterior shoulder pain which was noted to have been present in 2013. The visit with Dr. Frisella was requested by the insurance adjuster because of Petitioner's reports of increased shoulder pain. Petitioner specifically pointed to the front of his shoulder. Dr. Frisella's diagnosis was recurrent subcoracoid impingement. He also noted that Petitioner had been previously diagnosed with that condition in 2013 and that after the work accident in 2014 he had undergone an MRI that was negative for a tear. Dr. Frisella commented, "At this point, I would state that his persistent pain is related to subacromial impingement. This diagnosis predated his work injury, and therefore further treatment should be undertaken under his private insurance." Petitioner's exam was noted to be "nearly normal" and the mechanism of injury in April of 2014 was consistent with a strain. Additionally, Petitioner's physical examination was identical to the one in September of 2013. Dr. Frisella also noted that Petitioner had undergone an injection in September of 2013 that likely provided relief until now and it is wearing off. The next step would be a repeat injection. (PX G)

At the request of Respondent's insurance carrier, Petitioner presented to Dr. Emanuel on October 28, 2014 for a second opinion. Petitioner provided the doctor with a history of his shoulder problems pre-dating the April 28, 2014 work accident. Petitioner related that after his 2013 shoulder surgeries he still had some pain in his left shoulder but he continued to work. Petitioner also described the April 28, 2014 accident explaining that the weight of the trailer jerked his arm downward toward the ground with immediate severe pain in his shoulder "that took his breath away" with ongoing persistent discomfort thereafter. Petitioner had followed up with Dr. Frisella who recommended therapy and an MRI. Petitioner no longer wished to see Dr. Frisella who felt the ongoing pain was pre-existent and unrelated to the recent work accident. Dr. Emanuel performed a physical examination and reviewed the June MRI noting he felt it showed a full-thickness tear of the supraspinatus tendon closer to the musculotendinous junction near the rotator cuff interval. He also felt there was a probable tear of the rotator cuff with a torn capsule of the aromioclavicular joint. Dr. Emanuel felt that Petitioner's work injury of 4/28/14 was the "prevailing factor" in his current left shoulder condition and he recommended surgery. (PX E)

Dr. Emanuel subsequently agreed to take over Petitioner's medical care. Petitioner underwent surgery on February 18, 2015 and he followed up with Dr. Emanuel thereafter. He did well post-operatively and during the March 17th visit the doctor told Petitioner that during surgery he noted Petitioner had a large defect in the rotator cuff interval and there was no tissue for repair. It looked like a chronic condition. The supraspinatus and subscapularis were otherwise normal. Petitioner was deemed to be at maximum medical improvement as of May 19, 2015. He still reported some pain with lifting movements and certain movements. (PX E)

Petitioner signed his Application for Adjustment of Claim herein on May 18, 2015. He alleged a left shoulder injury due to moving a trailer to a trailer hitch ball. (PX A)

Petitioner was seen at Midwest Centre on July 8, 2015 regarding a bump on the left side of his neck of one month's duration. An ultrasound was ordered. (PX C)

Upon the referral of Cheri Jablonoski, Petitioner underwent a cervical MRI at Laser Spine Institute on November 19, 2015. It revealed degenerative changes in disc height and moderate neuroforaminal stenosis at C-56 and C6-7. There was also a moderate-sized right paracentral disc protrusion at C6-7 mildly compressing the spinal cord and adjacent nerve roots. (PX C, PX H)

Petitioner had an appointment with Dr. David Robson on December 2, 2015. A copy of the Questionnaire Petitioner completed on December 1, 2015 is found in Dr. Robson's deposition as an exhibit. There is no copy of the office visit note found in the record.

Petitioner underwent a C6-7 left paramedian epidural steroid injection on December 3, 2015, per the order of Dr. Robson. (PX I)

On December 18, 2015 Petitioner underwent a CT scan which showed a left-sided calcification in the region of the left parotid gland, possibly suggesting a sialolith. (PX C)

Petitioner underwent a second cervical epidural injection on June 7, 2016. (PX I)

It appears that Petitioner underwent no treatment between June 7, 2016 and November 1, 2016.

At the request of his attorney Petitioner presented for an independent medical evaluation with Dr. Robson on November 1, 2016. A written report was issued to Petitioner's attorney that same day. (PX C) According to the report Petitioner was injured in an accident on April 28, 2014 when he was moving a box trailer with another co-worker when the co-worker let go of the trailer causing all the weight to shift to Petitioner who "reported the new onset of neck and left shoulder pain." Petitioner's complaints that day included left-sided neck pain which radiated into his left occiput. He denied any left arm radicular symptoms, numbness, or tingling. He denied any weakness in the upper extremities. Petitioner had undergone two epidural steroid injections at C6-7 on the left, the last one having been performed on June 7, 2016. The injection reportedly provided him symptomatic relief regarding the pressure around his neck and head. Petitioner denied any neck pain prior to the work accident. Petitioner reported that his pain was relieved by walking, working, and injections. Petitioner was working as a tow truck driver without restrictions. Dr. Robson reviewed some prior medical records and the MRI report of November 19, 2015. The actual images were not available. He wrote, "After reviewing the extensive medical records regarding the patient's shoulder, the patient has never previously reported neck complaints. He has not formally, in any of the previous medical records, reported neck pain. Most of the records were focused on the shoulder." (PX C, pp. 7 – 8) Dr. Robson's assessment was C5-6, C6 -7 disc protrusions which he felt were related to the April 28, 2014 accident as the accident was the "prevailing factor" in the development of the neck complaints. He recommended a new MRI. (PX C[1])

At the request of Respondent, Dr. Emanuel examined Petitioner on March 16, 2017. (Joint Ex. 1) In his written report, Dr. Emanuel noted his review of his earlier notes pertaining to his treatment of Petitioner. He further stated that Petitioner told him that after the surgery he had difficulty swallowing which he told the doctor about; however, Dr. Emanuel had on recollection of it nor was it recorded in his notes. Petitioner also indicated that after his release he "complained, in his words, of persistent neck pain which was there all the time following the injury of 4/28/14." He had been to the Laser Spine Institute but didn't like them. He then went to Dr. Robson on his own and had received several cortisone injections with the first one making his symptoms worse and the second one resulting in some improvement. Dr. Robson has recommended another MRI and indicated surgery will probably be necessary. Petitioner also reported he had seen several ENT doctors regarding the painful swallowing but they were unable to make a diagnosis. Dr. Robson gave him the name of one who diagnosed a stone in his saliva land and that it was due to the anesthesia from the shoulder surgery. Dr. Emanuel had never heard of such a complication. Petitioner's complaint on the day of the visit was pain at the base of his skull with occipital headaches, radiation to the shoulder and down to his elbow but no further. He denied any symptoms of numbness or tingling below the elbow. Petitioner was working his regular job and having trouble with lifting and turning

[1] PX C is incorrectly labeled as Dr. Robson's May 16, 2016 Report.

his head to the right or left. He also reported discomfort with coughing or sneezing. Petitioner advised that he reported the neck pain initially through Workmen's Compensation and was told they would cover the shoulder first to see what happens and the neck later if the shoulder did not improve. However, it has denied any treatment for his neck. Dr. Emanuel examined Petitioner's left shoulder and noted some mild response to discomfort with palpation at C6-7. Spurling's test was negative but caused pain at the base of his neck. He lacked any radicular signs. Dr. Emanuel reviewed the MRI disc from June 9, 2014. Dr. Emanuel contacted an anesthesiologist who advised him that he was unaware of any correlation between a saliva gland stone and LMA anesthesia, which is what Petitioner had when he underwent surgery. Dr. Emanuel reviewed Dr. Robson's report of 11/1/16. (Joint Ex. 1)

Dr. Emanuel reviewed all of his past medical records going back to October of 2014 and "at no time, in my medical records, is there mention by the patient of complaints of neck pain." (Joint Ex. 1) He noted that Dr. Robson had reviewed a questionnaire completed by Petitioner on December 2, 2015 which would have been sixteen months after Dr. Emanuel's IME and 13 months after he had agreed to take over management of Petitioner's case. In Dr. Emanuel's opinion, the accident of April 28, 2014 was not the prevailing factor in causing any injury to Petitioner's spine. He felt Petitioner could work full duty without any restrictions. He gave a 0% disability rating for the cervical spine. (Joint Ex. 1)

Petitioner had an appointment with Dr. Robson on August 29, 2017. Dr. Robson noted that Petitioner had undergone an MRI prior to the visit and the doctor had reviewed the report and films. Petitioner's complaints that day included neck and left arm radiating pain, numbness, and tingling, unchanged following his April of 2014 injury. Petitioner was noted to be working without restrictions. Petitioner's left neck and trapezius were tender to palpation. He had neck pain elicited by motion. Neurologically, his left upper extremity was normal. Dr. Robson noted that the August 29, 2017 "MRI of the lumbar spine" showed a C5-6 left paracentral disc protrusion with bilateral foraminal narrowing. At C6-7 there was moderate canal narrowing as a result of a disc osteophyte complex and bilateral foraminal stenosis. Dr. Robson's assessment was that of foraminal stenosis at C5-6, and C6-7, likely the left C5-6 protrusion being the dominant feature causing the left arm symptoms. He recommended a discectomy and fusion at C5-6 and C6-7. He related the need for surgery to the neck injury occurring on April 28, 2014 and that the delay in diagnosis was due to the dominant complaints involving the shoulder, which, he noted, is a very similar type system complex and can be easily confused. He felt Petitioner should only be working at a sedentary level with no overhead lifting. (PX D, Ex. 2)

An MRI of Petitioner's cervical spine was purportedly performed on August 29, 2017. There is no actual report found in the record.

At the request of Respondent, Petitioner was examined by Dr. Michael Chabot on January 25, 2018. (RX 1) Dr. Chabot's history included that Petitioner was working full duty and taking no medication for pain.

Dr. Chabot interpreted x-rays of the cervical spine to show mild anterior spondylolysis to the cervical spine, facet degeneration, C 2-3 and C 3-4. He found evidence of mildly diminished disc space height C6, C7 with mild spondylolysis. There was no evidence on oblique images of significant foraminal narrowing and no evidence of instability on flexion/extension films.

Dr. Chabot concluded that the records he reviewed failed to document complaints of neck pain with radiation to the left upper extremity following his alleged work injury of 04/28/2014. Dr. Chabot agreed with Dr. Emanuel's evaluation and opinions regarding whether Petitioner's neck complaints are related to his alleged work injury of 04/28/2014. In Dr. Chabot's opinion there was insufficient documentation that Petitioner sustained a work injury of the cervical spine that resulted in radicular complaints involving the left upper extremity.

Dr. Chabot noted that Dr. Robson's physical examination and his visit on 11/01/2016 and the subsequent visit almost a year later on 08/29/2017 failed to document any evidence of an active radiculopathy. There was no evidence of muscle strength changes, sensory changes or reflex changes, which lead one to conclude that Petitioner was experiencing symptoms associated with an active radiculopathy.

Dr. Chabot was of the opinion that the changes in Petitioner's cervical spine at C-5 – 6 and C6 – 7 pre-dated Petitioner's injury of April 28th, 2014. He felt Petitioner had chronic progressive degenerative changes that are associated with genetic factors and not his work injury of 04/28/2014. In his opinion, these degenerative changes would progress regardless of what activity Petitioner performs.

Dr. Chabot concluded that Petitioner reached maximum medical improvement (MMI) regarding his work injury of 04/28/2014 and agreed with Dr. Emanuel's opinion that Petitioner had reached MMI by May 19, 2015. (RX 1)

Dr. Chabot issued an addendum report on July 27, '2018 (RX 2). This report was issued after Dr. Chabot had reviewed additional medical records. After reviewing those records he noted that his conclusions from his prior report remain unchanged. He still felt that any additional treatment Petitioner needed was to address chronic degenerative changes to his cervical spine that was unrelated to his work injury. In his supplemental report, Dr. Chabot disputed Dr. Hurford's assertion that reason for the injection on the left was because the history was positive for left upper extremity radiculopathy. He stated that a right-sided disc herniation would not result in left-sided complaints. (RX 2)

Deposition of Dr. Robson

The deposition of Dr. David Robson was taken on August 2, 2018. (PX D) Dr. Robson, a board certified orthopedic surgeon, testified that when he initially examined Petitioner, Petitioner complained of pain in the back of his neck and his left shoulder part way down the deltoid muscle. The doctor testified that Petitioner told him he was lifting a "camper" to put on a ball hitch and the "camper" dropped and he began having neck and shoulder pain. He testified that shoulder and neck pain can be confused. He explained that because of the proximity, symptoms can be very similar. (PX D, pp. 1 – 6)

Dr. Robson testified that Petitioner had undergone surgery for his shoulder but he never had complete resolution of his neck and shoulder symptoms which included pain in his neck, the left side of his shoulder and top part of his arm. Petitioner denied that the pain radiated into his hand. Dr. Robson further testified that a doctor who sees a patient for shoulder or neck pain is obligated to rule out the other part as a cause. He compared it to the common problem of discerning between low back pain and hip problems. Dr. Robson further testified that prior to his visit with Petitioner, Petitioner had not undergone an evaluation of his neck. (PX D, pp. 6-7)

Dr. Robson testified that when he saw Petitioner he asked that an MRI be done. According to the doctor, the MRI he ordered showed a herniated disc on the left side between the fifth and six cervical vertebra and narrowing as the nerve exited the spine at the C6/7 level. He noted that the herniation was on the left side, which was the symptomatic side. Dr. Robson testified that a C5/6 herniated disc would cause Petitioner's complaints. He explained that the C6 nerve would be affected by the herniation as it travels down the outside of the shoulder, down to the thumb. He noted that both times when he examined Petitioner, he had the Petitioner fill out pain diagrams. These diagrams were consistent as they both showed pain at the neck and shoulder. (PX D, pp. 7-8)

Dr. Robson testified that he prescribed two epidural steroid injections Petitioner's neck. These injections were performed by Dr. Patricia A. Hurford. The first injection on December 3, 2015 was at the C6/7 level and provided immediate relief. The second injection on June 7, 2016, provided fifty percent resolution of the symptoms immediately after the procedure. Dr. Robson explained that purpose of the injections was two-fold. The lidocaine injected had a short-term effect and was diagnostic. He explained that if one numbs the area that is irritated and the pain goes away, that is a confirmatory diagnosis. (PX D; PX pp. 8-9)

Dr. Robson also testified that both injections failed to resolve Petitioner's complaints. He then recommended surgery to remove the herniated disc at C5/6, decompress the foraminal narrowing in C6/7 and implant an interbody graft with fusion with a plate between those levels. Dr. Robson was of the opinion that the mechanism of injury experienced by Petitioner could have caused or contributed to the herniated disc. Dr. Robson noted that Petitioner never had problems in his neck before the accident and he had an incident that certainly could produce a herniated disc. (PX D, pp. 9 – 10)

On cross-examination Dr. Robson testified that his first visit with Petitioner was on December 2, 2015. He further acknowledged that Petitioner denied any real radicular symptoms in his left arm and hand. He further testified that even though the pain did not radiate all the way down to the hand, it made anatomical sense as nerves can be pinched in different ways. (PX D, pp. 10- 12)

Dr. Robson was then asked about the "April 16th, the one down there" which was the next time he saw Petitioner.[2] At that time Petitioner's primary complaint was neck pain and it was radiating about the same distance as in the December 2015 visit. Dr. Robson then pointed out that there were two pain drawings – one dated April 1, 2015 and the other one dated November 1, 2016. He said they were almost exact copies of one another. (PX D, p. 12)[3] When the pain drawings were marked as exhibits, the doctor acknowledged the actual dates on the reports.

Dr. Robson's next visit with Petitioner was on November 1, 2016. Again, that visit was held at the request of Petitioner's attorney. Dr. Robson testified that Petitioner was complaining of left-sided neck pain which radiated into his left occipital (the back/side of the head). He denied any radicular symptoms going all the way into his hand and he had undergone two steroid injections. The examination that day was consistent with earlier examinations. When the doctor palpated Petitioner's neck and trapezius, Petitioner said it hurt which would be a subjective indicator. He agreed that pain with motion would also be a subjective indicator. Dr. Robson concurred that Petitioner's grip strength was normal bilaterally. His neurological examination was completely normal. Dr. Robson also agreed that, according to Dr. Emanuel's notes, Petitioner was doing well three months after his shoulder surgery. (PX D, pp. 12 – 17)

Dr. Robson also agreed that the MRI report described a herniated disc at C5/6 and a bulging disc at C 6/7. He did not believe there was a difference between a herniated disc and a bulging disc and he felt a bulging disc justified removal if it was producing consistent complaints and there's been relief with an injection. Dr. Robson also agreed that he stated in his November 1, 2016 report that after reviewing Petitioner's extensive earlier medical records regarding his shoulder, it appeared that Petitioner had never previously reported neck complaints. (PX D, p. 17) It was his impression that the first medical records to document were neck pain were those belonging to him. (PX D, p. 18)

Dr. Robson also agreed that the earlier doctors treating Petitioner would have checked for a possible neck problem in light of the neck/shoulder overlap. The doctor also acknowledged that he stated in his August 29, 2017 note

[2] There is no copy of the office visit note found in the record.

[3] The pain drawings are actually dated 12/1/15 and 11/1/16. (See exhibits 5 and 6 to PX D and pp. 12-13 of PX D)

that Petitioner's neck and left arm radiating pain and numbness was unchanged since his injury in 2014. When counsel asked him about the inconsistency between that statement and his statement in his written report acknowledging no prior mention of neck complaints before his initial presentation to the doctor, Dr. Robson responded by stating he felt Petitioner had been mis-diagnosed all along and that his problem has always been a herniated disc. (PX D, pp. 18 – 21)

Dr. Robson acknowledged that he has never seen an MRI from before the accident but he believed Petitioner was asymptomatic. (PX D, pp. 21-22) Dr. Robson was also asked about some notes in his patient file indicating Petitioner had been seen in his office by a physician's assistant on other dates but for problems unrelated to this accident and the doctor indicated "Yes." He added, "I did not attribute his thoracic or lumbar pain to anything that happened at the time of the accident. I felt that his cervical spine was the problem as a result of the accident." (PX D, p. 22)

On redirect examination Dr. Robson testified that the MRI findings are objective signs and the MRI findings, in this instance, were consistent with Petitioner's complaints. When asked why he would perform surgery on someone with a normal neurological evaluation the doctor explained that it takes a major nerve root disruption or spinal cord disruption to cause a neurological deficit. He is recommending surgery because Petitioner is unable to resolve his condition with therapy, injections, rest, or medication of activity and the injection temporarily relieved his pain on two occasions. (PX D, p. 23 -24)

The Arbitration Hearing

Petitioner's case proceeded to arbitration on September 20, 2018 pursuant to a Section 19(b) Petition filed by Petitioner. Petitioner seeks an award of surgery as recommended by Dr. Robson. Disputed issues include causal connection and prospective care. Petitioner was the sole witness testifying at the hearing.

Petitioner testified that, at the time of the hearing, he was a little nervous. He described the accident of April 28, 2014 explaining that as his co-worker let go of his side of the trailer, the trailer "just pulled him down to the ground." Petitioner testified that the trailer was empty and that afterwards his left shoulder hurt and his neck hurt "a little". He initially treated with Dr. Frisella because he had treated him in the past and performed two shoulder surgeries. Dr. Frisella sent him for an MRI and told him he didn't see anything wrong but his shoulder still hurt. Petitioner testified that he then called the "work comp lady back" and told her his shoulder still hurt and she sent him to Dr. Emanuel.

Petitioner's attorney asked Petitioner if he had ever mentioned his neck hurt as well before going to Dr. Emanuel and he testified that he told the adjuster he wasn't sure it was in his shoulder and, maybe, it was in his neck and she told him they would fix his shoulder first and then his neck because they could only do one at a time.

Petitioner testified that he went to Dr. Emanuel who reviewed the MRI and advised him he needed surgery which was performed on February 18, 2015. Petitioner further testified that he told Dr. Emanuel that his neck hurt and he told him it was in his shoulder and that after his shoulder got fixed, his neck would be fine but it's not. Petitioner also testified that he told Dr. Emanuel about his neck and that after the doctor told him his neck would stop hurting after his shoulder was treated he told the doctor that he had advised him the neck pain would stop and that's why he didn't complain every time he went back there.

Petitioner was asked how his complaints were doing once he recovered and he replied that his shoulder still hurt and his neck hurts and "he didn't know." He then explained that after the surgery with Dr. Emanuel he still had

pain in his shoulder and it has progressed and it's the same type of pain he had in his shoulder before the surgery. His neck is worse now.

Petitioner testified that he continues to work for Respondent but doesn't lift anything. He drives the tow truck but doesn't do any tire changes because it is difficult to get the lug nuts off and it hurts his neck. It's also hard to pull out the winch cable. Petitioner testified that since his left shoulder surgery he has had to pull the winch cable but he doesn't want to because it hurts his neck.

Petitioner testified that Dr. Robson's recommended surgery would involve a plate and four screws and he wants to proceed with it "if it hurts bad enough" but he isn't sure because he doesn't think Dr. Robson has told him everything. He realizes he won't be able to turn his neck as much but the pain will be gone.

On cross-examination Petitioner acknowledged that he completed his treatment with Dr. Emanuel on May 19, 2015 and was released to return back to work which he did. He has continued working as a tow truck driver since then. He worked without the remote for the cable for about two years.

The Arbitrator concludes:

WITH REGARD TO ISSUE (F), WHETHER PETITIONER'S CURRENT CONDITION OF ILL-BEING IS CAUSALLY RELATED TO THE APRIL 28, 2014 ACCIDENT:

Petitioner failed to prove that his current condition of ill-being in his cervical spine/neck is causally related to the April 28, 2014 accident. Respondent stipulated that Petitioner's left shoulder condition is causally related to the accident. In concluding that Petitioner's cervical spine condition is not causally related to the April 28, 2014 accident, the Arbitrator relies upon the more persuasive opinions of Dr. Emanuel and Dr. Chabot over those of Dr. Robson.

At the outset the Arbitrator addresses Petitioner's credibility. While he testified that he was a little nervous at the time of his hearing, he did not appear to be in any visible distress. Furthermore, while testifying he moved his neck very freely back and forth and frequently reached out with his left arm/shoulder when testifying, displaying absolutely no difficulty doing same.

Petitioner signed his Application for Adjustment of Claim herein on May 18, 2015 alleging a left shoulder injury. There was no mention of a neck injury. Medical records pre-dating May 18, 2015 fail to mention or suggest any injury to Petitioner's neck as a result of his work accident. If Petitioner claims he injured his neck and shoulder at the time of the accident (as he told Dr. Robson) the Arbitrator finds it significant that Petitioner failed to include any mention of a neck injury on his Application for Adjustment of Claim.

As pointed out by Dr. Robson in his initial report to Petitioner's attorney, the first mention of any neck injury associated with the accident is contained in the doctor's November 1, 2016 report. While the doctor testified to seeing Petitioner on one or two occasions prior to that, those reports were not included in the exhibits, which, in and of itself, is very concerning. Petitioner was referred to Dr. Robson by his attorney. Not only are the visits of December of 2015 and April of 2016 missing from the record, but so is the second cervical MRI Petitioner underwent on August 29, 2017. Dr. Robson stated that the 2017 MRI showed a left-sided herniated disc. Dr. Chabot looked at the 2017 MRI and felt it revealed evidence of desiccation and degeneration of C6-7 greater than C5-6 and broad disc base bulging at C5-6 and C6-7, the latter of which was asymmetric to the right. He made no

mention of a left-sided herniated disc. Thus, there is a discrepancy between the two doctors as to exactly what the 2017 MRI revealed and, since the report from the MRI was not included in the record, the discrepancy remains unanswered.

Dr. Robson further testified that he (or others in his office) are treating Petitioner for thoracic and lumbar complaints/symptoms which the doctor did not feel were related to the accident herein. While the doctor may not feel these other symptoms and problems are related the Arbitrator does find it very interesting that Petitioner, in addition, to alleged cervical problems is also having issues with other regions of his spine.

Dr. Robson testified that he believes Petitioner has been mis-diagnosed from the beginning and that he has always had a herniated disc in his cervical spine. While Petitioner seeks to establish causation for Petitioner's alleged neck condition through Dr. Robson, the Arbitrator was not persuaded by the doctor's reports or testimony. That some of the records and the 2017 MRI were not included is, as already noted, concerning. Furthermore, the doctor's testimony was quite vague on many issues such as the difference between a bulging disc and a herniated disc, the reasons to perform surgery when an exam is neurologically normal, and how he tried to explain the difference between a lack of documentation of neck problems before November 1, 2016 and Petitioner's statements to him that he had been experiencing neck pain since the accident in 2014. He also misunderstood the mechanism of injury as Petitioner was not lifting a "camper" at the time of the accident. While Dr. Robson may have been insistent that the 2017 MRI showed a left-sided cervical herniated disc, he never commented upon, or explained, how that could be the result of the work accident when the 2015 cervical MRI was negative for a herniated disc. While Dr. Robson's report of November 1, 2016 notes that he reviewed the Laser Spine Institute cervical MRI of November 19, 2015, he made no reference of a left-sided herniated disc at that time nor did he review the actual films. Dr. Robson also never considered that Petitioner had been released by Dr. Emanuel as of May 19, 2015 and returned to full duty work. Thus, after the work accident and after his shoulder surgery with Dr. Emanuel he returned to full duty work and has continued to work full duty. The August of 2017 MRI was done over two years after Petitioner had returned to full duty work.

While Dr. Robson's causation theory is premised on an overlap between Petitioner's original shoulder complaints and what he feels is a neck problem, the Arbitrator did not find the doctor's explanation persuasive. In contrast, Dr. Emanuel had the advantage of having examined and treated Petitioner over several months after the accident and then, again, re-examining him and reviewing updated records in 2017 at which time Petitioner had a largely negative examination, including the absence of any radicular findings. Dr. Robson's testimony regarding the absence/presence of radicular complaints was not persuasive. He agreed that in November of 2016 when he examined Petitioner, any radicular complaints did not go all the way down his left arm. He agreed that Petitioner's neurological exam was normal. He then re-examined Petitioner in August of 2017 and, in contrast to his testimony about earlier visits, stated Petitioner's complaints of neck and left arm radiating pain, numbness and tingling were unchanged since his work accident. When questioned about the inconsistency between that statement what he noted in November of 2016 the doctor had no plausible explanation except to blame it on "semantics" or a mistake with dictation. Either way, missing office visits and a missing MRI cast a cloud on the weight to be afforded the doctor's opinions.

While Petitioner may take aim at Dr. Chabot's statement about the inconsistency between Dr. Robson's diagnosis of a left-sided herniated disc and Dr. Chabot's statement that the 2017 MRI showed a right-sided herniated disc, it's difficult to know who might be right as, again, the MRI report, itself, is missing from the record.

For the foregoing reasons, the Arbitrator finds that Petitioner failed to prove that his current condition of ill-being in his cervical spine is causally related to his work accident of April 28, 2014.

WITH RECARD TO ISSUE (K), WHETHER PETITIONER IS ENTITLED TO PROSPECTIVE MEDICAL CARE:

Consistent with her causation determination, prospective medical care for Petitioner's cervical spine is denied.

****

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Jennifer Kerber,

Petitioner,

vs. NO. 15WC 02310

McLean County Unit District #5,

Respondent.

19IWCC0313

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of medical expenses, causal connection, prospective medical care, 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 October 25, 2018 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.

19IWCC0313

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: JUN 1 9 2019
SJM/sj
o-6/4/2019
44

Stephen J. Mathis

L. Elizabeth Coppoletti

Douglas McCarthy

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

KERBER, JENNIFER
Employee/Petitioner

Case# **15WC002310**

19IWCC0313

McLEAN COUNTY UNIT DISTRICT No 5
Employer/Respondent

On 10/25/2018, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 2.42% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

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

0264 HEYL ROYSTER VOELKER & ALLEN
JAMES J MANNING
300 HAMILTON BLVD PO BOX 6199
PEORIA, IL 61601-6199

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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

Jennifer Kerber
Employee/Petitioner
v.
McLean County Unit District No. 5
Employer/Respondent

Case # **15** WC **2310**

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 **Christine Ory**, Arbitrator of the Commission, in the city of **Bloomington**, on **September 29, 2017** and reassigned for issuance of a decision to the Honorable **Barbara N. Flores**, Arbitrator of the Commission. After reviewing all of the evidence presented, the undersigned Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On September 11, 2014, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury Petitioner earned $11,152.36; the average weekly wage was $214.47.

On the date of accident, Petitioner was 38 years of age, *married* with 4 dependent children.

Petitioner *has* received all reasonable and necessary medical services as explained *infra*.

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

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

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

ORDER

Temporary Total Disability

Respondent shall pay Petitioner temporary total disability benefits of $214.47/week for 1 week, commencing February 3, 2015 through February 9, 2015, as provided in Section 8(b) of the Act.

Respondent shall pay Petitioner the temporary total disability benefits that have accrued from September 11, 2014 through September 29, 2017, and shall pay the remainder of the award, if any, in weekly payments.

Medical Benefits

Respondent shall pay reasonable and necessary medical services, pursuant to the medical fee schedule, of the following medical providers as provided in Sections 8(a) and 8.2 of the Act:

- $24,956.00 to Central Illinois Orthopedic Surgery
- $7,404.00 to Ireland Grove Center for Surgery
- $1,134.42 to Ambulatory Anesthesia
- $14,416.00 to Bloomington-Normal Healthcare Surgery Center
- $3,578.40 to Dr. Edward Pegg
- $1,512 to McLean County Anesthesia
- $9,753.00 to Applied Pain Institute

Permanent Partial Disability

As explained in the Arbitration Decision Addendum, in consideration of the factors enumerated in Section 8.1b, Respondent shall pay Petitioner permanent partial disability benefits of $214.47/week for 37.5 weeks, because the injuries sustained caused the 7.5% loss of the person as a whole (lumbar spine), as provided in Section 8(d)2 of the Act.

19IWCC0313

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

STATEMENT OF INTEREST RATE If the Commission reviews this award, interest at the rate set forth on the *Notice of Decision of Arbitrator* shall accrue from the date listed below to the day before the 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 24, 2018
Date

OCT 2 5 2018

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION *ADDENDUM*

Jennifer Kerber
Employee/Petitioner

v.

McLean County Unit District No. 5
Employer/Respondent

Case # **15** WC **2310**

Consolidated cases: **N/A**

FINDINGS OF FACT

The issues in dispute at this hearing include Respondent's liability for certain unpaid medical bills, Petitioner's entitlement to a period of temporary total disability benefits commencing on commencing February 3, 2015 to February 10, 2015, and the nature and extent of the injury. Arbitrator's Exhibit[1] ("AX") 1. The parties have stipulated to all other issues. AX1.

Background

Jennifer Renee Kerber (Petitioner) testified that she worked at Normal Community West High School through McLean County District Number 5 (Respondent) on September 11, 2014. She was employed as a satellite cook in 2014 and has been employed by Respondent for approximately seven years at the time of the hearing.

In her position, Petitioner would cook for the grade schools and help prep with two other ladies after which the food would be shipped out to the grade schools. Petitioner would then go throughout the kitchen to help others as needed and get things ready for the high school students to eat. Depending on the week, Petitioner worked the register or served food. At the end of the day, Petitioner would either fill up water or juices in coolers. Petitioner submitted photographs that depict what the food service line work entails. PX1.

Petitioner sustained an undisputed accident at work. AX1. Specifically, Petitioner testified that she developed a gradual onset of low back discomfort that she attributed to standing on an uneven floor, due to a drain, while serving food to students in the lunch line at the school. She testified that while she was working on the line on September 11, 2014 she felt achy and experienced pain. Petitioner explained that she tried to do some stretches or to stay on one side, but it was kind of hard to do so when so many kids came through wanting one or the other type of lunch. She estimated serving approximately two or three hundred students. At the end of her shift, Petitioner testified that she felt a lot of aching pain in her lower back.

Petitioner further explained the floor on which she stood during the lunch service. The food service line has a drain on the bottom of the floor that is lower than the floor level. Petitioner explained that most of the time her right foot was located on the drain and her upper body was engaged in reaching to grab food to put it on a plate for the kids. She would alternate back and forth on the line serving two meals at once.

Petitioner testified that she had the following day off for a medical appointment with Dr. Gratkins. When she returned to work she spoke with Debbie about it and told her that she was hurting and could barely move. Petitioner testified that she told her why she thought she was in pain. Petitioner also reported her symptoms to

[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.

Joe Adelman at a later point. Petitioner testified that she discussed the drain and the problem with stepping back and forth on the drain with her manager, Debbie, and later with Mr. Adelman.

Some corrections were made to the drain, but Petitioner explained that the cement did not increase the height and it actually made it rougher. Petitioner continued to work and placed a rubber mat down to try to adjust the floor height and provide a cushion. PX13. Ultimately, the drain was removed over a school break period, and the floor was more level. Petitioner testified that she continued to work on that line standing on the grate for some time before the correction was made, but she recalled her doctor placing work restrictions and going to a different line a couple times around December of 2014.

Medical Treatment

After reporting her injury to Respondent on September 11, 2014, Petitioner was sent to see Dr. Chow at OSF Occupational Health on September 18, 2014. PX2, RX2. Dr. Chow recorded a consistent history of accident and diagnosed Petitioner with a back strain and associated left leg pain. *Id.* Dr. Chow gave Petitioner a Toradol injection and prescribed Tramadol. *Id.* Dr. Chow also imposed work restrictions of no repetitive bending/stooping/or twisting, no static/chronic, bent postures, no lifting more than 10 pounds, and sit-stand as tolerated. *Id.* Dr. Chow's record states that Petitioner's left leg felt "funny[.]" *Id.* Petitioner explained that she told Dr. Chow about having back pain after serving on the line and while reaching for plates and twisting while standing on the drain. Petitioner explained that she told Dr. Chow that her left felt "funny" meaning that it was tingly and very sore. Petitioner testified that she was in so much pain that her children had to help her get dressed that week prior to going to see Dr. Chow.

The medical records further reflect that Petitioner continued to treat with Dr. Chow on September 26, 2014, October 10, 2014, October 30, 2014, and November 13, 2014. PX3, RX2. Dr. Chow continued to prescribe restrictions at each visit. *Id.* Dr. Chow prescribed Flexeril, Ibuprofen, and physical therapy. *Id.* Respondent provided work within the restrictions. *Id.*

On November 13, 2014, Dr. Chow referred Petitioner to Dr. Jhee for low back pain. *Id.* Respondent denied the request, but authorized more physical therapy. *Id.*, at 14, 15. On December 3, 2014, Dr. Chow's record states that Petitioner still had low back pain with pain traveling to her right hip and that the medicine was not helping with the pain. *Id.* Dr. Chow stated that Petitioner had a constant squeezing sensation in her low back. Dr. Chow stated that Respondent had not approved the referral to Dr. Jhee. *Id.* Dr. Chow ordered an MRI of Petitioner's low back and prescribed Valium. PX3 at 10-12.

On December 5, 2014, Petitioner underwent the recommended MRI of her lumbar spine. PX4. The interpreting radiologist noted low-grade early degenerative changes of the lumbar spine, particularly at the L4-5 level; no significant central stenosis; and no acute bony fracture or subluxation. *Id.* The radiologist also noted an incidental finding of a tiny right lateral annular tear of the disc and minimal bulge at L4-5 with some minimal lateral recess and right neural foramina encroachment, with no central stenosis. *Id.*

On December 11, 2014, Dr. Chow's records indicate that Petitioner was still having low back pain sitting and walking due to her injury. PX3 at 3, 4; RX2. Dr. Chow recorded that the MRI of the lumbar spine showed degenerative changes especially at L4-5. *Id.* On physical examination, Petitioner had no tenderness in the low back, she was able to walk on her heels and toes, and she exhibited a normal gait. *Id.* Dr. Chow's final diagnosis was of a low grade degenerative arthritis of the lumbar spine. *Id.* Dr. Chow's record indicates that

Petitioner may benefit from further physical therapy to strengthen the back, and that Petitioner wanted to contact Dr. Nord's office. *Id.*

In a separate work status note dated December 11, 2014, Dr. Chow continued Petitioner's work restrictions of no repetitive bending/stooping/twisting/reaching, lifting to no more than 25 pounds, sit-stand as tolerated. PX3; RX2. Dr. Chow stated that Petitioner could return to work without restrictions effective December 30, 2014. Petitioner continued working for Respondent without restrictions since that time. *Id.*

Petitioner testified regarding her December 11, 2014 follow up visit with Dr. Chow. She testified that Dr. Chow told her she had arthritis and there was nothing else she could do for her. Petitioner responded that she could not accept that, and she wanted a second opinion.

Petitioner began treating with Dr. Lawrence Nord, an orthopedic surgeon, on December 23, 2014. PX5. Petitioner had previously treated with Dr. Nord for a hand condition in 2013. *Id.* On December 23, 2014, Dr. Nord recorded a consistent history of accident. *Id.* Dr. Nord stated that there was a divot in the drain where Petitioner had to stand and that she has noticed low back pain which radiates at times since the accident. *Id.* On exam, Dr. Nord noted mild discomfort in the left lumbar area with some straight leg raising at 45 degrees on the left. *Id.* Dr. Nord diagnosed Petitioner with lumbar spine strain and radiculitis. *Id.* Dr. Nord stated that Petitioner's prognosis was guarded. *Id.* Dr. Nord renewed Petitioner's prescription for Meloxicam and Tramadol, he prescribed physical therapy, and he recommended an epidural injection with Dr. Ji Li. *Id.*

On January 12, 2015, Joe Adelman, the director of operations for Respondent, McLean County Unit District No. 5, sent an email to Petitioner. RX3. Mr. Adelman stated that he had a note from Dr. Chow dated December 11, 2014, which released her to return to work without restrictions as of December 30, 2014. *Id.* Mr. Adelman stated that he also had Dr. Nord's note of December 23, 2014 which placed Petitioner on restrictions. *Id.* Mr. Adelman stated that Respondent had work within the restrictions. *Id.* Mr. Adelman stated that Dr. Nord appeared to agree with Dr. Chow's assessment that Petitioner had a degenerative condition in her low back. *Id.* Mr. Adelman informed Petitioner that any further treatment would have to be run through her group health insurance. *Id.*

On January 20, 2015, Petitioner presented to Dr. Nord. PX9 at 5. Dr. Nord stated that Petitioner's current pain was 6/10 in her low back. *Id.* Dr. Nord stated that Petitioner had several issues with insurance and workman's compensation and she had been unable to start physical therapy. *Id.* Dr. Nord stated that standing or sitting in one position for an extended period of time, pushing and turning a cart, and reaching tends to exacerbate her symptoms. *Id.* Dr. Nord noted that rest and medications reduced Petitioner's symptoms. *Id.* Dr. Nord stated that Petitioner was frustrated because of complications with workman's compensation and her work restrictions. *Id.*

On February 2, 2015, Petitioner presented to Dr. Ji Li, a pain specialist. PX6 at 14. Dr. Li took a history that Petitioner had chronic back pain since September 11, 2014 after serving meals to a student and experiencing a gradual onset of low back pain. *Id.* Dr. Li stated that Petitioner had a continuous achy and burning pain into her thoracic and lumbosacral spine with minimal radicular symptoms to her legs. *Id.* Dr. Li stated that the pain is worsened by bending, twisting, lifting, prolonged sitting and standing. *Id.* On February 3, 2015, Dr. Li performed a bilateral L3-4, L4-5 TFESI. *Id.* Dr. Li took Petitioner off work from February 3, 2015 to February 9, 2015. PX6 at 18.

On February 10, 2015, Dr. Li's note states that Petitioner had a 30% relief of pain from the injection. PX6 at 20. The note states that Dr. Nord requested another injection. *Id.* On February 10, 2015, Dr. Nord's records indicate that Petitioner improved after the injection and that he recommended another injection. PX10 at 1-3. On February 17, 2015, Dr. Li repeated the injection. PX6 at 22.

On March 13, 2015, Dr. Nord's records indicate that Petitioner experienced significant improvement in her symptoms after the February 17, 2015 injection and that her pain was 1-4/10. PX10 at 4.

On April 3, 2015, Dr. Li performed a bilateral L3-4, L4-5, TFESI injection. PX6 at 23-26. On April 13, 2015, Dr. Nord recorded a history that Petitioner had increasing symptoms of 6 to 7/10 for her lumbar radiculitis and right leg pain. PX10 at 8, 10. Dr. Nord recommended a third epidural injection. *Id.*

On April 28, 2015, Dr. Nord stated that Petitioner improved after her third ESI injection, but she continued to experience a fairly constant burning pain in the center of her low back into the right lumbar spine with increased pain while standing for extended periods of time. PX10 at 12, 14. Dr. Nord stated that Petitioner had been participating in physical therapy at NORC and that she was performing home exercises as well as taking Ibuprofen or Tylenol to modulate her symptoms. *Id.* Dr. Nord ordered an EMG. *Id.*

On May 9, 2015, Petitioner underwent an EMG with Dr. Pegg. PX11. Petitioner reported low back pain that radiated into the right buttock area and sometimes a bit lower into the right hip. *Id.* Dr. Pegg stated that the EMG did not support lumbosacral radiculopathy at this time. *Id.*

On May 28, 2015, Petitioner treated with Dr. Li. PX6 at 28. Dr. Li stated that Petitioner was treating for a work-related injury with an open workers' compensation case. *Id.* Dr. Li noted that Petitioner would have an IME in Springfield on June 5. *Id.* He stated that Petitioner was still working with chronic pain. *Id.*

Section 12 Examination & Report – Dr. VanFleet

On June 5, 2015, Petitioner submitted to a medical evaluation with Dr. VanFleet at Respondent's request. RX1. Based on the review of the medical records, the history elicited from Petitioner and his physical examination, Dr. VanFleet rendered various opinions regarding Petitioner's condition of ill-being and its relation, if any, to her accident at work. *Id.*

Dr. VanFleet noted a consistent history of accident and stated that Petitioner was currently not working as school was out of session for the summer. RX1. He noted that Petitioner had a pain level as severe as 4/10 and that she takes occasional Tylenol or Ibuprofen. *Id.* Dr. VanFleet stated that Petitioner's pain was axial with no lower extremity pain at this point. *Id.* Dr. VanFleet stated that Petitioner was 5 feet 6 inches tall and weighed 250 pounds. *Id.* Dr. VanFleet noted that Petitioner was 5 feet 6 inches tall and weighed 250 pounds with a body mass index of 40.3. *Id.* On physical examination, Petitioner was able to flex and touch her fingers below her knees and was able to extend her back. *Id.* She had good range of motion at the hips and knee. *Id.* Reflexes at the knee and ankles were symmetric. *Id.* Strength testing was normal at 5/5. *Id.* There was no clonus and no evidence of tension signs on exam. *Id.* Dr. VanFleet reviewed the December 5, 2014 MRI films and noted that the lumbar spine showed some mild decreased disc signal intensity at the L4-5 level, but that it was very mild. Dr. VanFleet found no evidence of any focal neurologic compression. *Id.* In disagreement with the radiologist's findings, Dr. VanFleet did not see any evidence of an annular tear upon his review of the actual MRI films at that time. *Id.* He felt it was a very benign appearing lumbar MRI. *Id.*

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Dr. VanFleet opined that Petitioner's current medical condition at the time of his exam was not the result of her work-related injury, but instead related Petitioner's low back symptoms to her deconditioning, morbid obesity, as well as her inability to tolerate exercise. *Id.* He further opined that Petitioner's subjective symptoms did not match her objective findings. *Id.* Dr. VanFleet opined that Petitioner had been worked up extensively and had physical therapy as well as injections with no apparent evidence of any kind of radiculopathy. She had no focal neurologic compression noted on her lumbar MRI. *Id.* Dr. VanFleet opined that any further injection therapy would not be within the scope of acceptable medical care in his opinion. *Id.* Dr. VanFleet felt the Petitioner had nonspecific and subjective lumbar spinal pain that in all likelihood related to her significant body mass index. *Id.* He suggested Petitioner focus on a weight loss program and core muscle conditioning at home and that he would not recommend further restrictions. *Id.*

Petitioner testified that when she saw Dr. VanFleet, he was late and she spent three-to-four hours in his office waiting. She explained that Dr. VanFleet spent approximately 10 to 15 minutes with her.

Continued Medical Treatment

On June 22, 2015, Dr. Nord stated that Petitioner's pain was improving and that she was currently 2/10. PX10 at 16-19. Dr. Nord diagnosed Petitioner with resolving lumbar radiculitis, his prognosis was guarded, and he recommended that Petitioner continue weight loss and home exercises. *Id.*

On August 4, 2015, Dr. Nord stated that Petitioner had completed her physical therapy at NORC. PX10 at 20-22. Dr. Nord stated that the therapy had been helpful, and that Petitioner's pain was decreased. *Id.* Dr. Nord stated that Petitioner did not have pain radiating down the leg anymore and that she had some mild pain in her low back occasionally. *Id.* Dr. Nord stated that Petitioner was willing to have her restrictions increased so that she could return to her normal job function. *Id.* Dr. Nord placed Petitioner on a 30-pound weight restriction with no working on unlevel floors. *Id.* Dr. Nord continued these restrictions on September 22, 2015. PX10 at 24, 26.

On December 22, 2015, Dr. Nord stated that Petitioner was following up for lumbar radiculitis. PX10 at 28-31. Dr. Nord stated that Petitioner's back was much better than it had been a year ago and that she was taking Ibuprofen as needed. *Id.* Dr. Nord stated that Petitioner reported experiencing shooting pain that travels down her right leg on occasion. *Id.* Dr. Nord diagnosed right lumbar radiculitis, he maintained Petitioner's work restrictions and prescribed physical therapy. *Id.*

On December 22, 2015, the physical therapist, Sara Francois, stated that Petitioner was returning to NORC concerning right lumbar radiculopathy. PX10 at 92, 93. The therapist stated that Petitioner had been last seen on July 2, 2015 and that she had been working her normal job as a cook/server at a local school. PX10 at 92, 93. The therapist stated that Petitioner had some ongoing low back pain and that she should respond favorably with physical therapy. *Id.* On December 30, 2015, the therapist stated that Petitioner should progress her strengthening and stretching at home and she was encouraged to do this daily. PX10 at 94.

On February 7, 2016, Dr. Nord stated that Petitioner had moderate/significant progress with back pain since she had been doing physical therapy. PX10 at 32-34. Dr. Nord stated that Petitioner should continue physical therapy until the pain is consistently 3/10. *Id.* On March 29, 2016, Dr. Nord discontinued work restrictions, but prescribed ongoing physical therapy. PX10 at 38.

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On April 28, 2016, the therapist, Ms. Francois, recommended a TENS unit to manage symptoms when symptoms arise (mainly at work). PX10 at 123. On May 4, 2016, Ms. Francois stated that Petitioner was excited to receive her TENS unit as she was hopeful that this would help manage her symptoms during the work day with prolonged standing. *Id.*, at 124. On May 9, 2016, Ms. Francois stated that the TENS unit seemed to help Petitioner manage her symptoms both at home and work. *Id.*, at 125. On May 26, 2016, Ms. Francois stated that Petitioner's symptoms were improved and that she felt she was currently at 85 to 90% regarding return to her desired level of function. PX10 at 131, 132. The therapist noted that Petitioner continued to use a heat pack on occasion and that her current symptoms were in her right paraspinal musculature as well as the SI joint. *Id.* Ms. Francois stated that while symptoms remain, Petitioner made progress in that she had a good understanding of her current home and therapy exercises. *Id.*

On May 31, 2016, Dr. Nord stated that Petitioner was feeling better since the school year ended and she was off work. PX10 at 44-46. Dr. Nord stated that Petitioner continued to have discomfort in her back and right leg but not as severe as it had been. *Id.* Dr. Nord stated that Petitioner had increased pain and radicular symptoms if she has to ride in a car for a long distance. *Id.* Dr. Nord's diagnosis was right lumbar radiculitis improved with some continued pain. *Id.* Petitioner's prognosis was guarded. *Id.* Dr. Nord prescribed Meloxicam and a home exercise program. *Id.* Dr. Nord stated that these exercises included stretching and strengthening exercises to be completed 2 to 3 times daily. *Id.*

In a September 2, 2017 report, Dr. Nord stated that Petitioner's MRI of December 5, 2014 revealed L4-5 degenerative changes, a right lateral annular tear of the disc with minimal disc bulging and minimal lateral recess and right neural foraminal encroachment. *Id.* Dr. Nord stated that the abnormality on the MRI was causing compression of her right L5 nerve root causing her symptoms. *Id.* Dr. Nord stated that Petitioner has returned to work at Unit 5, but she still has symptoms of low back pain and right sciatica. *Id.* Dr. Nord opined that Petitioner's diagnosis of right L5 lumbar radiculitis is either caused or aggravated by her work incident of September 11, 2014. *Id.* Dr. Nord further opined that Petitioner's medical treatment had been reasonable and necessary and did improve her condition. *Id.*

Additional Information

Petitioner testified that she never had any low back or leg pain treatment or symptoms before September of 2014. She also testified that she had never been involved in any type of accident or injury to her back. Petitioner continues to work for Respondent, but her responsibilities are somewhat different. She explained that she was switched around and she no longer cooks and ships out food for the grade school. Petitioner works in a different area in the kitchen, but she continues the same duties after that point of the day. She has received regular pay raises or cost of living increases since 2014.

Regarding her current condition of ill-being, Petitioner testified that she cannot sit or stand too long before she feels achy. She no longer experiences pain down her legs, but it does go down from the back down into the lower buttocks more so on the right. Petitioner explained that she continues to experience symptoms at the end of the workday, but the severity depends on the type of work and how much lifting she does. She is also more cautious with her activities. Petitioner also takes over-the-counter medications like Tylenol or ibuprofen when needed maybe once every two weeks. She further testified that she continues to use the TENS unit as needed. Petitioner also continues to perform the home exercises prescribed by Dr. Nord. Petitioner also experiences increased pain after walking.

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 the hearing as follows:

In support of the Arbitrator's decision relating to Issue (J), whether the medical services that were provided to Petitioner were reasonable and necessary, whether Respondent has paid all appropriate charges for all reasonable and necessary medical services, the Arbitrator finds the following:

"Under section 8(a) of the Act (820 ILCS 305/8(a) (West 2006)), a claimant is entitled to recover reasonable medical expenses, the incurrence of which are causally related to an accident arising out of and in the scope of her employment and which are necessary to diagnose, relieve, or cure the effects of the claimant's injury." *Absolute Cleaning/SVMBL v. Ill. Workers' Compensation Comm'n*, 409 Ill. App. 3d 463, 470 (4th Dist. 2011) (*citing University of Illinois v. Industrial Comm'n*, 232 Ill. App. 3d 154, 164 (1st Dist. 1992). Whether a medical expense is either reasonable or necessary is a question of fact to be resolved by the Commission, and its determination will not be overturned on review unless it is against the manifest weight of the evidence. *F&B Manufacturing Co. v. Industrial Comm'n*, 325 Ill. App. 3d 527, 534 (1st Dist. 2001).

In consideration of the record as a whole, the Arbitrator finds the opinions of Dr. Nord to be more persuasive than those of Dr. VanFleet, Respondent's Section 12 examiner, in this case. Petitioner's treating physician, Dr. Nord, opined that Petitioner's accident caused, or aggravated, Petitioner's low back and radicular symptoms. He also opined that the medical treatment rendered to Petitioner was reasonable and necessary to alleviate her from the effects of her injury at work. The medical evidence supports Dr. Nord's opinions.

While Petitioner had a degenerative condition in the low back, about which all of the examining physicians agree, Petitioner's accident is not in dispute and there is no evidence that Petitioner had any prior low back condition that required medical treatment or prevented her from full duty, unrestricted work before September 11, 2014. Thereafter, Petitioner began to experience ongoing low back and radicular symptoms through the date of her release from care by Dr. Nord, her treating orthopedic surgeon, on May 31, 2016. These symptoms, which waxed and waned as reflected in the medical records, began only after September 11, 2014. Petitioner's testimony and the medical records also reflect that Petitioner continued to make progress throughout her treatment and that she did not reach maximum medical improvement until May 31, 2016. Petitioner made improvements after the steroid injections with Dr. Li, albeit limitedly, and from the physical therapy through NORC. She also attained some relief from continued medication and the use of a TENS unit as prescribed by the therapist. Eventually, Petitioner was released with increased restrictions on August 18, 2015 and later without restrictions.

Thus, the Arbitrator finds that following medical bills are for the reasonable and necessary medical treatment rendered to Petitioner to alleviate her from the effects of her injury at work:

- $24,956.00 to Central Illinois Orthopedic Surgery
- $7,404.00 to Ireland Grove Center for Surgery
- $1,134.42 to Ambulatory Anesthesia
- $14,416.00 to Bloomington-Normal Healthcare Surgery Center
- $3,578.40 to Dr. Edward Pegg
- $1,512 to McLean County Anesthesia

- $9,753.00 to Applied Pain Institute

Accordingly, the Arbitrator finds that the medical bills submitted into evidence by Petitioner that remain unpaid are to be paid by Respondent as provided in Sections 8(a) and 8.2 of the Act.

In support of the Arbitrator's decision relating to Issue (K), Petitioner's entitlement to temporary total disability benefits, the Arbitrator finds the following:

Petitioner claims that she is entitled to temporary total disability benefits from February 3, 2015 to February 10, 2015.

"The period of temporary total disability encompasses the time from which the injury incapacitates the claimant until such time as the claimant has recovered as much as the character of the injury will permit, i.e., until the condition has stabilized." *Gallentine v. Industrial Comm'n*, 201 Ill. App. 3d 880, 886 (2nd Dist. 1990). The dispositive test is whether the claimant's condition has stabilized, i.e., reached MMI. *Sunny Hill of Will County v. Ill. Workers' Comp. Comm'n*, 2014 IL App (3d) 130028WC at *28 (June 26, 2014, Opinion Filed); *Mechanical Devices v. Industrial Comm'n*, 344 Ill. App. 3d 752, 760 (4th Dist. 2003). To show entitlement to temporary total disability benefits, a claimant must prove not only that he did not work, *but also that he was unable to work. Gallentine*, 201 Ill. App. 3d at 887 (*emphasis* added); *see also City of Granite City v. Industrial Comm'n*, 279 Ill. App. 3d 1087, 1090 (5th Dist. 1996).

As explained more fully above, the Arbitrator finds the opinions of Petitioner's treating physician, Dr. Nord, to be persuasive in this case. He opined that Petitioner's low back condition was caused or aggravated by the accident at work. Petitioner's condition required extensive conservative medical treatment, and she was restricted from working full duty by Dr. Li for one week from February 3, 2015 through February 9, 2015. PX6 at 18. Thus, the Arbitrator finds that Petitioner has established that she is entitled to temporary total disability benefits for this period.

In support of the Arbitrator's decision relating to Issue (L), the nature and extent of the injury, the Arbitrator finds the following:

Section 8.1b of the Illinois Workers' Compensation Act ("Act") addresses the factors that must be considered in determining the extent of permanent partial disability for accidents occurring on or after September 1, 2011. 820 ILCS 305/8.1b (LEXIS 2011). Specifically, Section 8.1b states:

> For accidental injuries that occur on or after September 1, 2011, permanent partial disability shall be established using the following criteria:
>
> (a) A physician licensed to practice medicine in all of its branches preparing a permanent partial disability impairment report shall report the level of impairment in writing. The report shall include an evaluation of medically defined and professionally appropriate measurements of impairment that include, but are not limited to: loss of range of motion; loss of strength; measured atrophy of tissue mass consistent with the injury; and any other measurements that establish the nature and extent of the impairment. The most current edition of the American Medical Association's "Guides to the Evaluation of Permanent Impairment" shall be used by the physician in determining the level of impairment.

(b) In determining the level of permanent partial disability, the Commission shall base its determination on the following factors:

> (i) the reported level of impairment pursuant to subsection (a);
> (ii) the occupation of the injured employee;
> (iii) the age of the employee at the time of the injury;
> (iv) the employee's future earning capacity; and
> (v) evidence of disability corroborated by the treating medical records. No single enumerated factor shall be the sole determinant of disability. In determining the level of disability, the relevance and weight of any factors used in addition to the level of impairment as reported by the physician must be explained in a written order. *Id.*

Considering these factors in light of the evidence submitted at the hearing, the Arbitrator addresses the factors delineated in the Act for determining permanent partial disability.

With regard to subsection (i) of §8.1b(b), the Arbitrator notes that no permanent partial disability impairment report was offered into evidence. Thus, the Arbitrator assigns no weight to this factor.

With regard to subsection (ii) of §8.1b(b), the occupation of the employee, the Arbitrator notes that Petitioner was employed as a cook at the time of the accident. Thus, the Arbitrator assigns significant weight to this factor.

With regard to subsection (iii) of §8.1b(b), the Arbitrator notes that Petitioner was relatively young at 38 years of age at the time of the accident with the expectation of decades of work ahead of her. Thus, the Arbitrator assigns significant weight to this factor.

With regard to subsection (iv) of §8.1b(b), the future earning capacity of the employee, the Arbitrator notes that, Petitioner returned to full duty work and has received cost-of-living increases thereafter. Thus, the Arbitrator finds no evidence of a reduction in Petitioner's future earning capacity and assigns significant weight to this factor.

With regard to subsection (v) of §8.1b(b), evidence of disability corroborated by the treating medical records, the Arbitrator notes that Petitioner sustained an undisputed accident at work. Petitioner's complaints are consistent with the medical records, including treatment by Respondent's occupational health physician and an evaluation with Dr. VanFleet at Respondent's request. The record as a whole also supports the opinion of Dr. Nord that Petitioner's condition in the lumbar spine and radiculopathy was caused or aggravated by her accident at work. While Respondent offered the opinions of its Section 12 examiner, Dr. VanFleet, it is notable that Petitioner was asymptomatic prior to her accident at work further supporting the opinion of Dr. Nord that Petitioner's condition is causally related to the undisputed accident. After completing medical treatment, Petitioner testified about ongoing disability and pain which is corroborated by the treating medical records and physical therapy records reflecting her symptoms and the treatment necessary to attempt to ameliorate her pain. Specifically, she testified that she continues to experience low back pain and pain into her right buttock after the accident. At the end of a work day she notices mid back pain and, if the work day is busier, she experiences more back pain. Petitioner also testified that if she sits or stands too long, she experiences pain into her back and right buttock. To manage her symptoms, Petitioner continues to perform home exercises and utilize her TENS unit. Thus, the Arbitrator assigns significant weight to this factor.

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Based on all of the foregoing, and in consideration of the factors enumerated in Section 8.1b, which does not simply require a calculation, but rather a measured evaluation of all five factors of which no single factor is conclusive on the issue of permanency, the Arbitrator finds that Petitioner has established permanent partial disability to the extent of 7.5% loss of use of the person as a whole (lumbar spine) pursuant to Section 8(d)2 of the Act.

STATE OF ILLINOIS	)		
	) SS.		
COUNTY OF SANGAMON	)		

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

William Bradley,

Petitioner,

vs. NO. 16WC 02804

USF Holland,

19IWCC0314

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 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 September 4, 2018 is hereby affirmed and adopted.

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

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

No bond is required for the removal of this cause to the Circuit Court. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: JUN 19 2019
SJM/sj
o-6/4/2019
44

Stephen J. Mathis

L. Elizabeth Coppoletti

Douglas McCarthy

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

BRADLEY, WILLIAM
Employee/Petitioner

Case# **16WC002804**

USF HOLLAND
Employer/Respondent

19IWCC0314

On 9/4/2018, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 2.21% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in 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 BOSHARDY
1610 S 10TH ST
SPRINGFIELD, IL 62703

2904 HENNESSY & ROACH PC
PAUL N BERARD
2501 CHATHAM RD SUITE 200
SPRINGFIELD, IL 62704

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

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
NATURE AND EXTENT ONLY

William Bradley
Employee/Petitioner

v.

USF Holland
Employer/Respondent

Case # **16** WC **2804**

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 **Michael Nowak**, Arbitrator of the Commission, in the city of **Springfield**, on **2/23/18**. By stipulation, the parties agree:

On the date of accident, **11/6/15**, 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 $**51,352.21**, and the average weekly wage was $**987.54**.

At the time of injury, Petitioner was **55** years of age, ***single*** with **no** dependent children.

Necessary medical services and temporary compensation benefits have been provided by Respondent.

Respondent shall be given a credit of $**18,607.12** for TTD, $**3,909.58** for TPD, $**0** for maintenance, and $**0** for other benefits, for a total credit of $**22,516.70**.

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

Based on the factors enumerated in §8.1b of the Act, which the Arbitrator addressed in the attached findings of fact and conclusions of law, and the record taken as a whole, Respondent shall pay Petitioner permanent partial disability benefits of $592.52/week for 37.625 weeks, because the injuries sustained caused the 17.5% loss of the right leg, as provided in Section 8(e) of the Act.

Respondent shall pay Petitioner compensation that has accrued from **7/2//16** through **2/23/18**, and shall pay the remainder of the award, if any, in weekly payments.

The parties stipulated that Respondent is due a credit in the amount of $3,841.05 in overpayment of temporary total disability benefits.

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.

Michael K. Nowak, Arbitrator

8/27/18
Date

ICArbDecN&E p.2

SEP 4 - 2018

FINDINGS OF FACT

On January 28, 2016, Petitioner filed an Application for Adjustment of Claim alleging that on November 6, 2015, he tore his right medial meniscus when he slipped off a trailer. At the February 23, 2018, arbitration hearing, the only issued before the Arbitrator was the nature and extent of Petitioner's injuries. Pursuant to the parties' request for hearing admitted as Arbitrator's Exhibit 1, Respondent has paid all temporary partial disability and temporary total disability that was due and is entitled to a credit of $3,841.05 for an overpayment of temporary total disability.

At the time of his accident, Petitioner was a 55 year-old truck driver for Respondent. He sustained an injury to his right knee when he slipped off the back of a truck and came down on his right foot causing his right knee to give way.

Petitioner first presented for medical care on November 13, 2015, when he sought care at Abraham Lincoln Memorial Hospital for low back, right wrist and right knee pain. He reported falling from about four feet at work and landing on his right foot. He denied any foot or ankle pain. Right knee x-rays revealed mild osteoarthritis and a small area of bony density. He was diagnosed with a right knee strain and right wrist contusion. He was released back to regular duty. (PX 2)

On November 20, 2015, Petitioner sought follow up care at Abraham Lincoln Memorial Hospital for constant and dull pain in his right knee as well as swelling. He was diagnosed with a right knee sprain and prescribed a right knee MRI. (PX 3)

On November 23, 2015, Petitioner presented to Medical Arts Physicians and Dr. Matthew Rossi. He reported stepping off of a trailer on November 6, 2015, and injuring his right knee. He reported trying to work with it, but having increased swelling. Dr. Rossi noted that Petitioner was off of work. A right lower extremity deep vein duplex was normal. Dr. Rossi recommended a right knee MRI. (PX 4)

On December 2, 2015, Petitioner followed up with Dr. Rossi. He reported continued right knee pain. He was in a knee immobilizer. Dr. Rossi continued to recommend a right knee MRI pending authorization. (PX 4)

On December 16, 2015, Petitioner followed up with Dr. Rossi for recheck of his bilateral carpal tunnel syndrome and right knee injury. Petitioner reported his right knee pain is too painful to work on it. Dr. Rossi noted his effusion had improved. He continued to recommend a right knee MRI and physical therapy. He continued to keep Petitioner off of work. (PX 4)

On December 23, 2015, Petitioner underwent a right knee MRI at Hopedale Medical Complex. The radiologist's impression was medial collateral ligament strain, medial meniscus tears and small knee effusion with moderate sized leaking popliteal cyst. (PX 4)

On December 30, 2015, Petitioner sought follow up care with Dr. Rossi. Dr. Rossi noted that Petitioner's right knee MRI revealed a posteromedial meniscal tear with a flap and edema. (PX 4)

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On January 27, 2016, Petitioner sought follow up care with Dr. Rossi. Dr. Rossi opined that Petitioner's MRI revealed internal derangement in the right knee. Dr. Rossi referred Petitioner to Dr. Brett Wolters, an orthopedic surgeon at Springfield Clinic. (PX 4)

On February 5, 2016, Petitioner presented to Springfield Clinic and Dr. Brett Wolters. Petitioner reported being injured while working for USF Holland as a truck driver. He reported stepping backwards off a trailer and landing on his right foot with an extended leg. He reported having right knee pain that increased over the following days. Dr. Wolters opined that Petitioner's right knee MRI revealed a large Baker cyst and medical meniscal flap tear which protrudes into the posterior medial compartment near the PCL. Dr. Wolters recommended a right knee arthroscopy with partial medial meniscectomy. Petitioner was released back to light-duty of no squatting, climbing ladders or walking more than 10 minutes. (PX 5)

On February 8, 2016, Dr. Lawrence Li of the Orthopedic & Shoulder Center performed Section 12 examination at the request of Respondent for Petitioner's right knee injury. Petitioner reported a consistent accident history of getting off the back of a trailer and slipping and landing on his right leg. Dr. Li opined that Petitioner's right knee meniscus tear is related to his November 6, 2015, work accident and that his need for surgery is also related to this work accident. (RX 1)

On April 18, 2016, Dr. Wolters performed a right knee arthroscopic partial medial meniscectomy and chondroplasty of medial femoral condyle. (PX 5)

On April 27, 2016, Petitioner presented for his first post-operation follow up appointment with Dr. Wolters. He reported doing pretty well with some achy pain at night. Dr. Wolters opined Petitioner could continue to work light-duty of desk work only. Dr. Wolters recommended he follow up in four weeks for a possible full-duty release. (PX 5)

On May 25, 2016, Petitioner sought post-surgery care after his recent right knee surgery with Dr. Wolters. He reported having significant improvement after his surgery. Dr. Wolters recommended physical therapy and opined he could likely return to work full-duty without restrictions in two weeks. (PX 5)

On June 10, 2016, Petitioner sought follow-up care for his right knee. He reported his pain and range motion is improving. He reported three or four locking episodes on May 25, 2016. Petitioner reported that he did not believe he would be able to return to work on Monday, but he was optimistic he would be able to return two weeks from then. Dr. Wolters assessment was status post right knee arthroscopic partial, medial, meniscectomy and chondroplasty. Dr. Wolters' released Petitioner back to work with restrictions on June 27, 2016. However, he advised that if he did not believe he was ready to return to work with restrictions at that time to call him and come in for an examination and he would reassess those light duty restrictions. (PX 5)

On July 29, 2016, Petitioner sought follow up care with Dr. Wolters for his right knee. He reported his pain is much better, although he had some catching through his patella region. He did not take any pain medication for the knee. He was working full duty without restrictions. Dr. Wolters' assessment was status post right knee arthroscopic medial meniscectomy and small chondroplasty of medial femoral condyle Grade II-III. Dr. Wolters opined Petitioner's articular cartilage looked very good. He opined Petitioner was likely 20 or 30 years away at least before considering any knee replacement surgery. Dr. Wolters opined Petitioner had reached

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MMI and released him to work full duty. He did not believe Petitioner would require any further treatment for his right knee. (PX 5)

On February 21, 2017, Petitioner presented to Dr. Wolters with complaints of pain and catching in his right knee. Petitioner reported daily pain and sporadic catching and giving way of his knee. Petitioner mentioned thinking about a knee replacement. Dr. Wolters opined that Petitioner was nowhere near a knee replacement. He believed Petitioner struggles were related to not exercising. Dr. Wolters recommended home exercises to strengthen his knee and thigh. (PX 5)

Petitioner was evaluated a second time by Dr. Li on November 9, 2017. Dr. Li found Petitioner to be at MMI for his right knee and performed an impairment rating pursuant to the AMA Guides to the Evaluation of Impairment, 6th Edition. Dr. Li found Petitioner to have sustained 1% lower extremity impairment as a result of his November 6, 2015, work injury, right knee meniscus tear and subsequent right knee surgery. (RX 1)

On January 15, 2018, Dr. Li was deposed. Dr. Li is a board certified orthopedic surgeon concentrating on knee, shoulder and hand conditions. Dr. Li is also certified to perform impairment ratings pursuant to the AMA Guides to Evaluation of Permanent Impairment, 6th Edition. Dr. Li testified that at the time of his November 9, 2017, examination, Petitioner walked without a limp, did not have an antalgic gait and did not use any aids. He had normal range of motion and stable collateral ligament examination. Dr. Li testified he basically had a negative examination of the right knee, or this knee exam was normal. Dr. Li testified he performed an impairment rating for Petitioner's right knee and found him to have sustained 1% impairment to his right lower extremity. (RX 1)

Petitioner testified that he notices pain walking over rough ground and climbing stairs. He testified that his right knee sometimes locks or catches. He occasionally takes Advil or Tylenol for pain. He testified that his right knee gets stiff after driving or sitting for long periods, and that he has to stretch it out after doing so. Petitioner testified he has received a raise since his work injury and has no reason to not believe he will continue to receive raises in the future. He has been working full-duty since his release to work without restrictions.

CONCLUSIONS

Pursuant to §8.1b of the Act, permanent partial disability from injuries that occur after September 1, 2011 is to be established using the following criteria: (i) the reported level of impairment pursuant to subsection (a) of §8.1b of the Act; (ii) the occupation of the injured employee; (iii) the age of the employee at the time of the injury; (iv) the employee's future earning capacity; and (v) evidence of disability corroborated by the treating medical records. 820 ILCS 305/8.1b. The Act provides that, "No single enumerated factor shall be the sole determinant of disability." 820 ILCS 305/8.1b(b)(v).

With regard to subsection (i) of §8.1b(b), the Arbitrator notes that Dr. Lawrence Li prepared an Impairment Rating according to the AMA Guides to the Evaluation of Permanent Impairment, 6th Edition and determined that according to the Guides the Petitioner had sustained a 1% impairment to his lower extremity. (RX p. 13) Dr. Li acknowledged that the AMA Guides to the Evaluation of Permanent Impairment, 6th Edition were not designed to assess disability in workers' compensation settings and impairment was not equate to disability. (RX 1, p. 18) Dr. Li further acknowledged that when performing an impairment rating exam he is not permitted to consider the occupation or age of the worker. (RX 1, p. 18) Dr. Li agreed that the impairment

rating provides no insight into the impact of Petitioner's injury on his ability to perform his job in the future. (RX 1, p. 18) The Arbitrator therefore gives *some* weight to this factor.

With regard to subsection (ii) of §8.1b(b), the occupation of the employee, the Arbitrator notes Petitioner continues to work as an 18 wheel truck driver. The Arbitrator therefore gives *lesser* weight to this factor.

With regard to subsection (iii) of §8.1b(b), the Arbitrator notes that Petitioner was 55 years of age at the time of his accident. Petitioner has a substantial amount of work life remaining. The Arbitrator therefore gives *some* weight to this factor.

With regard to subsection (iv) of §8.1b(b), Petitioner's future earnings capacity, the Arbitrator notes there is no direct evidence of reduced earning capacity contained in the record. However, The Petitioner stated that he felt that if his injury would impact his future earning capacity if he changed jobs and went to work for another employer due to the weakness in his leg. The Arbitrator therefore gives *some* weight to this factor.

With regard to subsection (v) of §8.1b(b), evidence of disability corroborated by the treating medical records, the Arbitrator notes the Petitioner was a credible witness.

Petitioner was last examined at his treating surgeon's office on February 21, 2017. On February 21, 2017 it was noted that six months after Dr. Wolters pronounced Petitioner at maximum medical improvement, Petitioner continued to experience pain that had not improved since his previous visit on July 29, 2016. (PX 5) Dr. Wolters office also recorded that Petitioner continued to experience catching in his knee and his knee would give way. (PX 5)

Dr. Wolters' office note from February 21, 2017 recorded that Petitioner had pain almost every day of his life when is walking and there were no factors which made the pain better or worse. (PX 5) Dr. Wolters' noted Petitioner's pain was located at the medial joint line of his right knee and occasionally the pains are sharp when he is walking. Dr. Wolters also noted the Petitioner would be awakened occasionally by pain in the knee and uses a pillow between his knees. (PX 5)

On examination Dr. Wolters noted tenderness to palpation over the right pes anserine bursa. (PX 5) Dr. Wolters felt the Petitioner was struggling with his knee because he was not exercising since last summer and suggested that he purchase a stationary bicycle and further instructed Petitioner on home exercises. (PX 5)

Petitioner testified that he continues to experience right knee aching pain, which worsens when the weather changes or with walking and climbing stairs. Petitioner takes Advil every day. Petitioner notices his knee will catch and pop at least once or twice per day and it occurs when he has to straighten the leg from a bent position. Petitioner also notices that walking on rough ground causes aches in his knee. Petitioner also has weakness in his leg. Petitioner purchased an exercise bike and continues to exercise.

Based on the above factors, and the record taken as a whole, the Arbitrator finds that Petitioner sustained permanent partial disability to the extent of 17.5% loss of use of the right leg pursuant to §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 COOK	)	☒ Reverse Employment	☐ Second Injury Fund (§8(e)18)
			☐ PTD/Fatal denied
		☐ Modify Choose direction	☐ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Arturo Martinez,
Petitioner,

vs. No. 12 WC 15634

Chicago Field, and Illinois State Treasurer's Office as Custodian of the Injured Workers' Benefit Fund,
Respondents.

19IWCC0315

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by Respondent, Illinois State Treasurer's Office as Custodian of the Injured Workers' Benefit Fund, and notice given to all parties, the Commission, after considering the issues of Accident and Employment, and being advised of the facts and law, reverses the Decision of the Arbitrator.

The Arbitrator found, "Petitioner and Respondent-Employer Chicago Field proved they were operating under the Act on October 24, 2011,"[1] because Petitioner testified he was working, "at height, namely on a ladder cleaning gutters." The Arbitrator also found Petitioner testified credibly that Respondent Chicago Field directed his work, and that when Petitioner fell, he had been working on Respondent's ladder.

Petitioner testified that in October 2011 he was employed by Respondent Chicago Field as a laborer, having heard about the job through a friend. His duties included cleaning gutters and installing shingles. He was paid $400.00 per week, in cash. On October 24, 2011 while cleaning gutters, Petitioner fell approximately 10 feet off a ladder which had not been secured correctly. He was treated at Our Lady of the Resurrection Medical Center; underwent surgery with Dr. Silva for a fractured right tibia, and after two days, was released to perform therapy at home. Petitioner claimed he never attempted to return to work at Chicago Field after his injury because he lost contact with them. In 2014, Petitioner found employment with another employer, Weber Grill.

[1] The Arbitrator probably meant to say, "*Petitioner* proved…" Chicago Field was not present at the arbitration hearing, and it did not prove anything. In particular, Chicago Field did not prove that it and Petitioner were, "operating under the Act."

In determining whether Petitioner herein has proved an employer-employee relationship existed at the time of his accident, the cases of *Ware v. Industrial Commission,* 318 Ill.App.3d 1117, 1122 (1st Dist., 2000), and *Roberson v. Industrial Commission,* 866 N.E.2d 191, 200 (Ill. 2007) are informative. They hold that in assessing whether such an employer-employee relationship exists between parties, multiple factors must be considered. Those include whether the employer: may control the manner in which the person performs the work; may discharge the person at will; dictates the person's schedule; pays the person on an hourly basis; withholds income and social security taxes from the person's compensation; supplies the person with materials and equipment, and whether the employer's general business encompasses the person's work. Other relevant factors include, to a lesser extent, the label which the parties have placed on their relationship and whether the relationship was long, continuous and exclusive. While no one factor is determinative of employment status, the most important factor is the Respondent's right to control the manner in which the person performed the work.

The Arbitrator found that, "Petitioner testified that the supervisor told him what to do and when to work. Additionally, the supervisor told him where to go." The Arbitrator also found that Petitioner was working on Respondent's ladder when he fell, and that, "Petitioner's work duties included cleaning out the gutters, hanging shingles, and any other duties assigned by the supervisor. Petitioner said the supervisor would assign each week's schedule and work to Petitioner. Petitioner stated the supervisor directed what time he should arrive on the job and when he could leave work."

The Commission views the evidence differently regarding the existence of an employer-employee relationship given Petitioner's testimony. While Petitioner did testify his duties were to clean gutters and install shingles, he did not testify that he performed, or was assigned to perform, "any other duties assigned by the supervisor." Rather, Petitioner testified that he always performed the same tasks. Contrary to the Arbitrator's findings, Petitioner never testified that the supervisor assigned him, "each week's schedule and work," or told him what to do, or told him when he should arrive on the job or when to leave work.

There was no evidence in the record which showed that Chicago Field owned or supplied the ladder from which Petitioner fell, or that it withheld taxes from Petitioner's compensation. Petitioner admitted he was paid in cash. Although he was paid $400.00 per week, Petitioner presented no testimony that he was paid at a specific hourly rate or that he worked a set number of hours each week. Petitioner admitted he had not been working at this job very long; only for about a month before his accident. Petitioner presented no evidence that his relationship with Chicago Field was exclusive.

In addition, Petitioner presented no evidence that Chicago Field's general business encompassed the same type of work which he performed for them. When Petitioner was asked what Chicago Field's business was, he answered, "I don't know anything about the company. I was never there. My friend took me to the worksite to work there." There is no evidence in the record describing the type of work which Chicago Field performed.

The burden is on the Petitioner to prove all elements of his claim by a preponderance of credible evidence. *Martin v. Industrial Commission,* 90 Ill.2d 288 (1982). Considering the record as a whole, the Commission finds the scant evidence that Petitioner was an employee of Chicago Field to be outweighed by the evidence showing he was not. The Commission finds Petitioner did not meet his burden of proving his relationship with Chicago Field was that of employer-employee.

Finally, the Commission finds irrelevant to Petitioner's claim that Chicago Field may have been a business described as "extra hazardous" pursuant to Section 3 of the WC Act. That section provides that the Act "shall apply automatically and without election" to all employers and their *employees* in businesses engaged in certain enumerated activities, including the maintenance and remodeling structures. *820 ILCS 305/3 (2011).* Because the Commission finds Petitioner did not prove he was an employee of Chicago Field, Section 3 has no application to him. That section does not change the relationship of a person who is not an employee into that of employer-employee.

As a result of the Commission's findings herein, the Commission reverses the Arbitrator's Conclusion of Law finding that Petitioner proved an employee-employer relationship with Chicago Field on October 24, 2011, rendering all other issues moot.

IT IS THEREFORE ORDERED BY THE COMMISSION that the December 15, 2017 decision of the Arbitrator in this matter is vacated, and all benefits to Petitioner are denied.

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

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: JUN 19 2019

o-05/23/19
mp/mcp
68

Marc Parker

Deborah L. Simpson

Barbara N. Flores

STATE OF ILLINOIS	)	
	) SS.	
COUNTY OF COOK	)	

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Jadwiga Wroblewska,

Petitioner,

vs. NO: 10 WC 14284

19IWCC0316

Chicago Public Schools,

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 April 24, 2017, 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: JUN 2 0 2019
DDM:yl
o 6/18/19
52

D. Douglas McCarthy

L. Elizabeth Coppoletti

Maria E. Portela

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

WROBLEWSKA, JADWIGA Case# **10WC014284**
Employee/Petitioner

CHICAGO PUBLIC SCHOOLS/EDWARDS ELEMENTARY SCHOOL
Employer/Respondent

19IWCC0316

On 4/24/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.94% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

2291 BELLAS & WACHOWSKI
PETR C WACHOWSKI
15 N NORTHWEST HWY
PARK RIDGE, IL 60068

0559 CHICAGO BOARD OF EDUCATION
MICHAEL COHEN ESQ
ONE N DEARBORN ST SUITE 900
CHICAGO, IL 60602

19IWCC0316

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

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Jadwiga Wroblewska
Employee/Petitioner
v.
Chicago Public Schools/Edwards Elementary School
Employer/Respondent

Case # **10 WC 014284**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Jeffrey Huebsch**, Arbitrator of the Commission, in the city of **Chicago**, on **March 6, 2017**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **October 1, 2008**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**92,963.52**; the average weekly wage was $**1,787.76**.

On the date of accident, Petitioner was **66** years of age, ***single*** with **0** dependent children.

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

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

Respondent shall be given a credit of $**0** for TTD, $**0** for TPD, $**0** for maintenance, and $**0** for other benefits, for a total credit of $**0**. The stipulation of the Parties is that no TTD benefits are sought as a result of this accident.

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

ORDER

Claim for compensation denied. Petitioner failed to prove that she sustained accidental injuries which arose out of and in the course of her employment by Respondent on October 1, 2008 and failed to prove that her current condition of ill-being regarding her low back is causally related to the alleged injury.

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

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

Signature of Arbitrator

April 24, 2017
Date

APR 24 2017

FINDINGS OF FACT

Petitioner testified via a Polish to English interpreter.

Petitioner was employed by Respondent as a teacher. Petitioner functioned as a "roving" teacher. Basically, she would teach in a classroom for 3 months and then move to another classroom. Roving teachers were required to move their textbooks when they were assigned a new classroom. Petitioner testified that she would move 700 pounds of textbooks when she moved to a new classroom. She would use a cart and had to load and unload the cart. She was not allowed to ask students to help her move the books. The books were heavy. In 2008, Petitioner was on vacation in September. When Petitioner returned to work in October, she had to move books to a new classroom.

Petitioner testified that, on October 1, 2008, she had to move textbooks from a locker to a classroom. At about 3:00 pm, Petitioner lifted heavy books (30 pounds?) and felt a crack in her back. She was in pain and fell to the floor. A custodian helped Petitioner to her classroom. She took some ibuprofen and rested at the school. The custodian helped her to her car. Petitioner did not seek emergency treatment. She was in a great deal of pain. She made an appointment with her HMO physician and was seen by Dr. Bednarska on October 13, 2008 for complaints of low back pain. (PX 9)

Petitioner testified that she felt well before the lifting incident. On direct examination, Petitioner twice denied having back symptoms prior to the alleged accident. This testimony is not true, as Petitioner's medical records show a 20 plus year history of low back pain.

Dr. Khalid Husain, DPM, wrote a letter to Dr. Bednarska, dated October 6, 2008, advising that he had seen Petitioner on that date. She was complaining that her orthotics were worn out, causing her to develop low back pain and sciatic pain. Husain suggests new orthotics be authorized by Bednarska. There is no mention of the back pain having its origin in a lifting incident at work. (PX 9) Petitioner claimed a bill for the prescription Methylprednisolone ordered by Dr. Husain on October 6, 2008. (PX 15)

Petitioner was seen by Dr. Bednarska as an emergency walk-in on October 13, 2008 (12 days after the alleged accident). She complained of low back pain after she lifted heavy boxes at work. (PX 9) Dr. Bednarska referred Petitioner to Dr. Roman Daczkewycz, an orthopedic surgeon.

Petitioner was first seen by Dr. Daczkewycz on November 17, 2008. The diagnosis was: 1.) Low back pain with degenerative osteoarthritis of the lumbar spine and an old L2 compression fracture; 2.) Greater trochanteric bursitis of the right hip, r/o right radiculopathy. The history was of low back pain, radiating down the right hip for the last month or so. The patient has been doing some repetitive bending, lifting and straining of her spine in moving books and equipment from room to room. She had right sciatica in the past. X-rays from Resurrection Medical Center of November 3, 2008 were said to show a loss of height at L2, most likely related to an old fracture. The patient fell on her back on ice years ago and had some back pain at that time. No other treatment or history was noted. Physical therapy and a lumbar MRI were recommended. She was given an injection to the hip and advised to return to work at modified duty. The lumbar MRI was done on December 11, 2008 at Resurrection and was said to show a mild L2 compression, probably recent and secondary to osteoporosis, mild to moderately advanced degenerative changes and mild left L5-S1 foraminal stenosis. Dr. Daczkewycz issued a prescription for an ESI on December 16, 2008. The diagnosis was: Low Back Pain with degenerative osteoarthritis lumbosacral spine and old L2 compression fracture.(PX 6)

Petitioner underwent a L2 vertebroplasty in February of 2009. The report is not in evidence. Petitioner had follow-up with Dr. Bednarska, who referred Petitioner to Dr. Cerullo. Dr. Cerullo recommended injections (performed by Dr. Villoch) and offered the possibility of surgery. Petitioner declined surgery. She also had treatment in Poland. Some bills were paid by group, some by Medicare and Petitioner had about $14,000.00 in out of pocket expenses. (PX 9, 1, 2, 14, 15, 16, 17) Physical therapy was provided by Global Health Clinic and Accelerated Rehab. (PX 11, 10)

Petitioner was first seen by Dr. Cerullo on June 23, 2009. She was seen for low back pain and bilateral leg pain. She had a long history of leg pain (20 years), was treated and did better. Her symptoms reoccurred in October of 2008: after lifting books, she developed severe low back pain. The history noted by Dr. Villoch on November 6, 2009 was that the patient had a longstanding history of low back pain and bilateral lower extremity pain (onset 1987 -1989), she did well for 10 years and then dancing in 2002 increased her pain. She then experienced a sudden onset of pain in the low back, secondary to lifting books at work. (PX 1, 2)

Petitioner was seen by Dr. Kern Singh for a §12 examination at the request of Respondent on January 12, 2015. Dr. Singh also reviewed medical records and diagnostic films, including the December 11, 2008 lumbar MRI. An interpreter was used. Petitioner gave Dr. Singh a history of repetitively lifting heavy books weighing approximately over 10 pounds, over 10 times on October 1, 2008 when she noticed increasing complaints of back pain. She specifically stated that she had no back pain complaints that predate the injury in question. "When specifically asked, she states that absolutely no back pain has existed prior to the October 1, 2008, injury in question." Dr. Singh noted several records for prior treatment for low back complaints. Dr. Singh thought that the December 11, 2008 MRI showed an old L2 compression fracture. There was no acute edema or signal changes noted. There was no acute pathology. There was no causation as to Petitioner's current complaints. The fracture was a chronic and longstanding osteoporotic fracture. Petitioner's radicular complaints were documented in 2005 and they were unchanged in 2009. Petitioner was at MMI. She could work full duty without restrictions. (RX 1)

Petitioner was seen by Dr. Mark Sokolowski on February 16, 2015. Dr. Sokolowski charted that Petitioner was referred by Dr. Bednarska. Petitioner testified that she did not recall who referred her to Dr. Sokolowski (Dr. Villoch?). The history was of a work related injury several years ago where she sustained a L2 compression and developed back pain. She underwent vertebroplasty in 2008. Dr. Sokolowski does not chart the mechanics of the work injury. Dr. Sokolowski recommended up to 3 ESI's per year and if the patient's pain is intractable, then L4-L5 decompression and fusion. Dr. Sokolowski authored a report to Petitioner's attorney, dated September 14, 2015. He reviewed the December 11, 2008 lumbar MRI and thought that the L2 fracture was recent. "Therefore, it is my opinion *beyond a reasonable degree of surgical certainty* that the MRI of December 11, 2008, demonstrates a fracture which is recent and consistent with the history of work injury on October 1, 2008." (PX 13)

Petitioner continued to work as a teacher until she retired at age 68. She wanted to work until she was 70, but retired because of back pain. She has constant back pain. She does not do recreational activities, such as swimming, skiing or biking anymore. She needs help with household chores. She continues to take a lot of pain pills, daily. She has difficulty walking. She can't bend. She has difficulty sleeping. She has increased pain if she sits too long.

CONCLUSIONS OF LAW

To obtain compensation under the Act, Petitioner has the burden of proving, by a preponderance of the evidence, all of the elements of his claim. O'Dette v. Industrial Commission, 79 Ill. 2d 249, 253 (1980) Decisions of an arbitrator shall be based exclusively on evidence in the record of proceeding and material that has been officially noticed. 820 ILCS 305/1.1(e)

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 failed to prove that she sustained accidental injuries which arose out of and in the course of her employment by Respondent on October 1, 2008. Petitioner's story does not add up.

First, Petitioner's testimony is found to be not credible. She twice denied back problems prior to the alleged injury on direct examination. She also denied prior back problems to Dr. Singh. The medical records clearly document prior back treatment and Petitioner did tell several treating doctors of the prior history. Second, while Petitioner testified regarding a specific event that occurred on October 1, 2008 (lifting a specific stack of books and feeling a "crack" and then falling on the floor in pain), this history is not contained in the treating records. Third, it is noted that Petitioner did not seek immediate emergency care for her severe pain – and, in fact, saw a podiatrist and related her low back pain and sciatica complaints to worn orthotics 5 days after the alleged injury and 7 days before seeking treatment from her HMO doctor for low back pain related to lifting books at work. Finally, the Arbitrator incorporates the findings below on the issue of causation in support of this finding of a failure of proof on the issue of accident.

WITH RESPECT TO ISSUE (F), IS PETITIONER'S PRESENT CONDITION OF ILL-BEING CAUSALLY RELATED TO THE INJURY, THE ARBITRATOR FINDS AS FOLLOWS:

The Arbitrator finds that Petitioner failed to prove a causal connection regarding her present condition of ill-being (Osteoporotic compression fracture of L2; status post vertebroplasty and degenerative disc disease at L5-S1) and any injury of October 1, 2008, based upon the Arbitrator's finding above on the issue of accident and the persuasive opinion of Dr. Singh, in addition to the treating medical records.

Dr. Singh's causation opinion best comports with the evidence adduced. We have a lumbar compression fracture in a 66 year old osteoporotic female Petitioner with a significant prior history of back issues and several versions of how the injury occurred. Here the radiologist at Resurrection and Dr. Daczkewycz also identify the L2 fracture as old.

Dr. Sokolowski's causation opinion relates the L2 fracture to "the work injury of October 1, 2008", without identifying the mechanics of how the injury occurred. Further, Dr. Sokolowski does not appear to consider Petitioner's prior back problems, inviting the finder of fact to speculate in order to be persuaded by his opinion that was rendered "beyond a reasonable degree of surgical certainty."

The Arbitrator declines to find causation regarding a lumbar vertebral compression fracture related either to the incident described by Petitioner at trial, or those described in the medical records, absent a compelling expert opinion. Dr. Sokolowski's opinion does not achieve this status. Accordingly, there has been a failure of proof on the issue of causation and Petitioner's claim for compensation is denied.

WITH RESPECT TO ISSUE (J), WERE THE MEDICAL SERVICES THAT WERE PROVIDED TO PETITIONER REASONABLE AND NECESSARY AND HAS RESPONDENT PAID ALL APPROPRIATE CHARGES FOR ALL REASONABLE AND NECESSARY MEDICAL SERVICES, AND WITH RESPECT TO ISSUE (L), WHAT IS THE NATURE AND EXTENT OF THE INJURY, THE ARBITRATOR FINDS AS FOLLOWS:

As the Arbitrator has found that Petitioner failed to prove that she sustained accidental injuries which arose out of and in the course of her employment by Respondent on October 1, 2008 and has failed to prove a causal connection between the alleged accident and her current condition of ill-being regarding her low back, the Arbitrator needs not decide these issues.

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

THOMAS DIETRICH,

Petitioner,

vs. NO: 17 WC 37201

CHICAGO TRANSIT AUTHORITY,

Respondent.

19IWCC0317

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-causal connection only, medical expenses-causal connection only, and permanent partial disability, and other-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.

FINDINGS OF FACTS AND CONCLUSIONS OF LAW

The Commission notes that, as to the issue of temporary total disability/credit, Petitioner testified about receiving sick and vacation payments of unknown amounts. No evidence was presented by either party on the issue. Respondent claimed Section 8(j) credit of $37,638.44 towards lost time benefits but presented no evidence to support their burden of proving the claimed credit. Petitioner did not stipulate of any such credit. Therefore, Respondent is not due any credit against the TTD award, as noted in the Decision of the Arbitrator. The Commission, herein, affirms and adopts the Decision of the Arbitrator, in full.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed April 24, 2018 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: JUN 2 1 2019

DLG/jsf
5/23/19
045

Barbara N. Flores

Marc Parker

Dissent

I respectfully dissent from the Decision of the majority. The Commission affirmed and adopted the Decision of the Arbitrator, who found that Petitioner proved he sustained a compensable accident and awarded him $17,791.72 in medical expenses, 16&6/7 weeks of temporary total disability benefits, and 15 weeks of permanent partial disability benefits representing loss of 3% of the person-as-a-whole. I would have reversed the Decision of the Arbitrator, found that Petitioner did not sustain his burden of proving a compensable accident, and denied benefits.

Petitioner was Acting Vice President of Vehicle maintenance for Respondent and in that role, he had to travel to 20 different locations. As such he was a traveling employee. On November 7, 2017 he was at a location remote from his office. He was walking up stairs to attend a meeting scheduled for 2:30 p.m. at that facility. He testified that he was rushing because he planned to speak to the general manager prior to the meeting. He also testified he was carrying a portfolio. He realized he had left his glasses, spun around on the staircase to return to get them, and fell on the stairs. He did not know whether he slipped on something or missed a step. There was no evidence that the stairs were in any way defective or in a hazardous condition. He was taken to an Emergency Department by ambulance and the treating records indicated that the accident occurred at 1:33 p.m.

The Arbitrator found that Petitioner sustained his burden of proving the accident was compensable because he was a traveling employee, and as noted above the majority affirmed and adopted his decision. In my opinion if a traveling employee is injured in the course of traveling, the requirement that the accident occur in the course of his/her employment is satisfied. However, I do not believe that the status of traveling employee necessarily fulfills the requirement that an accident arise out of the employment. In my opinion, a claimant must still establish that the accident arose out of the employment. In the instant claim Petitioner had to prove that his fall was associated with a risk of employment rather than associated with a personal risk or was idiopathic in nature. Petitioner testified that he did not know how he fell. There was nothing defective or hazardous with the staircase. He was not required to use the stairs because there was an elevator, as well as other stairs available. It is also difficult to establish that he was under any undue time pressure because the accident occurred an hour prior to the scheduled meeting. Therefore, in my opinion, Petitioner's fall was idiopathic in nature and he did not sustain his burden of proving the accident arose out of his employment.

For the reasons stated above, I would have reversed the Decision of the Arbitrator, found that Petitioner did not sustain his burden of proving a compensable accident, and denied benefits. Therefore, I respectfully dissent from the Decision of the majority.

DLS/dw
O-5/23/19

Deborah L. Simpson
Deborah L. Simpson

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION
CORRECTED

DIETRICH, THOMAS Case# **17WC037201**
Employee/Petitioner

CHICAGO TRANSIT AUTHORITY
Employer/Respondent

19IWCC0317

On 8/1/2018, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 2.16% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0147 CULLEN HASKINS NICHOLSON ET AL
JOSE M RIVERO
10 S LASALLE ST SUITE 1250
CHICAGO, IL 60603

0515 CHICAGO TRANSIT AUTHORITY
J BARRETT LONG
567 W LAKE ST 6TH FL
CHICAGO, IL 60661

STATE OF ILLINOIS)
)SS.
COUNTY OF Cook)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION

CORRECTED ARBITRATION DECISION

Thomas Dietrich
Employee/Petitioner

Case # **17WC037201**

v.

Consolidated cases: **none**

Chicago Transit Authority
Employer/Respondent

19IWCC0317

An *Application for Adjustment 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 **Chicago**, on **4/24/2018 & 5/14/18**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. [ ] Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?

B. [ ] Was there an employee-employer relationship?

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

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

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

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

G. [ ] What were Petitioner's earnings?

H. [ ] What was Petitioner's age at the time of the accident?

I. [ ] What was Petitioner's marital status at the time of the accident?

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

K. [x] What temporary benefits are in dispute?
[ ] TPD [ ] Maintenance [x] TTD

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

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

N. [x] Is Respondent due any credit?

O. [ ] Other ______

STATEMENT OF FACTS & CONCLUSION OF LAW 17 WC 37201

Findings of Fact:

Petitioner, Thomas Dietrich, works for Respondent, CTA as an acting vice president where he is responsible for the performance and maintenance of al buses and railcars owned by Respondent. (T.6-7). Petitioner's job requires that he travel from site to site throughout the city to conduct inspections and participate in meetings. (T. 8). He uses a CTA-provided vehicle to travel around to these places. (T. 8). He does have a central office at the CTA's building at 567 Lake Street. (T. 7). He has worked for the CTA for approximately 30 years. (T. 7).

On November 7, 2017, Petitioner arrived to his office in the morning. (T. 9). Petitioner was scheduled to have a meeting later that afternoon at the CTA's Skokie location. (T.9). The meeting was scheduled to take place at 2:30 pm. (T. 10).

Petitioner stated that he arrived at the Skokie building prior to the meeting which was to be help on the second floor of the building. (T.11). Before participating in the meeting, he was planning to speak with the general manager about an overhaul program prior to the meeting. (T.14).

Petitioner took a flight of stairs to reach the second floor, and walked up the left side of the staircase. (T.11, 14). Petitioner stated that he was rushing up the stairs to meet with the general manager since they had a lengthy conversation planned and he was slightly behind schedule. (T. 37). As he was ascending the stairs on the left side, he was holding a portfolio he used for work in his right hand and holding the stair railing with his left hand. (T. 15). He was about two-thirds up the staircase, when he realized he did not have his reading glasses, which he needs to read. (T. 15, 17). He testified that he spun around toward his right side, again with his portfolio in his right hand, preventing him from grasping the railing with his right hand. (T.15-16). As he was turning and went to step down, he fell with his feet going under him causing him to fall on the stairwell, lower back hitting a stair tread first. (T. 17). Petitioner stated that the portfolio he was holding flew from his hand as he was falling down. (T. 17).

Petitioner does not recall whether he slipped on something or simply missed a step. (T. 20). He denied felling dizzy or experiencing any type of vertigo at that moment. (T. 36). In fact, he believed that the fact he was rushing may have contributed to his having fallen. T. 37).

Petitioner was taken by ambulance to North Shore Hospital that day. (T. 20). There, a history was taken of "58-year-old male presents with complain of fall back pain. Patient was walking up the stairs when he forgot something and turned around. Patient then slipped and hit the back thoracic lumbar region…"(PX. 1, pg. 16). The triage report states "Pt. states that was on the stairs, forgot his glasses so turned and missed the step falling back. (PX.1, pg. 24). A CT scan of is spine was taken and revealed evidence of a prior fusion at L4-S1 and otherwise normal. (PX. 1, pg., 19). He was diagnosed with thoracic and lumbar back pain and given medication. (PX. 1, pg. 23).

As a part of his job, Petitioner is required to travel throughout the city. At the time he suffered his injury, he was not at his home office, but rather at Respondent's location in Skokie. Petitioner was as traveling employee at the time of his accident. The inquiry on defense leads the Arbitrator to infer it was based for the most part on the idea that the worker was not a traveling employee under the Act -with the Appellate Court standards linked thereto. The Arbitrator must follow the black letter law of the Court on traveling employees. He was not a construction worker electing to work on a long term, far job site, he was not commuting to his place of employment on Lake Street nor was he on a vacation with a tangential work element such as on a water craft or even walking in Hawaii.

The determination of whether an injury suffered by a traveling employee, such as the claimant in this case, arose out of and in the course of his employment is governed by different rules than are applicable to other employees. Hoffman v. Industrial Commission, 109 Ill. 2d 194, 199 (1985). The relevant inquiry becomes not necessarily whether a hazardous condition caused Petitioners' fall, but whether Petitioner's actions were reasonable and foreseeable. Mlynarczyk v. Illinois Workers' Compensation Commission, 2013 Ill. App. D 120411WC. The Arbitrator finds that, even assuming it was Petitioner's "misstep" that caused his fall, it was reasonable and foreseeable for Petitioner to misstep while descending stairs when he spun around to retrieve his reading glasses.

In this particular case, the Arbitrator finds the petitioner is a traveling employee.

Based upon the totality of the evidence, , the Arbitrator finds that Petitioner sustained an injury that arose out of and in the course of his employment with the Respondent. This is based upon the law of traveling employees as per the Appellate Court under the guides of reasonableness and foreseeability. The current cases considered neutral risk cases thereby scrutinizing the arising out of context of the law are inapposite.

With respect to issue (F), whether Petitioner's condition of ill-being is causally related to the injury, the Arbitrator finds as follows:

Petitioner was able to work full duty prior to his work injury of November 7 2017. When the accident occurred, Petitioner sought immediate care for his lower back injury and the subsequent treatment and temporary disability was continuous until his release in March.

Based upon the totalilty of the evidence including the chain of events, the Arbitrator finds that Petitioner's condition of ill-being is causally related to the injury of November 7, 2017.

With respect to issue (K) whether Petitioner is entitled to temporary total disability the Arbitrator finds as follows:

The Arbitrator gives this factor some weight. Petitioner noted his back pain now is constant as compared to his prior back pain, which was occasional. He currently takes Advil to alleviate his pain. The medical records are adopted herein.

3. Earning Capacity

The Arbitrator gives this factor neutral . Petitioner testified that he is earning less than what he was earning at the time of the accident. This was not clearing probative given the Petitioner's self-description of his current job duties as it relates to the nature of injury.

4. AMA rating

The Arbitrator gives this factor no weight as no party offered and AMA rating.

5. Position

The Arbitrator gives the factor neutral weight. Petitioner's job requires no lifting or heavy work.

Accordingly, based upon the totality of the evidence the Arbitrator finds that Petitioner sustained an injury to the lumbar spine resulting in permanent partial disability to the extent of three per cent (3%) loss of use of person as a whole.

The Respondent shall pay the Petitioner and his attorney the following: 15 weeks of permanent partial disability under section 8(d)2 of the Act at the rate of sixty per cent of the average weekly wage calculated based upon the stipulated average weekly wage under section 10 in the Request for Hearing stipulations, Arb Exhibit one.

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Linda Geyler,
Petitioner,

vs.

NO: 16WC 4139
19IWCC0318

Harlem School District,
Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the 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 July 24, 2017, 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: JUN 25 2019

o061819
MEP/jrc
049

Maria Portela

Deborah Simpson

Douglas McCarthy

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

GEYLER, LINDA
Employee/Petitioner

Case# **16WC004139**

HARLEM SCHOOL DISTRICT
Employer/Respondent

19IWCC0318

On 7/24/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.10% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

2489 BLACK & JONES
JASON ESMOND
308 W STATE ST SUITE 300
ROCKFORD, IL 61101

2461 NYHAN BAMBRICK KINZIE & LOWRY
GARY WALLACE
20 N CLARK ST SUITE 1000
CHICAGO, IL 60602

STATE OF ILLINOIS)
)SS.
COUNTY OF WINNEBAGO)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Linda Geyler
Employee/Petitioner

Case # **16** WC **4139**

v.

Harlem School District
Employer/Respondent

19IWCC0318

An *Application for Adjustment 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 **June 20, 2017**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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. [ ] Is Petitioner's current condition of ill-being causally related to the injury?
G. [ ] What were Petitioner's earnings?
H. [ ] What was Petitioner's age at the time of the accident?
I. [ ] What was Petitioner's marital status at the time of the accident?
J. [x] Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. [x] What temporary benefits are in dispute?
[ ] TPD [ ] Maintenance [x] TTD
L. [x] What is the nature and extent of the injury?
M. [ ] Should penalties or fees be imposed upon Respondent?
N. [ ] Is Respondent due any credit?
O. [ ] Other

FINDINGS

On **September 2, 2015**, Respondent ***was*** operating under and subject 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*** causally related to the alleged accident.

In the year preceding the injury, Petitioner earned $**21,928.40**; the average weekly wage was $**421.70**.

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

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

ORDER

Petitioner failed to prove that her injury arose out of her employment with the Respondent and, therefore, 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

July 20, 2017
Date

JUL 24 2017

FACTS:

The parties stipulated that Petitioner was an employee of Respondent on September 2, 2015 and that timely notice of her injury was provided to Respondent. The parties stipulated that Petitioner was 62 years of age and married, with no dependent children, at the time of her injury. The parties also stipulated that Petitioner's earnings in the year preceding her injury were $21,928.40, resulting in an average weekly wage of $421.70. The parties further stipulated that Petitioner's current condition of ill-being is casually related to her September 2, 2015 injury. Respondent disputed that Petitioner sustained an accidental injury that arose out of and in the course of her employment.

Petitioner testified that she had worked for Respondent as a substitute teacher since approximately 1999. She worked an average of 3 days per week. Her assignments were received by calling into a system each morning or the night prior for a job assignment. She would generally be assigned a teaching job for 1 day at a time. She worked only in the Harlem School District, but could be positioned at various locations, including preschools, middle schools, the junior high school, or the high school.

On the day of her injury, she had been assigned a job at the high school, teaching an English class. She arrived at 8 a.m. and reported to the office to collect the folder with the teaching materials for the day. She taught the class for the day and collected her things to leave the classroom. Petitioner testified that she was carrying a stack of paperwork left from the teacher, her purse, a bag with her lunch, and a water bottle. She was leaving to drop off the teacher's materials in the office before leaving for the day. Petitioner testified that, as she exited the classroom, her foot got stuck on the floor and she began to fall. She testified that she dropped everything she was carrying and fell to the ground, landing on her right side. Petitioner testified that she did not see anything on the floor that would have caused her to fall.

Petitioner was taken to the nurse's office and they called the workers' compensation carrier to report her fall. The recorded statement confirms the history that she did not trip over anything, nor was there any noticeable defect on the floor. She was then transported to the hospital, where she reported experiencing pain in her right leg, knee, and arm. Petitioner was seen at Rockford Memorial Hospital and initially diagnosed with a sprain of the right knee. She was referred to Ortho IL where she began physical therapy on September 18, 2015. Petitioner had some improvement with physical therapy, but due to ongoing pain, was prescribed an MRI. The MRI revealed a tibial plateau fracture and a suspected medial meniscal tear. On October 22, 2015, she was provided crutches and a knee immobilizer and taken out of physical therapy. Physical therapy was resumed on December 7, 2015 and continued through February of 2016. A CT scan, performed on March 25, 2016, evidenced deformity and posterolateral downsloping of the posterolateral tibial plateau, typical of prior trauma. On May 3, 2016, Dr. Enke discontinued physical therapy and recommended a home exercise program. At that time, Petitioner deferred injections or a surgical option.

Petitioner returned to work on March 6, 2016. She continued to use a cane due to pain and stiffness in her knee. She testified that she had continued to use a cane since the injury for stability when walking. Petitioner testified that she now avoided preschool or middle school jobs as she had difficulty performing the maneuvers required to assist the younger children. She testified that her knee continues to be stiff. She occasionally takes Meloxicam for the stiffness in her knee. She has difficulty traversing stairs, generally needing ramps to get around.

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 is claiming accidental injuries of September 2, 2015. After hearing testimony and reviewing all trial exhibits, the Arbitrator finds that the Petitioner has failed to prove that her condition of ill-being arose out of her employment with Respondent. In support thereof, the Arbitrator cites the following facts and conclusions of law.

The Petitioner testified she was employed by the Respondent as a substitute teacher. On September 2, 2015, she was assigned to Harlem High School. She taught an English class that day. At the end of the day, after school let out, the Petitioner testified she was exiting her classroom as she was entering the hallway. She was carrying her purse, another bag, and a water bottle.

As she was walking in the hallway, the Petitioner testified that her foot stuck on the floor causing her to fall. She injured her right knee. Petitioner was treated conservatively by Ortho Illinois for a lateral tibial plateau fracture. (PX 1). She returned to work in March, 2016 and was discharged from care in May, 2016.

Central to the claim of accident are the facts surrounding the cause of the Petitioner's fall in the school hallway on September 2, 2015. On cross-examination, the Petitioner admitted that nothing in the hallway caused her to fall. She admitted the hallway was mostly empty of people. She admitted that there was no debris or substance on the floor which caused her to fall. Petitioner further admitted that she was walking normally and not rushing. She admitted that she was wearing rubber soled shoes. Finally, the Petitioner admitted that nothing that she was carrying in her hands caused or contributed to her fall.

Shortly after the September 2, 2015 incident, the Petitioner provided a recorded statement to Ms. Angelica Herrera, claims handler for Sedgwick. (RX 1). In her recorded statement, the Petitioner admitted that one of her rubber soled shoes just caught on the floor. (RX 1, pg. 3). The Petitioner further admitted to Ms. Herrera that there wasn't any debris on the floor. "The floor was clear" (RX 1, pg. 6).

Respondent Exhibit 2 are the initial records for treatment rendered by Rockford Health Systems on September 2, 2015. Those records indicate a history given by the Petitioner that she misstepped causing her to fall with no allegations of anything on the floor causing her fall.

Finally, Respondent Exhibit 3 is a DVD of the surveillance video captured by a security camera located in the hallway where the Petitioner fell. The video shows the Petitioner's fall in the hallway as it occurred. The Arbitrator notes that the hallway was clear and that there was no debris on the floor. The Petitioner appears to merely misstep and fall.

Based on the entirety of the above facts, the Arbitrator concludes that no element of the Petitioner's employment with Respondent caused or contributed to the Petitioner's fall on September 2, 2015. The cause of the Petitioner's fall on September 2, 2015 is purely personal to the Petitioner.

Because the cause is purely personal to the Petitioner, the Arbitrator must conclude that the Petitioner's fall on September 2, 2015 did not arise out of her employment with the Respondent.

Accordingly, determination of the remaining disputed issues is moot and Petitioner's claim for compensation is denied.

STATE OF ILLINOIS)		
) SS.	☐ Affirm and adopt (no changes)	☐ Injured Workers' Benefit Fund (§4(d))
COUNTY OF MADISON)	☐ 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

BYRON E. CLEMONS, SR.,

Petitioner,

vs. NO: 17 WC 31434

ALTON MENTAL HEALTH CENTER,

Respondent.

19IWCC0319

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issue of permanent disability and being advised of the facts and law, 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.

Permanent Disability

The Commission views the evidence differently with respect to Section 8.1b(b) factor (v).

(v) evidence of disability corroborated by the treating medical records

In analyzing the evidence of disability as corroborated by the treating medical records, the Arbitrator documented Petitioner's MRI showed (1) a complete disruption of the ACL with reactive edema/contusion; (2) an oblique tear inner margin/root attachment of the posterior horn of the lateral meniscus; and (3) mild joint effusion. The Arbitrator further noted the operation consisted of a partial lateral meniscectomy, chondroplasty of the lateral tibial plateau, and partial synovectomy and that the surgery did not address the ACL injury, "which may be the source of Petitioner's continued symptoms."

The Commission notes, however, Dr. Dusek's December 1, 2017 pre-operative opinion

that if Petitioner "has an anterior cruciate ligament injury it does not seem to be producing functional instability. His pain is typically over the lateral meniscus." (Px2, p. 7) Dr. Dusek then recommended the arthroscopic surgery to the right knee and specified "Of course, we would look at everything. We would further evaluate arthroscopically the status of his ACL." (Px2, p. 7) The Commission believes this note implicates the lateral meniscus rather than the ACL as the source of Petitioner's pain and further that Dr. Dusek would have addressed the ACL during surgery if necessary. Therefore, it would be speculative to presume the ACL is the source of Petitioner's continued symptoms absent any further opinion by Dr. Dusek in this regard. The Commission notes Dr. Dusek's post-operative notes are silent regarding any further ramifications of the ACL contusion noted on MRI to Petitioner's post-operative recovery.

The Arbitrator also noted the post-surgical records document ongoing swelling and pain consistent with Petitioner's testimony at trial. The Commission believes the Petitioner's testimony is not entirely consistent with Dr. Dusek's office notes. The only documented swelling In Petitioner's right knee was at the January 2, 2018 first post-operative visit, only 12 days after surgery. By February 8, 2018, only six weeks postoperatively, Petitioner had no effusion and full motion of the knee. (Px2, p. 13) On March 9, 2018, the History of Present Illness section states specifically that swelling had not recurred. Petitioner did report some "persistent moderate soreness" at this visit, thus the doctor injected the right knee with Depo-Medrol.

Petitioner returned for his last office visit with Dr. Dusek on April 20, 2018, and Dr. Dusek documented that Petitioner reported that his knee swells up from time to time, "Nevertheless today it is not swollen." (Px2, p. 20) The Physical examination showed that Petitioner had full motion and walked with a good gait. Dr. Dusek opined that Petitioner "is marked improved from his preoperative condition and fully able to continue at his gainful employment." Petitioner was released from care at maximum medical improvement, approximately four months after his surgery. (Px2, p. 21)

The Commission finds that the post-surgical records on February 8, 2018, March 9, 2018 and on April 20, 2018 document there was no swelling in Petitioner's knee and, in fact Petitioner also testified his symptoms "have stayed since the injury, post-surgery and after the surgery, before and after the surgery.' (T, p. 23) This testimony is inconsistent with Dr. Dusek's February 8, 2018 office note which documented that only 6 weeks post-surgery "he still has about 50% of his pre-operative discomfort at this point." (Px2, p. 13) The testimony is also inconsistent with the comments in Dr. Dusek's notes from Petitioner's last office visit on April 20, 2018 as referenced. Finally, Petitioner has never returned to Dr. Dusek since the last office visit.

Having weighed the evidence and analyzed the Section 8.1b(b) factors, the Commission finds Petitioner sustained a 20% loss of use of the right leg under Section 8(e).

All else is affirmed.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed December 3, 2018, as modified above, is hereby affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner

the sum of $568.11 per week for a period of 43 weeks, as provided in §8(e) of the Act, for the reason that the injuries sustained caused 20% loss of use of the 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.

No county, city, town, township, incorporated village, school district, body politic or municipal corporation is required to file a bond to secure the payment of the award and the costs of the proceedings in the court to authorize the court to issue such summons. *820 ILCS 305/19(f)(2)*. Based upon the named Respondent herein, no bond is set by the Commission. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: JUN 25 2019
LEC/bsd
O05/21/19
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L. Elizabeth Coppoletti
Elizabeth Coppoletti

Thomas J. Tyrrell
Thomas J. Tyrrell

Maria Elena Portela
Maria Portela

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

CLEMONS SR, BYRON E
Employee/Petitioner

Case# **17WC031434**

ALTON MENTAL HEALTH
Employer/Respondent

19IWCC0319

On 12/3/2018, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 2.47% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in 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
MATTHEW CHAPMAN
3673 HWY 111 PO BOX 488
GRANITE CITY, IL 62040

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

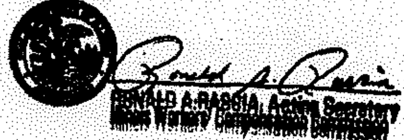
4948 ASSISTANT ATTORNEY GENERAL
WILLIAM H PHILLIPS
201 W POINTE DR SUITE 7
SWANSEA, IL 62226

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

1745 DEPT OF HUMAN SERVICES
BUREAU OF RISK MANAGEMENT
PO BOX 19208
SPRINGFIELD, IL 62794-9208

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

DEC 3 - 2018



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
NATURE AND EXTENT ONLY

Byron E. Clemons, Sr.
Employee/Petitioner

v.

Alton Mental Health
Employer/Respondent

Case # **17** WC **31434**

Consolidated cases: **N/A**

19IWCC0319

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 **Nancy Lindsay**, Arbitrator of the Commission, in the city of **Collinsville**, on **October 22, 2018**. By stipulation, the parties agree:

On the date of accident, **10/15/17**, 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 $**49,236.00**, and the average weekly wage was $**946.85**.

At the time of injury, Petitioner was **30** years of age, ***married*** with **3** dependent children.

Necessary medical services and temporary compensation benefits have been provided by Respondent. Respondent agrees that it has paid, or will pay, the medical bills contained in PX 5 subject to the Medical Fee Schedule and with Respondent receiving credit for any medical bills previously paid, including any paid by a group medical plan for which Respondent gets credit under Section 8(j) of the Act.

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**.

After reviewing all of the evidence presented, the Arbitrator hereby makes findings regarding the nature and extent of the injury and attaches the findings to this document.

ORDER

Respondent shall pay Petitioner permanent partial disability benefits of $**568.11/week** for **48.375 weeks**, because the injuries sustained caused the **22.5%** loss of use of Petitioner's right leg, as provided in Section 8(e) of the Act.

Respondent shall pay Petitioner compensation that has accrued between **October 15, 2017** and **October 22, 2018** 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

November 29, 2018
Date

DEC 3 - 2018

FINDINGS OF FACT and CONCLUSIONS OF LAW
REGARDING THE NATURE AND EXTENT OF PETITIONER'S INJURY

The Arbitrator finds:

On October 15, 2017, Petitioner was employed as a Security Therapy Aide at the Alton Mental Health Center, a state-run mental health facility in Alton, Illinois. On that date, a resident kicked Petitioner in the right leg. Petitioner heard a pop and felt pain in his right knee. Before this incident, Petitioner was working full duty with no physical restrictions. Petitioner had never experienced any pain or other symptoms related to his right knee.

Petitioner initially sought treatment at the St. Anthony's Health Center emergency room. (PX 1) At the ER, Petitioner reported pain on the right side of his knee. Petitioner reported that, after the resident kicked him in the knee, he heard a "pop" and felt burning within his knee. On physical examination, the emergency room physician noted tenderness on the right lateral joint line with slight edema to the knee. (PX1, 5) X-rays were taken, which did not reveal any fractures. Petitioner was diagnosed with a right knee sprain and discharged. (PX1, 6) Petitioner was told to follow up with an orthopedist. (PX1, 9)

On October 19, 2017, Petitioner saw Dr. Dennis Dusek, a board-certified orthopedic specialist. (PX 2). Dr. Dusek noted that Petitioner reported burning pain on the distribution of the peroneal nerve since the injury and pain over the lateral joint line, as well as the region of the proximal tibial fibular joint. (PX2,1) On physical examination, Petitioner had slightly diminished sensation over the peroneal nerve to the right leg. The knee still had a small effusion. Dr. Dusek also noted a lateral joint line tenderness and positive Apely grind sign for the lateral meniscus to the right knee. (PX2,2) Dr. Dusek recommended an MRI of the right knee. Dr. Dusek also indicated that an EMG of the peroneal nerve may be indicated. (PX2, 3)

On November 14, 2017, Petitioner underwent an MRI of the right knee. (PX 3) The MRI revealed a complete disruption of the ACL with reactive edema/contusion and a pattern typical thereof; oblique tear inner margin/root attachment posterior horn lateral meniscus; and a mild joint effusion. (PX 3)

On December 1, 2017, Dr. Dusek noted the torn lateral meniscus. Dr. Dusek also noted that, although the proximal tib fib joint appeared to have not been fractured, there was a bone bruise on the lateral tibial plateau likely from the force of the kick to his right knee. Petitioner still had burning pain down his peroneal nerve. Dr. Dusek advised Petitioner that he may need time for that to settle down as well as time for the bone bruise to settle down. Dr. Dusek noted the concern about the anterior cruciate ligament. Dr. Dusek recommended arthroscopic surgery to the right knee, focusing on the lateral meniscus. He would further evaluate the status of the ACL. Dr. Dusek also restricted Petitioner from work in the meantime. (PX2, 7)

Petitioner testified that Dr. Dusek told him that, if Petitioner was a young athlete, surgery directed to the ACL might be appropriate. Since Petitioner was over thirty and not participating in high school or college sports, Dr. Dusek was going to try to avoid surgery on the ACL if possible.

On December 22, 2017, Dr. Dusek performed a right knee arthroscopic partial lateral meniscectomy, chondroplasty of the lateral tibial plateau and a partial synovectomy. (PX 4) In the operative report, Dr. Dusek noted some mild erythema to the anterior cruciate ligament without a complete disruption. Dr. Dusek also saw a hairline crack to the articular cartilage of the lateral femoral condyle. Dr. Dusek also noted that at the undersurface of the posterior horn of the lateral meniscus, there was a high grade and complete tear through the lateral meniscus about one-third of the way from the inner rim to the popliteus hiatus. Dr. Dusek further noted

an area on the tibial plateau with a high-grade articular cartilage injury with an unstable articular cartilage fragment.

On January 2, 2018, Dr. Dusek noted that Petitioner still had a fair amount of pain and swelling. Petitioner was taking Norco for the pain. Dr. Dusek aspirated 72ccs of fluid from the knee. (PX2, 11) Dr. Dusek prescribed Meloxicam and continued to keep Petitioner off all work. On February 8, 2018, Dr. Dusek noted that Petitioner still had about 50% of his pre-operative discomfort. Petitioner was taking Glucosamine and Chondroitin. Dr. Dusek returned Petitioner to sedentary duty and was hopeful that he could return to full duty in one month. (PX2, 14) On March 9, 2018, Dr. Dusek noted that Petitioner's pain in the knee was gradually diminishing. On physical exam, Dr. Dusek noted that Petitioner still had some persistent moderate soreness. Dr. Dusek injected the knee with 80mg of Depo Medrol. Dr. Dusek also advised Petitioner to start taking Aleve, two tablets a day for the next several weeks. (PX2, 18) Dr. Dusek indicated that Petitioner could resume full duty March 19, 2018. (PX2, 19)

On April 20, 2018, Dr. Dusek noted that Petitioner's knee would still swell from time to time. Petitioner was still taking two Aleve twice a day with meals and was also still taking Glucosamine and Chondroitin. Petitioner had full motion and walked with a good gait. Dr. Dusek noted that Petitioner had a permanent impairment but was improved from his pre-operative condition. Petitioner was deemed at maximum medical improvement and released from care to return as needed. (PX 2, 20)

Petitioner testified that his position with Respondent requires him to supervise and assist mentally ill criminals in their activities of daily life. His job can include substantial walking. Petitioner testified that his knee still swells after working, approximately three times per week, especially with sixteen hour workdays. When his knee is sore and swollen, Petitioner has declined overtime hours. He doesn't do that regularly estimating it was maybe 2 – 3 times per month. Petitioner has also had his family physician fill out FMLA paperwork for when Petitioner takes time off due to his knee. Petitioner explained that he takes approximately one to two days off per month to rest his knee. To treat the swelling, Petitioner stays off his feet and ices his knee. Petitioner still uses a brace for his knee when he is not working. Petitioner testified that STA's are not permitted assistive devices at the facility.

On cross-examination Petitioner was asked if his symptoms come and go or wax and wane and he replied, "No." He explained that his symptoms have remained the same since the injury and after surgery. When asked if he has good days and bad days, he responded that he has "okay days and bad days." Regarding the swelling in his knee, Petitioner explained that it occurs with certain duties at work and working 16 hour days. Before the surgery it was more on the right side but since the surgery it appears that his entire knee will swell up. He acknowledged that he wasn't wearing his knee brace on the day of the hearing.

Petitioner was also asked whether his knee had worsened to a point that he needed to return and see Dr. Dusek and he explained that there are certain days he feels like he needs to call him; however, the doctor explained to him that with his kind of injury and his ACL as it is, his knee is going to swell and he's not just around the corner so if he doesn't have to go and see him he isn't.

Respondent tendered no exhibits and did not elect to have Petitioner examined by a doctor of its own choosing.

The Arbitrator concludes:

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

The Arbitrator notes that 820 ILCS 305/8.1b governs determination of permanent partial disability. In particular, the Arbitrator is to consider the following factors:

(i) The reported level of impairment pursuant to the AMA evaluation under the Sixth Edition;
(ii) The occupation of the injured employee;
(iii) The age of the employee at the time of injury;
(iv) Evidence of disability corroborated by the treating medical records. No one single factor shall be the sole determinant of disability.

With regard to Petitioner's case herein and each of the foregoing factors, the Arbitrator notes the following:

(i) Neither party submitted an AMA evaluation and, therefore, no weight is given to this factor.

(ii) The occupation of the injured employee. Petitioner's job as a Security Therapy Aide requires him to work on his feet throughout the day, which causes pain and swelling in the knee. Petitioner's job also exposes him to physical confrontation, squatting, and lifting, which will likely further exacerbate Petitioner's permanent disability. Petitioner's testimony was unrebutted. The Arbitrator gives this factor some weight.

(iii) Petitioner's age at the time of his injury. Petitioner was 30-years-old at the time of his injury. As such he may reasonably be expected to work and live with the effects of his injury for a reasonable time into the future. The Arbitrator notes that it is unlikely that Petitioner's condition will improve as he ages. Petitioner's age is given some weight.

(iv) Petitioner's future earning capacity. Petitioner testified that he has turned down overtime hours due to pain and swelling in his knee. Petitioner has also filed FMLA paperwork in anticipation of days off that he needs to take when the knee is too sore to perform his job duties. This factor is given some weight.

(v) Evidence of disability corroborated by the treating medical records. The MRI showed (1) a complete disruption of the ACL with reactive edema/contusion; (2) an oblique tear inner margin/root attachment of the posterior horn of the lateral meniscus; and (3) mild joint effusion. The operation consisted of a partial lateral meniscectomy, chondroplasty of the lateral tibial plateau, and partial synovectomy. The Arbitrator notes that the surgery did not address the ACL injury, which may be the source of Petitioner's continued symptoms. The operative findings included a hairline crack to the articular cartilage of the lateral femoral condyle; a high grade and complete tear through the lateral meniscus about one-third of the way from the inner rim to the popliteus hiatus; and an area on the tibial plateau with a high-grade articular cartilage injury with an unstable articular cartilage fragment. The post-surgical records document ongoing swelling and pain consistent with Petitioner's testimony at trial. Petitioner is still taking Aleve twice a day and Glucosamine. The Arbitrator gives this factor substantial weight.

Having considered all of the factors as required by statute, and noting that Petitioner was a very credible witness, the Arbitrator concludes that Petitioner has been permanently partially disabled to the extent of 22.5% of Petitioner's right leg.

****

STATE OF ILLINOIS	)	[X] Affirm and adopt (no changes)	[ ] Injured Workers' Benefit Fund (§4(d))
	) SS.	[ ] Affirm with changes	[X] 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

Stephanie Woods,

Petitioner,

vs. NO: 12WC 21799

City of Chicago,

Respondent.

19IWCC0320

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 disability, causal connection, nature and extent, credit for overpayment of benefits and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed February 5, 2018, is hereby affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION Respondent shall pay the petitioner the sum of $**857.09**/week for life, commencing **01/17/2018**, as provided in Section 8(f) of the Act, because the injury caused the permanent and total disability of the petitioner.

IT IS FURTHER ORDERED BY THE COMMISSION that commencing on the second July 15th after the entry of this award, the petitioner may become eligible for cost-of-living adjustments, paid by the ***Rate Adjustment Fund***, as provided in Section 8(g) of the Act.

IT IS 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: JUN 25 2019

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LEC/jrc
043

Elizabeth Coppoletti

Maria Portela

Douglas McCarthy

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

WOODS, STEPHANIE
Employee/Petitioner

Case# **12WC021799**

CITY OF CHICAGO
Employer/Respondent

19IWCC0320

On 2/5/2018, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.62% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

2675 COVEN LAW GROUP
MATTHEW T SMART
180 N LASALLE ST SUITE 3650
CHICAGO, IL 60601

0766 HENNESSY & ROACH PC
JOSEPH ZWICK
140 S DEARBORN ST SUITE 700
CHICAGO, IL 60601

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

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

STEPHANIE WOODS
Employee/Petitioner

v.

CITY OF CHICAGO
Employer/Respondent

Case # **12** WC **21799**

Consolidated cases: **D/N/A**

19IWCC0320

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Molly Mason**, Arbitrator of the Commission, in the city of **Chicago**, on **01/16/2018**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. [ ] Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. [ ] Was there an employee-employer relationship?
C. [ ] Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. [ ] What was the date of the accident?
E. [ ] Was timely notice of the accident given to Respondent?
F. [ ] Is Petitioner's current condition of ill-being causally related to the injury?
G. [ ] What were Petitioner's earnings?
H. [ ] What 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 X Maintenance [ ] TTD
L. [x] What is the nature and extent of the injury?
M. [ ] Should penalties or fees be imposed upon Respondent?
N. [x] Is Respondent due any credit for a claimed overpayment of maintenance benefits?
O. [ ] Other ______

FINDINGS

On **06/04/2012**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**66,853.28**; the average weekly wage was $**1,285.64**.

On the date of accident, Petitioner was **49** years of age, ***single*** with **0** dependent children.

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

Respondent ***has*** paid, or agreed to pay, all appropriate charges for all reasonable and necessary medical services.

Respondent shall be given a credit of $**55,101.85** for TTD, $**0** for TPD, $**198,244.24** for maintenance, and $ **0** for other benefits.

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

ORDER

Respondent shall pay reasonable and necessary medical expenses of $558.09 (Illinois Spine Institute, PX G) subject to the fee schedule.

Respondent stipulated to temporary total disability but, via its "reverse" 19(b) petition, claimed Petitioner was not entitled to the substantial maintenance benefits it paid after August 29, 2013. PX G. For the reasons set forth in the attached decision, the Arbitrator denies the "reverse" 19(b) petition and finds Petitioner was entitled to maintenance from August 30, 2013 through the hearing of January 16, 2018. Respondent shall receive credit for its maintenance payment of $198,244.24, per the parties' stipulation. Arb Exh 1.

For the reasons set forth in the attached decision, the Arbitrator finds that Petitioner falls into the "odd lot" classification and is permanently and totally disabled. Respondent shall pay Petitioner permanent and total disability benefits of $**857.09**/week for life, commencing **01/17/2018**, 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.

19IWCC0320

Molly C Mason

Signature of Arbitrator

2/2/18
Date

FEB 5 - 2018

Summary of Disputed Issues

The parties agree Petitioner injured her lower back while working as a garbage collector for Respondent on June 4, 2012. Petitioner underwent a lumbar fusion on January 29, 2013. Dr. Graf, who was originally Respondent's Section 12 examiner, performed this surgery. A valid functional capacity evaluation performed on August 13, 2013 showed Petitioner to be performing at a light to medium physical demand level. Dr. Graf imposed restrictions following the evaluation. There is no dispute that Respondent was unable to accommodate the restrictions. MedVoc Rehabilitation and Vocamotive, successively, provided vocational rehabilitation services to Petitioner over the course of several years. Kari Stafseth, Petitioner's counselor at Vocamotive, originally viewed Petitioner as potentially employable but ultimately concluded there is no stable market for Petitioner's services. Petitioner maintains she is permanently and totally disabled under an "odd lot" theory.

Respondent paid substantial maintenance benefits after August 29, 2013 (the date on which Dr. Graf imposed restrictions) but contends, via a "reverse" 19(b) petition, that Petitioner was not entitled to those benefits due to lack of compliance with the job search process. Applying the same argument, Respondent maintains permanency should be assessed under 8(d)2 rather than 8(f).

Arbitrator's Findings of Fact

Petitioner testified she is currently 55 years old. She began working for Respondent in 2000. Her job involved collecting garbage in alleys. There was no limit as to the type or weight of garbage she was required to lift.

Petitioner testified she graduated from high school in 1980. She denied attending any college courses or undergoing any specialized training thereafter. The MedVoc representative who interviewed her in January 2014 noted she worked as a housekeeper at Cook County Hospital for about eight or nine years before being hired by Respondent. The interviewer indicated that Petitioner reported working full-time and earning $13.00 per hour when she left to begin working for Respondent. RX 1.

Petitioner testified she wears a prosthesis in her left eye. She denied having a driver's license. The initial MedVoc interview report reflects Petitioner reported having vision deficiencies since childhood. RX 1. Her records document a left eye enucleation. PX 2.

Petitioner denied having any back problems or injuries prior to the accident of June 4, 2012. On that date, she lifted a boxed television while performing her regular garbage collector duties. She testified to an immediate and severe onset of lower back pain. She notified her supervisor. Paramedics transported her to the Emergency Room at Little Company of Mary

Hospital, where personnel recorded a consistent account of the lifting incident. Petitioner complained of left-sided lower back pain. She was given Valium and a Toradol injection. She was diagnosed with an acute lumbar strain and directed to remain off work until she could seek follow-up care. PX A-B.

Petitioner began a course of care at MercyWorks on June 5, 2012. PX C. Dr. Diadula took her off work and recommended physical therapy. At the doctor's direction, Petitioner underwent a lumbar spine MRI on July 19, 2012. The scan showed degenerative loss of disc height with associated bulging and stenosis at L5-S1. PX D. On July 24, 2012, Dr. Diadula reviewed the MRI results and directed Petitioner to remain off work and see Dr. Cupic for pain management. Dr. Cupic administered a left L4-L5 epidural steroid injection on September 9, 2012 and a transforaminal injection at L5-S1 om October 4, 2012. PX E. On October 12, 2012, Petitioner informed Dr. Diadula the injections were "not working." The doctor kept her off work and referred her to Dr. Nelson, an orthopedic surgeon. PX C. On October 12, 2012, Dr. Nelson examined Petitioner and reviewed the MRI. He diagnosed an L5-S1 herniation causing left-sided nerve root pain. He causally related the herniation to the lifting incident. He recommended that Petitioner see a spinal surgeon since she had failed conservative care. PX F.

Records and itemized billing in PX G reflect Dr. Graf, a spine surgeon, examined Petitioner at Respondent's request on November 16, 2012.

A handwritten note in PX G reflects that, on November 16, 2012, Dr. Graf recorded a history of the work accident and complaints of 9/10 lower back pain, worse on the left. In an "IME Quick Report," the doctor recommended a "new high field MRI" of the lumbar spine and recommended that Petitioner stay "off work until further notice."

Petitioner continued seeing Dr. Graf following the Section 12 examination. On December 6, 2012, the doctor interpreted the new MRI as showing a left lateral disc herniation at L5-S1 with compression of the S1 and L5 nerve roots. He recommended both an anterior interbody fusion and a posterior decompression on the left at L5-S1. PX G.

Petitioner was admitted to St. Alexius Medical Center on January 29, 2013. On examination, Dr. Graf noted that Petitioner was experiencing a fungal rash of her buttocks. He recommended that Petitioner delay surgery so he could perform the anterior and posterior procedures simultaneously. He noted that Petitioner was intent on proceeding with at least the anterior portion. Dr. Graf operated the same day, performing an anterior lumbar interbody fusion and decompression at L5-S1. Petitioner developed mild leukocytosis and a low grade fever postoperatively. She was started on an antibiotic and was discharged from the hospital on February 1, 2013. PX I.

Petitioner continued seeing Dr. Graf following the surgery. Post-operative X-rays showed the implant to be in excellent position. PX G. At the doctor's recommendation, Petitioner underwent additional physical therapy for a number of months. In July 2013, Dr. Graf noted that Petitioner was experiencing "return of her left lower extremity pain." He

prescribed lumbar spine MRI and CT scans. Following these studies, Dr. Graf recommended a functional capacity evaluation. PX G.

On August 13, 2013, Petitioner underwent the recommended evaluation at Accelerated Rehabilitation. The evaluator rated the evaluation as valid. He indicated he had a job description available. He described Petitioner's former sanitation labor job as "very heavy" in terms of the physical demand level. He found Petitioner capable of performing light to medium physical demand work with occasional two-handed lifting of 30 pounds floor to waist and frequent two-handed lifting of 20 pounds floor to waist. PX L. Dr. Graf released Petitioner to work, subject to these restrictions, on August 29, 2013. He directed Petitioner to return to him on a yearly basis thereafter for X-rays. On August 27, 2014, he noted that repeat X-rays showed a solid fusion at L5-S1. He released Petitioner from care with "permanent restrictions still in place." PX L.

Petitioner testified she attended an initial vocational rehabilitation meeting with "Natalie" of MedVoc in January 2014. The initial meeting took place at her attorney's office. Natalie recommended she look for work as a greeter, customer service representative or cashier. Thereafter, she met representatives of MedVoc at her local public library at 74th and Racine in Chicago. She could not recall whether MedVoc provided her with assistance with her resume or mock interviews. MedVoc did provide her with a keyboard. She is "not computerized" and needed help. She obtained assistance but "still had a hard time" using a computer. In October 2015, she switched vendors and began working with "Miss Kari" at Vocamotive. Early on, she noticed that Vocamotive was giving her more "one on one" attention. She attended a "job lab" where she did on-camera "mock interviews" until she "got it right." Vocamotive provided her with an "itinerary" of jobs every Monday. She could not recall receiving similar documents from MedVoc. Between October 2015 and approximately a year ago, she made regular visits to Vocamotive's office in Hinsdale. She received a Metra pass and taxi coupons which she used to travel from her home on the south side of Chicago to Hinsdale. About a year ago, she began conducting her job search online, from home. She continues to look for work five days a week.

Petitioner returned to Dr. Graf on July 10, 2015 and complained of "progressively worsening back pain." On re-examination, the doctor noted positive straight leg raising on the right. He recommended a course of physical therapy. Petitioner saw the doctor again about a year later, on June 15, 2016. The doctor noted a complaint of intermittent back pain. He also noted that Petitioner was undergoing retraining and learning computer skills. He obtained X-rays, which showed a solid fusion at L5-S1. He directed Petitioner to return to him as needed. At the next visit, on May 19, 2017, Dr. Graf described Petitioner as having some intermittent pain but "happy overall." He again directed Petitioner to return to him as needed. PX G.

In addition to various medical records, Petitioner offered into evidence an itemized bill from the Illinois Spine Institute (Dr. Graf). This bill reflects an outstanding balance of $558.09 stemming from the office visits of July 10, 2015, June 15, 2016 and May 19, 2017. PX G.

On November 22, 2017, Respondent filed a "reverse" Section 19(b) petition alleging that Petitioner was not entitled to the maintenance benefits it paid after August 29, 2013 due to a "consistent lack of effort" in the rehabilitation/job search process.

Under cross-examination, Petitioner testified she continues to see Dr. Graf on a yearly basis. She is happy with the doctor's care. She was always truthful with the doctor.

Petitioner acknowledged that her attorney recommended Vocamotive. She further acknowledged that MedVoc might have helped her prepare a resume. She cannot recall the details of all the vocational rehabilitation meetings she has attended. She would defer to the reports as to those details. After she changed vendors, she regularly traveled to Vocamotive's office in Hinsdale. The commute was "uncomfortable" but she made it because she "had to."

On redirect, Petitioner testified she graduated from high school and never attended college.

Under re-cross, Petitioner testified she graduated from high school in 1980. Vocamotive loaned her the computer she currently uses at home.

Kari Stafseth, a vocational rehabilitation counselor affiliated with Vocamotive, testified on behalf of Petitioner. Stafseth testified that individuals come to Vocamotive from various sources, including attorneys and insurance carriers.

Stafseth acknowledged she has no independent recollection of Petitioner. She relied on her reports while testifying. Those reports (PX M) reflect she first met with Petitioner on September 21, 2015. As of that date, Petitioner was 53 years old. Stafseth testified that she learned of Petitioner's back injury and surgery from the medical records she reviewed. Petitioner also informed her of her glass eye and visual impairment. Petitioner was polite and communicative. Petitioner indicated she graduated from high school and underwent no formal training thereafter. She acknowledged being able to type using a "hunt and peck" method. She denied being computer proficient.

Stafseth testified she did not perform any testing at the initial meeting. Petitioner presented with no meaningful transferable skills. Petitioner had previously worked with MedVoc. No job offers were documented. Petitioner denied having driven at any point. That was significant since it meant she would have to rely on public transportation to get to work.

Stafseth she viewed Petitioner as "prospectively employable" as of the initial meeting. At that point, she believed Petitioner could find work as a cashier, receptionist or clerk, earning somewhere in the range of $10.00 to $13.00 per hour. She recommended vocational rehabilitation while simultaneously noting that Petitioner had already been undergoing vocational rehabilitation for a year and a half. She also recommended computer training and assistance with job placement, including resume preparation, mock interviews and workshops. She directed Petitioner to start developing job leads. As of the second meeting, in November

2015, Petitioner had started training in Windows 7 but her low scores prompted her (Stafseth) to recommend against additional training. Petitioner had also attended two out of four recommended workshops. She (Stafseth) viewed Petitioner as compliant. By December 16, 2015, Petitioner had attended all four of the recommended workshops. There was a "bump in the road" at this point, since Petitioner was admitted to the hospital in mid-December, but Petitioner remained communicative and compliant. As of January 25, 2016, Petitioner was still diligently looking for work and had interviewed with Yankee Candle and Books-A-Million. Neither of these businesses offered Petitioner a job. As of February 2017, Petitioner had interviewed with two additional prospective employers, Buona Beef and Four Eyes, but had not been hired.

Stafseth testified that Petitioner continues to work with Vocamotive. Her report of December 2017 will not be her last. A subsequent report is in progress. She has recommended that Vocamotive close its file due to the duration of Petitioner's diligent job search. She is now of the opinion that no stable market exists for Petitioner's services.

Stafseth testified she has communicated with Respondent during the time she has been working with Petitioner. She believes Respondent has paid Vocamotive's bills. She has no concern with Petitioner's level of commitment.

Under cross-examination, Stafseth testified that Joseph Belmonte owns Vocamotive. She conceded that motivation is a "piece of the puzzle" in any successful job search but stated she has seen clients who did not really want to return to work obtain job offers by dint of participating in the rehabilitation process. At the initial Vocamotive meeting, Petitioner reported owning a computer. Petitioner did not pass Windows 7 or Internet Basics during keyboarding training. This is why additional training was not recommended.

Stafseth testified she viewed Petitioner as "prospectively employable" at the initial meeting. She obtained the records from MedVoc at the time of that meeting.

Stafseth testified that, if a person is applying for work at a restaurant or bar, it is not unreasonable for him/her to complete an application while sitting at the bar. However, she would not recommend that the person order a drink.

Stafseth acknowledged that Petitioner expressed a desire to retire. When a client expresses such a desire, you have to consider the length of the job search and the client's level of frustration. She does not know whether someone's desire to retire means he does not want to work.

On redirect, Stafseth testified she has worked at Vocamotive since July 1, 2008. Over the years, she has worked with clients who were not motivated. In those cases, she communicated with all of the involved parties to recommend that services be terminated. During the two years she worked with Petitioner, Petitioner was "fully compliant." She never felt as if there was a basis for recommending that Vocamotive stop working with Petitioner.

She cannot recall the date(s) on which Petitioner expressed a desire to retire. She does not believe that this desire affected Petitioner's job search.

Under re-cross, Stafseth testified she cannot recall how many times Petitioner mentioned wanting to retire. If Petitioner was completing applications and not describing her availability as "open," this is not what she would have recommended. If Petitioner received E-mails concerning job openings, she would have been directed to follow up. However, Petitioner had computer-related problems throughout the job search process. Specifically, Petitioner had difficulty using E-mails. This difficulty was self-reported. Petitioner came to Vocamotive's Hinsdale office twice weekly. She (Stafseth) typically communicated with Petitioner in person. Sometimes they communicated via telephone. Her only in-person interactions with Petitioner took place at the office. She last met with Petitioner in approximately April 2017. Vocamotive has communicated with Petitioner since then to provide job leads. She believes Petitioner still has a computer that Vocamotive let her borrow. Petitioner received the job leads via E-mail.

On further redirect, Stafseth testified that Petitioner's computer proficiency increased over the two years she worked with her. Petitioner had difficulty with E-mails but this did not affect her overall compliance.

Under additional re-cross, Stafseth testified that, over time, Petitioner's typing speed score increased from the lower 20s, in terms of words per minute, to the low 30s. Anyone who uses a computer for two years should become more proficient. The fact that Petitioner's typing speed increased did not enhance her marketability.

Petitioner offered into evidence reports that Stafseth authored or co-authored between October 2015 and December 2017. PX M. In her initial report of October 2, 2015, Stafseth noted that Petitioner lost her left eye in an accident that took place when she was five and had never driven or held a driver's license. She opined, based on Petitioner's limited educational and work history, that Petitioner lacked transferable skills. She viewed Petitioner as "prospectively employable" and most likely to find work as a customer service representative, cashier, receptionist or clerk. Based on the duration of Petitioner's previous involvement with MedVoc, she described Petitioner as having "an exposure for total disability." On November 10, 2015, Stafseth noted that Petitioner failed to attend a job search workshop due to a conflicting appointment with her primary care physician. In a report dated December 16, 2015, Stafseth described Petitioner's reading, math and spelling test scores as "lower than anticipated." On February 18, 2016, Stafseth noted that Petitioner expressed concern about interviewing for a job that paid only minimum wage. She also noted that one interviewer (from Yankee Candle) described Petitioner as a "wonderful person" but lacking retail experience. She also described Petitioner as missing a scheduled appointment due to having to go to City Hall to complete paperwork. In a subsequent report, she noted that Petitioner repeatedly "input her E-mail address incorrectly," despite receiving an error message. In a report dated April 25, 2016, Stafseth noted that Petitioner described completing an application at Edible Arrangements in a room that was so crowded that applicants were using the walls, floor and windows to complete paperwork. In the same report, Stafseth noted that Petitioner called in to

say she had to put her job search efforts on hold for a few days due to her husband being in the hospital for treatment of a stroke. She went on to note that Petitioner resumed looking for work a few days later because she "did not want to get too behind on her job search." She indicated that Petitioner reported making 53 contacts during the week of April 8 through 14, 2016 and 60 contacts, including two "field visits," the following week. In a report issued in May 2016, she described Petitioner as meeting another Vocamotive employee at Water Tower Place and dropping in to multiple businesses to inquire about employment. An interview in Palatine was cancelled in June 2016 after Stafseth determined it would take Petitioner five hours, round-trip, to travel to Palatine via public transportation. Petitioner began an internship at 3-Switch, a business in Chicago, in July 2016 but "had trouble following verbal directions" at the beginning. On August 4, 2016, the owner of the business reported to a Vocamotive employee that Petitioner "remained enthusiastic and positive" but had a "large learning curve." He asked that Petitioner decrease her days per week from two to one. In August 2016, Petitioner interviewed with a staffing agency. This agency offered Petitioner a temporary, two-week data entry job but, based on the difficulties Petitioner had encountered during her internship, Stafseth advised Petitioner to decline the offer. In October 2016, Stafseth noted that Petitioner had been ill but had continued to look for work. The following month, Stafseth noted that Petitioner had failed to open some job-related E-mails and continued to require "a great deal of one-on-one assistance." Stafseth also noted, however, that Petitioner had completed a large number of applications, had made field visits and was scheduled to interview with Macy's. In December 2016, Stafseth noted that a Vocamotive employee had seen Petitioner crying in the hallway and stating she felt as if no employer wanted to hire her. Stafseth also noted that Macy's declined to hire Petitioner following her interview. In January 2017, Stafseth noted that Petitioner reported 83 contacts, including 14 field visits, for the period December 21, 2016 through January 4, 2017. She also noted that, in late January, Petitioner met Ms. Beck of Vocamative at the Chicago Ridge Mall and visited multiple businesses within the mall. Stafseth indicated that, according to Ms. Beck, Petitioner "interacted with employers in an appropriate manner" and "presented herself as a friendly and confident job seeker." She described Petitioner as interviewing at Buona Beef and Four Eyes and not being hired by the latter. In March 2017, Stafseth noted that Petitioner also interviewed with La-Z-Boy but was not hired. After noting Petitioner's original reading, spelling and math test scores, along with the duration of the job search, she found it "unlikely" that Petitioner would find work and recommended that the file be closed. In May 2017, Stafseth again recommended file closure, citing Petitioner's "diligent" but unsuccessful job search. She continued to document Petitioner's efforts, noting that Petitioner reported 89 contacts, including 18 field visits, for the week of May 15 through 29, 2017. Petitioner became a "remote" client at this point but continued to report field visits. In July 2017, Stafseth again noted multiple contacts, including field calls. She indicated that Petitioner "reported she is ready to retire." In a subsequent report, Stafseth indicated she counseled Petitioner about failing to include cover letters with her applications. In August 2017, Stafseth again recommended that the file be closed, noting that Petitioner had not been following up on leads and was having difficulty using her computer. In her last report, dated December 1, 2017, Stafseth noted that Petitioner reported 90 contacts, including 5 field visits, for the week of October 16 through October 20, 2017, 111 contacts, including 9 field

calls, for the week of November 6 through November 10, 2017 and 105 contacts, including 13 field visits, for the week of November 27 through December 1, 2017.

Kathleen Doehla, a certified vocational rehabilitation counselor, testified on behalf of Respondent. Doehla testified she has worked for MedVoc for five years. She worked with Petitioner in 2013 and has an independent recollection of her. Initially, she acted as a job placement specialist, meeting with Petitioner twice weekly. During this period, another individual, Natalie Maurin, acted as Petitioner's case manager. In late 2014, Maurin left MedVoc and she (Doehla) became Petitioner's case manager.

Doehla testified she initially met with Petitioner in early 2013. They met at a public library in the Englewood area. Moran had met with Petitioner earlier. Doehla testified that, at the initial meeting, Petitioner reported owning a laptop computer. As of that meeting, Doehla was of the opinion that Petitioner could find work as a retail clerk or cashier, earning between $10.18 and $14.25 per hour. Following the initial meeting, MedVoc helped Petitioner prepare a resume and provided her with 3 to 10 job leads per week.

Doehla testified she sent Petitioner a letter on June 13, 2014 to remind her she was required to make 10 job contacts per week and provide MedVoc with confirmation of those contacts. At that point, Doehla viewed Petitioner as failing to cooperate with the job search process in terms of making and recording contacts. In addition to sending the letter, she met with Petitioner and spoke with her via telephone.

Doehla testified to an incident of September 30, 2014 [September 29, 2014, according to the reports in RX 1] that prompted her to view Petitioner as non-compliant with the job search process. Petitioner was scheduled to apply for a job at a Hard Rock Café on that date. The job involved working in the gift shop. Doehla testified that, unbeknownst to her, Petitioner arrived at the restaurant earlier than they had agreed and completed an application. By the time Doehla arrived, Petitioner was sitting at the restaurant's bar, drinking a beverage which Doehla believed to be alcoholic.

Doehla testified that MedVoc offered Petitioner training in keyboarding and Microsoft Office. Petitioner was allowed to take a computer home. As of November 3, 2014, the goal was to get Petitioner to a typing rate of 35 words per minute. Petitioner met this goal and completed three programs. If Petitioner, during an internship, reported having no proficiency in Excel, that would be inconsistent with her (Doehla's) notes. If Petitioner also reported difficulty with E-mail transmissions, that would also be inconsistent.

Doehla testified that, eventually, MedVoc's services were terminated. She last saw Petitioner in August 2015, at which point she continued to believe Petitioner was employable. In her opinion, the lack of a job offer at that time was due to lack of effort on Petitioner's part.

Doehla testified to having conversations with Petitioner during which Petitioner indicated she was "ready to retire."

Under cross-examination, Doehla testified she has worked with at least 100 individuals during her five years at MedVoc. There have been occasions during that period when she has recommended that MedVoc stop providing services due to non-compliance. There are various degrees of non-compliance. It is "situational" in nature. If the non-compliance was so severe as to include an individual failing to appear for a scheduled meeting, she would recommend that services be terminated. Clients have asked MedVoc to terminate services. As of September 2015, Petitioner was still actively working with her. She was still sending reports out and Respondent was paying for MedVoc's services. She never recommended that services be terminated. After June 13, 2014, MedVoc continued to bill Respondent and receive payments. In her report of December 8, 2014, she noted that Petitioner was typing at the rate of 26 words per minute.

Doehla conceded it was possible she arrived late to the meeting at the Hard Rock Café. When she arrived at the restaurant, she observed Petitioner and Petitioner's husband at the bar. Both Petitioner and her husband were drinking. They told her they were "making a day of it." By the time she arrived, Petitioner had completed the job application.

Respondent offered into evidence a collection of records from MedVoc Rehabilitation. RX 1. These records reflect Natalie Maurin, CRC, contacted Petitioner's counsel via letter on December 31, 2013, having previously left three phone messages for him, and asked him to contact her for the purpose of scheduling a vocational assessment. A subsequent letter reflects the assessment took place on January 17, 2014, at Petitioner's counsel's office. In her initial report of January 20, 2014, Maurin described Petitioner as "very pleasant and cooperative throughout the initial vocational evaluation." She indicated Petitioner was born on July 1, 1962 and reported graduating from Calumet High School in 1980. She further indicated that Petitioner "denied any college, vocational training and military experience." She stated that Petitioner reported working as a housekeeper at Cook County Hospital for eight or nine years prior to being hired by Respondent. She described Petitioner as having a prosthetic eye. She indicated Petitioner denied ever having a driver's license. She indicated Petitioner reported owning a laptop and being able to navigate the Internet and check E-mails. After summarizing Petitioner's medical records, she noted that Petitioner reported having some difficulty climbing stairs, getting out of the bathtub and doing grocery shopping on her own. She indicated that Petitioner reported starting a job search for Respondent in September 2013, having submitted 50 to 60 applications to date and receiving "only one phone call back." She noted that Petitioner expressed some interest in computer classes but reported "practicing on her own" and "feel[ing] quite comfortable on a computer." She viewed Petitioner as a candidate for positions such as cashier, greeter, customer service representative and receptionist. She indicated that "while active in job placement," Petitioner would be required to follow up on leads provided by MedVoc and contact a minimum of ten prospective employers per week, with five of those to be "in person." A labor market survey report dated February 25, 2014 reflects that, of the 24 prospective employers MedVoc contacted, 8 declined to participate and 7 indicated they were not hiring. The average wage range was $9.18 to $11.18 per hour. Kathleen Doehla described accompanying Petitioner to a food mart, a shoe store and a Subway

restaurant on April 9, 2014, to watch while Petitioner completed applications. None of these businesses was hiring. Doehla described Petitioner as filling out the applications properly. Doehla and Petitioner visited other prospective employers on May 19, 2014, with Doehla making the same comments. MedVoc supplied Petitioner with a computer and a home study program in June 2014. On June 13, 2014, Doehla sent Petitioner a "reminder letter" indicating she needed to provide online confirmations of her job contacts. In her report of August 20, 2014, Doehla described Petitioner as having only "minor" issues with her job search. Doehla sent Petitioner a "reminder" letter on October 7, 2014, advising her to wait until a MedVoc representative was present to complete any application and informing her that her consumption of an alcoholic beverage "while completing an application" at Hard Rock Café on September 29, 2014 was inappropriate. In a report dated November 3, 2014, Doehla described Petitioner as "thriving through MedVoc's" computer program. In a December 8, 2014 report, Doehla again noted Petitioner's progress with computer training but indicated Petitioner had failed to contact five prospective employers in person during that reporting period. In a report dated January 15, 2015, Doehla described Petitioner as "doing extremely well" in the computer training program. In a subsequent report, Doehla described Petitioner as reacting negatively to the idea of working in a factory located in Orland Park, based partly on the distance. In a March 2015 report, Doehla noted that Petitioner reported having been hospitalized and being unable to complete some applications as a result. In a May 2015 report, Doehla noted that Petitioner expressed a desire to expand her search to include home health care providers. Doehla also noted that Petitioner responded favorably to her own suggestion that Petitioner look for jobs in schools. She subsequently noted that Petitioner underwent some TB testing in the course of applying for a school cafeteria job. In her report of August 19, 2015, Doehla noted that Petitioner had not been hired by a home health care provider due to lack of reliable transportation and experience with Alzheimer's patients. She commented that Petitioner would have better success if she "put forth a more valid effort." On August 24, 2015, Doehla sent Petitioner another "reminder" letter directing her to increase her "in person" contacts and avoid applying for management positions for which she was not qualified.

Arbitrator's Credibility Assessment

Dr. Graf, the spine surgeon who treated Petitioner over an extended period, was originally Respondent's Section 12 examiner. None of the doctor's reports document symptom magnification or positive Waddell's signs. PX G.

Petitioner had some difficulty recalling the details of her interactions with employees of MedVoc and Vocamotive. This is not surprising, given the lengthy duration of vocational rehabilitation efforts. Petitioner did, however, take issue with some aspects of Doehla's account of the events that took place at the Hard Rock Café on September 29, 2014. She maintained she contacted Doehla via telephone after arriving at the café and proceeded to complete a job application at Doehla's direction, since Doehla was running late. Doehla, in contrast, contended that Petitioner disregarded her instructions to wait for her before completing an application. Doehla also testified that, when she arrived at the café, she encountered Petitioner and her husband sitting at the café's bar, drinking beverages she

believed to be alcoholic. Under cross-examination, Doehla conceded it was possible she arrived late for the appointment. On rebuttal, Petitioner contended that the café's bartender offered her a non-alcoholic beverage after she completed an application in a different area.

Much was made of the Hard Rock Café incident but there is no evidence indicating the café declined to hire Petitioner because of it. While Doehla viewed Petitioner's conduct as inappropriate, as stated in her "reminder" letter of October 7, 2014 (RX 1), she at no time recommended that MedVoc discontinue providing services. In the reports that Doehla issued after October 7, 2014, she consistently commended Petitioner for working to improve her computer skills.

Stafseth of Vocamotive also noted some deficiencies but consistently documented a large number of weekly job contacts, including multiple contacts made during a period in April 2016 when Petitioner reported that her husband was in a rehabilitation center following a stroke. In two reports, Stafseth described Petitioner as meeting a Vocamotive employee (Ms. Beck) at Water Tower Place and Chicago Ridge Mall and visiting numerous businesses located inside the malls. She indicated that Ms. Beck described Petitioner as "extremely friendly, outgoing and motivated with" the prospective employers they encountered during their visit to Water Tower Place and interacting appropriately with prospective employers at Chicago Ridge Mall. She also noted that Petitioner willingly participated in an internship but had difficulty with the computer-related tasks she was asked to perform. It was at Stafseth's recommendation that Petitioner subsequently declined a temporary two-week data entry job obtained through a staffing agency. The overwhelming "takeaway" from Stafseth's testimony and reports is that Petitioner presented herself well but brought few skills to a competitive marketplace.

While there is evidence that Petitioner became frustrated with the job search process and did not always follow instructions to the letter, the Arbitrator finds no evidence of sabotage. See further below.

Arbitrator's Conclusions of Law

Is Petitioner entitled to reasonable and necessary medical expenses?

Petitioner claims an outstanding bill in the amount of $558.09 from the Illinois Spine Institute. PX G. As noted earlier, this bill consists of charges for Petitioner's last three visits to Dr. Graf in 2015, 2016 and 2017. The Arbitrator finds these charges to be reasonable, necessary and causally related to Petitioner's undisputed back injury. Dr. Graf was a physician of Respondent's, not Petitioner's, selection. The 2013 fusion included the placement of surgical hardware. The Arbitrator finds it reasonable for Petitioner to have returned to Dr. Graf on an annual basis for examinations and, if deemed necessary, X-rays.

The Arbitrator awards Petitioner the Illinois Spine Institute bill in the amount of $558.09 (PX G), subject to the fee schedule.

Is Petitioner entitled to maintenance from August 30, 2013 through the hearing? What is tne nature and extent of the injury?

The Arbitrator has already found that Petitioner was largely compliant with the job search process. The Vocamotive records, in particular, document very large numbers of weekly contacts, including field visits, even during holiday periods and times when Petitioner was ill or dealing with a relative's illness. There were deficiencies, to be sure, especially with E-mail transmissions, but the Vocamotive employees who watched Petitioner interact with prospective employers described her as presenting herself well. The Vocamotive records reflect that Respondent continued to use its services in this claim for months after Stafseth began recommending file closure. Petitioner continued looking for work during this period, despite her frustration and the rejection letters she received. The Arbitrator finds that Petitioner was entitled to maintenance benefits from August 30, 2013 through the hearing of January 16, 2018. Respondent is entitled to credit for the $198,244.24 in maintenance benefits it paid during this period. Arb Exh 1. The Arbitrator denies Respondent's "reverse" 19(b) petition and declines to find any overpayment of maintenance benefits.

The Arbitrator turns to the issue of permanency. Based on the date of accident, the Arbitrator has considered the factors set forth in Section 8.1b. Neither party offered an AMA Guides impairment rating, presumably because there is no dispute as to the need for the permanent restrictions imposed by Dr. Graf. The Arbitrator addresses other factors below.

The Arbitrator, having considered the testimony, documentary evidence and relevant case law, finds that Petitioner is permanently totally disabled under an "odd lot" theory. A claimant can establish that he falls into the "odd lot" category in one of two ways: 1) by showing diligent but unsuccessful attempts to find work; or 2) by showing that, because of his age, skills, training and work history, he will not be regularly employed in a well-known branch of the labor market. Westin Hotel v. Industrial Commission, 372 Ill.App.3d 527, 544 (2007). The Arbitrator relies on the following in finding that Petitioner made both of these showings:

1. Petitioner's age (55) as of the hearing;
2. The permanent lifting-related restrictions imposed by Dr. Graf following the valid functional capacity evaluation;
3. The fact that the permanent restrictions, which are not in dispute, prevented Petitioner from being able to resume her previous, high paying position as a garbage collector for Respondent;
4. The fact that Respondent did not provide Petitioner with work within her restrictions;
5. Petitioner's lack of formal education past high school;
6. Petitioner's narrow work history (eight or nine years as a hospital housekeeper followed by twelve years as a garbage collector for Respondent);
7. Petitioner's lengthy and ultimately unsuccessful job search, through Respondent's internal program and two outside vendors;

8. Petitioner's prosthetic eye and lack of a driver's license.
9. The fact that, as of the hearing, Petitioner had been out of the work force for 5 ½ years;
10. Doehla's concession that she never recommended VocMed discontinue providing services to Petitioner;
11. Stafseth's persuasive opinions, i.e., that Petitioner initially presented with no meaningful transferable skills; that Petitioner conducted a diligent but unsuccessful job search; and that, as of the hearing, no stable labor market exists for Petitioner.

With respect to the eighth enumerated factor, the Arbitrator notes that, in Illinois, "it is axiomatic that employers take their employees as they find them." Baggett v. Industrial Commission, 201 Ill.2d 187, 199 (2002).

The Arbitrator recognizes there were some problems with Petitioner's job search efforts along the way, as documented by personnel at both MedVoc and Vocamotive. Petitioner did not always comply with MedVoc's job confirmation requirements and, on one occasion, was observed to be drinking a beverage at a bar at one of the businesses to which she applied for work. Doehla testified she believed the beverage to be alcoholic. Petitioner denied this and testified the bartender offered her a beverage after she filled out an application. Doehla testified that Petitioner (who was accompanied by her husband) commented she was "making a day of it." Doehla's underlying report reveals that Petitioner's "day," prior to submitting the application, did not involve revelry. Rather, it had consisted of traveling downtown to "turn in her job search to the City of Chicago." Because Petitioner finished this task early, she went to the Hard Rock Café early. Petitioner credibly testified she informed Doehla of this, via telephone, with Doehla instructing her to go ahead and start filling out the application. Doehla did not refute this. She conceded she "possibly" arrived late to the appointment. She also conceded that Petitioner had finished completing the application by the time she arrived. Overall, Petitioner's conduct at the restaurant did not prompt Doehla to recommend that MedVoc terminate services. In fact, in the same report in which Doehla documented the Hard Rock Café' incident, she conceded that Petitioner was "doing very well" with respect to her home computer training. Doehla concluded her subsequent report of December 8, 2014 by stating that Petitioner "needed no assistance when applying online as her computer skills have improved significantly." In her report of February 17, 2015, Doehla noted that Petitioner willingly increased her participation in home keyboarding sessions to two hours per day in an effort to bump up her typing speed. In some of her later reports, Doehla noted that Petitioner cancelled or deferred certain appointments due to her husband's and her own hospitalizations but Doehla did not describe Petitioner as non-compliant. In the spring of 2015, Doehla noted that Petitioner suggested expanding her search to include jobs relating to health care. Doehla agreed with this suggestion. RX 1. Petitioner interviewed for a job as a companion aide in August 2015 but was not offered the position, with Doehla noting the prospective employer was looking for someone with more reliable transportation and experience with Alzheimer's patients. Petitioner continued looking for work during the summer of 2015, despite the fact she was participating in therapy at Dr. Graf's recommendation. A second home health care provider also declined to hire her, with Doehla again noting this entity was looking for someone

with experience with Alzheimer's patients. RX 1. As noted earlier, Petitioner's hospital work experience was in housekeeping, not patient care.

The Arbitrator also recognizes that, at various times, Petitioner expressed a desire to stop looking for work and simply retire. The Arbitrator does not find this surprising. Petitioner's job with Respondent, while unskilled, came with a high hourly wage. It cannot have been easy for her to switch gears, later in life, to look for a retail or customer service job, especially since she had never held such a job. [See Mathias Biegel v. City of Chicago, 16 IWCC 807, a case in which a unanimous Commission (Tyrrell, Brennan and Lamborn) upheld this Arbitrator's "odd lot" award in a case in which the claimant, a former ironworker, repeatedly expressed a desire to retire.] It is to Petitioner's credit that, during the time she worked with MedVoc, she suggested the parameters of her search be expanded to include jobs in the health care field.

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

Carlos Salgado,

Petitioner,

vs. NO: 16WC 17992

National Beverage Corp./Home Juice,

Respondent.

19IWCC0321

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, Section 11 and 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 13, 2017, 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.

19IWCC0321

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

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

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $30,000.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: JUN 25 2019

Maria Portela

o061819
MEP/jrc
049

Elizabeth.Coppoletti

Douglas McCarthy

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

SALGADO, CARLOS
Employee/Petitioner

Case# **16WC017992**

NATIONAL BEVERAGE CORP/HOME JUICE
Employer/Respondent

19IWCC0321

On 12/13/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.46% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

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

0532 HOLECEK & ASSOCIATES
STUART M PELLISH
161 N CLARK ST SUITE 800
CHICAGO, IL 60601

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

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

Carlos Salgado
Employee/Petitioner

v.

National Beverage Corp./Home Juice
Employer/Respondent

Case # **16** WC **17992**

Consolidated cases: ____

19IWCC0321

An *Application for Adjustment 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 Andros**, Arbitrator of the Commission, in the city of **Chicago**, on **September 25, 2017**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☒ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☐ What was the date of the accident?
E. ☐ Was timely notice of the accident given to Respondent?
F. ☒ Is Petitioner's current condition of ill-being causally related to the injury?
G. ☐ What were Petitioner's earnings?
H. ☐ What was Petitioner's age at the time of the accident?
I. ☐ What was Petitioner's marital status at the time of the accident?
J. ☒ Were the 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 19, 2016**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**36,140.00**; the average weekly wage was $**695.60**.

On the date of accident, Petitioner was **33** 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

C.
The Arbitrator finds Petitioner was not intoxicated under the strictly construed Act section 11. Thus the Arbitrator finds he has proven by a preponderance of the evidence an accident occurred on May 19, 2016 that arose out of and in the course of Petitioner's employment by Respondent.

F.
The Arbitrator finds Petitioner has proven by a preponderance of the evidence his current condition of ill-being is directly related to his work-injury on May 19, 2016 while employed by Respondent.

J.
Respondent shall pay to the Petitioner and his attorney under section 8a for medical bills of $1,133.38 owed to Illinois Orthopedic Network, $14,254.76 owed to ATI Physical Therapy, $6,725.00 owed to Edgebrook Open MRI and $457.73 owed to Nova Pharmacy. Any outstanding medical bills shall be paid per the statutory medical fee schedule.

K.
The Arbitrator awards prospective medical care which is reasonable and necessary to relieve Petitioner of his his condition of ill being under the adopted opinions and surgical prescription of Dr. Chandrasekhar Sompalli. Respondent shall authorize this in writing along with all pre and post operative reasonable and necessary test, treatment and ancillary care and therapy.

L.
The Arbitrator finds Petitioner has proven by a preponderance of the evidence that he is entitled to temporary total disability benefits from May 24, 2016 through June 30, 2016. This represents 5 and 2/7th weeks of disability at a rate of $463.73 totaling $2,451.28. In addition, Petitioner is entitled to temporary partial disability benefits from July 1, 2016 through August 21, 2017. This represents 59 and 2/7th weeks of temporary partial disability benefits at a rate of $82.93 totaling $4,916.59. The Arbitrator orders this TTD to be paid to the Petitioner and his 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.

#001 Arb George Andros
Signature of Arbitrator

December 12, 2017
Date

ICArbDec19(b)

DEC 13 2017

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

ARBITRATOR'S FINDINGS OF FACT 16 WC 17992

Petitioner, Carlos Salgado, was a 33-year-old married man with two children under the age of 18, and employed by National Beverage Corp./Home Juice on May 19, 2016. Petitioner testified he was employed by Respondent as an order picker and forklift driver and had been working in that capacity for Respondent for about three years prior to his work-injury. His job duties included moving orders of beverage products throughout the warehouse. This work required a lot of heavy lifting from the floor to overhead.

Petitioner testified that on May 19, 2016 he reported to work around 2:30 PM. He was doing his usual job duties when he felt a pop and extreme pain in his right shoulder while pulling a heavy case of juice from over shoulder level. The injury took place around 4:30 PM. He indicated that the juice weighed about 50 lbs. and he was pulling it off a shelf, but it got caught and he noticed the right shoulder pop while trying to pull it loose. Petitioner is right-handed.

Petitioner reported the injury to his supervisor, Jorge Rodriguez, following the incident. Notice is not in dispute. He was directed to seek medical attention at Occupational Health Centers of Illinois in Franklin Park and presented for medical attention on the date of the injury. Petitioner presented with right shoulder pain from the work-injury (Px 2). He was advised to take medications and return to work with no above the shoulder work (*id.*). He also underwent a drug test.

At a follow-up appointment on May 23, 2016 Petitioner was advised to attend physical therapy and return to work with limited use of the right arm (*id.*). Petitioner testified Respondent did not accommodate these restrictions (*id.*).

Petitioner also began physical therapy at Occupational Health on May 23, 2016 (*id.*). The result of the drug test came back on May 24, 2016 and it was positive for marijuana (Rx 1). Petitioner was subsequently fired by Respondent.

Petitioner treated again at Occupational Health on May 30, 2016, June 16, 2016 and June 23, 2016 (Px 2). He was advised at all three appointments to continue physical therapy and return to work with no above the shoulder work (*id.*). Petitioner testified that his treatment was then stopped due to lack of approval from Respondent's insurance company.

Once Petitioner was fired from Respondent, he sought new employment and was hired to work for Remedy Staffing on July 1, 2017. He was sent to work at Zurn Industries as a forklift driver making $14.28 per hour. He testified that this job only required forklift driving and no lifting.

Dr. Chandrasekhar Sompalli then saw Petitioner for an initial exam on November 5, 2016 (Px 1). Petitioner was still complaining of right shoulder pain from the May 19, 2016 work-injury (*id.*). It was recommended that Petitioner remain off work, have x-rays of the right shoulder and undergo a right shoulder MR arthrogram (*id.*).

On November 16, 2017 Petitioner underwent a CT of the right shoulder, an MRI arthrogram of the right shoulder and x-rays of the right shoulder at Edgebrook Radiology (Px 1). The MRI revealed a partial thickness tear of the articulating undersurface of the distal supraspinatus and sublabral recess (*id.*). (emphasis added)

He later received a right shoulder injection and was advised to attend physical therapy (Px 1). Petitioner started physical therapy at ATI Physical Therapy on December 1, 2016 (Px 3). On January 14, 2017 he was advised to continue physical therapy (Px 1).

On February 9, 2017 Petitioner was discharged from ATI Physical Therapy after 21 visits (Px 3). Dr Sompalli saw Petitioner again on February 11, 2017 and administered another right shoulder injection (Px 1).

At Respondent's request, Petitioner presented for a Section 12 examination with Dr. Mark Levin on March 23, 2017 (Px 6). Petitioner had right shoulder complaints of cracking and popping as a result of his work-injury (*id.*). Dr. Levin indicated that Petitioner was not at maximum medical improvement and was a candidate for right shoulder surgery (*id.*).

Petitioner saw Dr. Sompalli again on April 1, 2017 and was advised to resume physical therapy (Px 1). Petitioner started physical therapy at ATI again on April 17, 2017 (Px 3). Dr. Sompalli saw Petitioner for a follow-up on May 22, 2017 and was able to comment on the exam of Dr. Levin. Dr. Sompalli was in agreement that the injury was work-related and required surgical intervention (Px 1).

Dr. Sompalli saw Petitioner for a final time on July 19, 2017 (Px 1). He continued to recommend Petitioner undergo the recommended surgery, but discharged him from care as the surgery was not being approved (*id.*).

Petitioner testified that he continues to suffer from right shoulder pain and popping. He mentioned that it is very hard for him to reach above shoulder level. To treat the shoulder, his wife helps him with ice packs and heating pads. When the shoulder starts to really hurt, Petitioner takes over the counter medications. He testified that he would like to proceed with the surgery recommended by both Dr. Sompalli and Dr. Levin.

Regarding the issue (C), did an accident occur that arose out of and in the course of Petitioner's employment by Respondent, the Arbitrator finds the following:

Petitioner credibly testified that on May 19, 2016 he injured his right shoulder while trying to pull out a case of juice which was stuck on a shelf.

He testified that he felt a pop in the shoulder and reported the injury to his supervisor, Jorge Rodriguez. He was advised by Respondent to seek medical care at Occupational Health and did so on the same date of the work-injury. All of the medical records conform to the testimony of Petitioner as it relates to how he was injured.

Respondent's only evidence disputing this claim is the eScreen Specimen Result Certificate which shows Petitioner's drug test on May 19, 2016 came up positive for marijuana (Rx 1). Section 11 of the Illinois Workers' Compensation Act addresses the issue of intoxication. The focus in this case is intoxication via cannabis.

The Act notes that, "No compensation shall be payable if…(i) the employee's intoxication is the proximate cause of the employee's accidental injury or (ii) at the time of the employee incurred the accidental injury, the employee was so intoxicated that the intoxication constituted a departure from the employment…The employee may overcome the rebuttable presumption by the preponderance of the admissible evidence that the intoxication was not the sole proximate cause or proximate cause of the accidental injuries" (IWCA- 820 ILCS 305 at 79-80).

Petitioner credibly testified that he did not show up to work on May 19, 2016 under the influence of marijuana. He testified that he had smoked marijuana the weekend before the work-injury. It should be noted that the work-injury occurred on a Thursday meaning that Petitioner's testimony would mean he had at least three full days since he smoked marijuana before the work-injury on May 19, 2016.

In addition, Petitioner credibly testified that he showed up to work on May 19, 2016 and had been working for about two hours before his work-injury. None of his supervisors sent him home before the injury for being intoxicated.

Lastly and most importantly, Respondent had Petitioner examined for a Section 12 examination with Dr. Mark Levin on March 23, 2017 ; Dr. Levin did not share any opinion that would have indicated that the proximate cause of Petitioner's injury was marijuana intoxication (Px 6). Dr. Levin also did not mention that Petitioner was so intoxicated that it constituted a departure from his employment (*id.*).

Thus, The Arbitrator finds Petitioner was not intoxicated at the time of his work-injury under the strict guidelines of the Act enacted as reform legislation in 2011.

Based upon the totality of the evidence, He has proven by a preponderance of the evidence an accident occurred on May 19, 2016 that arose out of and in the course of Petitioner's employment by Respondent.

Regarding the issue (F), is Petitioner's current condition of ill-being causally related to the injury, the Arbitrator finds the following:

Petitioner credibly testified that his right shoulder was still a problem for him. The medical records of Dr. Sompalli and the Section 12 examination of Dr. Levin confirm that Petitioner still suffers from the work-injury he sustained to his right shoulder on May 19, 2016 (Px 1 & Px 6).

Based upon the totality of the evidence, The Arbitrator finds Petitioner has proven by a preponderance of the evidence that he continues to suffer from right shoulder pain and that his current condition of ill-being is directly related to his work-injury on May 19, 2016 while employed by Respondent.

Regarding issue (J), were medical services provided reasonable and necessary, the Arbitrator finds the following:

Having found Petitioner's current condition of ill-being is related to his work-injury on May 19, 2016, and based upon the totality of the evidence the Arbitrator orders the Respondent to authorize and pay for alll medical care provided to Petitioner as defined in the treating doctors admitted records .

Based upon the totality of the evidence, respondent shall pay to the Petitioner and his attorney the medical bills of $1,133.38 owed to Illinois Orthopedic Network, $14,254.76 owed to ATI Physical Therapy, $6,725.00 owed to Edgebrook Open MRI and $457.73 owed to Nova Pharmacy. Any outstanding medical bills shall be paid per the statutory medical fee schedule.

Regarding the issue (K), Is Petitioner entitled to any prospective medical care, the Arbitrator finds the following:

All of Petitioner's medical care to date has been reasonable and necessary. Petitioner credibly testified he still has problems with his right shoulder. Both Dr. Sompalli and Dr. Levin opined that Petitioner does require right shoulder surgery (Px 1 & Px 6). Since Petitioner's present condition of ill-being is causally related to his work-injury, any further medical care Dr. Sompalli prescribes in order for Petitioner to reach maximum medical improvement should be deemed reasonable.

Based upon the totality of the evidence, he Arbitrator awards prospective medical care which is reasonable and necessary to relieve Petitioner of his pain per the adopted medical opinions and records of Dr. Chandrasekhar Sompalli.

Regarding the issue (L), what temporary benefits are in dispute, the Arbitrator finds the following:

There is no dispute that Petitioner was fired before he was at maximum medical improvement. Occupational Health still had him on restrictions of limited use of the right arm as of May 23, 2016 (Px 2). Petitioner remained off work from May 24, 2016 through June 30, 2016 and he was not paid TTD for this time.

Petitioner initiated a job search and was hired by Remedy Staffing. He started work for Remedy Staffing on July 1, 2016 working as a forklift driver at Zurn Industries. He testified that his new wage was $14.28 per hour. He earned that until he was hired away from Remedy Staffing to work for Zurn Industries as a part of their company on August 21, 2017. There is no dispute that he was making $17.39 while working for Respondent. This means Petitioner should have been paid temporary partial disability benefits.

Based upon the totality of the evidence, The Arbitrator finds Petitioner has proven by a preponderance of the evidence that he is entitled to temporary total disability benefits from May 24, 2016 through June 30, 2016. This represents 5 and 2/7th weeks of disability at a rate of $463.73 totaling $2,451.28. In addition, Petitioner is entitled to temporary partial disability benefits from July 1, 2016 through August 21, 2017. This represents 59 and 2/7th weeks of temporary partial disability benefits at a rate of $82.93 totaling $4,916.59.

The unpaid TTD shall be paid to the Petitioner and his attorney.

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Timothy A. Broderick,
Petitioner,

vs. NO: 10 WC 15752

Freeway Ford/ Sterling,
Respondent.

19IWCC0322

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 and 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 15, 2017, 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: JUN 25 2019
o062019
BNF/mw
045

Barbara Flores

Deborah Simpson

Marc Parker

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

BRODERICK, TIMOTHY A Case# **10WC015752**
Employee/Petitioner

FREEWAY FORD/STERLING
Employer/Respondent

19IWCC0322

On 8/15/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.11% 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:

0863 ANCEL GLINK
DOUG SULLIVAN
140 S DEARBORN ST 6TH FL
CHICAGO, IL 60603

2461 NYHAN BAMBRICK KINZIE & LOWRY
ROBERT E HARRINGTON
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)
- [x] None of the above

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

TIMOTHY A. BRODERICK,
Employee/Petitioner

Case # **10 WC 15752**

v.

Consolidated cases:

FREEWAY FORD/STERLING,
Employer/Respondent

19IWCC0322

An *Application for Adjustment 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 T. CRONIN**, Arbitrator of the Commission, in the city of **CHICAGO**, on **January 19, 2017** and **March 21, 2017**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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. [ ] Is Petitioner entitled to any prospective medical care?
L. [x] What temporary benefits are in dispute?
[ ] TPD [ ] Maintenance [x] TTD
M. [x] Should penalties or fees be imposed upon Respondent?
N. [x] Is Respondent due any credit?
O. [ ] Other

FINDINGS **19IWCC0322**

On **March 22, 2010**, the date of the alleged accident, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

In the year preceding the injury, Petitioner earned $**73,657.48**; the average weekly wage was $**1,121.60**.

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

Respondent is entitled to a credit of $**111,915.76** for TTD, $**0** for TPD, $**0** for maintenance, and $**0** for other benefits, for a total credit of $**111,915.76**.

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

Respondent is entitled to a credit for all medical that they have paid.

ORDER

- As he finds Petitioner failed to prove by a preponderance of credible evidence that he sustained an accident on March 22, 2010 that arose out of and in the course of his employment by Respondent, the Arbitrator denies compensation. All other issues have been rendered moot.
- Respondent shall be given a credit of **$111,915.76** for TTD benefits that they have paid Petitioner.
- Respondent shall be given a credit for all medical bills that they have paid.

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

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

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

Signature of Arbitrator

8-14-17
Date

AUG 15 2017

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

ILLINOIS WORKERS' COMPENSATION COMMISSION
ATTACHMENT TO 19(b)ARBITRATION DECISION

TIMOTHY A. BRODERICK,
Employee/Petitioner

v.

Case # **10 WC 15752**

FREEWAY FORD/STERLING,
Employer/Respondent

FINDINGS OF FACT

The 54-year-old, right-hand dominant heavy truck mechanic, testified that he injured his left arm and shoulder in the course of his employment on March 22, 2010. He testified on direct examination that on that date, he lifted the turbocharger, and reached across to mount it, he felt a pinch and "then felt like a zipper open up in his left shoulder." He testified that he "felt a warm feeling and then excruciating pain and then lost all strength in his left arm." He testified that the turbocharger dropped to the floor. (March 21, 2017, Transcript, p. 43)

On cross-examination, Petitioner was shown a copy of the Application for Adjustment of Claim that he caused to be filed in this matter. The signature line on this document was dated March 20, 2010. The Arbitrator notes this would have been two days before the alleged March 22, 2010, accident. Above the signature was an attestation clause that states, in relevant part, the following: "Be sure all blanks are completed correctly and you understand the statements before you sign this." Petitioner identified his signature on the document. (Resp. Ex. 1)

Petitioner later testified on redirect examination from his attorney that it was reasonable to conclude that the Application for Adjustment of Claim had a clerical error relative to the signature date and that it should have read April 20, 2010, instead of March 20, 2010. He testified that April 20, 2010, was the day he visited his attorney for the first time and the day he signed the Attorney's Representation Agreement. (March

21, 2017, Transcript, p. 229) Petitioner was asked by his attorney if his recollection was fresher in his mind in 2010 or as he sat here at trial. He testified that he would think it would be fresher in his mind in 2010. (March 21, 2017, Transcript, p. 228) Toward the end of his testimony, Petitioner testified that he did not actually know the date of accident, but knew it occurred in the afternoon. (March 21, 2017, Tr., pp. 206-207).

Petitioner missed no time from work immediately following the alleged date of accident. He testified that he completed a full shift on March 22, 2010, (March 21, 2017, Transcript, p. 187). Petitioner's timecards that were admitted into evidence as Resp. Ex. 2 demonstrate that he worked full time from March 22, 2010 through the last date he worked for Respondent on May 28, 2010. (Resp. Ex. 2) The timecards show that he worked at least 8 hours a day every day that he was at work between March 22, 2010, and May 28, 2010. (Resp. Ex. 2)

Petitioner sought no medical treatment for 9 days following the alleged date of accident. Petitioner testified he did not go to the Emergency Room. He testified the first day he sought any medical treatment following the alleged March 22, 2010, accident was on March 31, 2010 when he presented to Hinsdale Orthopaedics. (March 21, 2017, Transcript, p. 191)

The initial treating records from Hinsdale Orthopaedics contain no history of an alleged March 22, 2010 work-related accident, or any alleged work-related accident. Petitioner testified that on March 31, 2010, he presented at Dr. Burra's office of Hinsdale Orthopedics. He testified that upon arrival at that date, he completed and signed a "history sheet" or "intake sheet" before he was seen by a physician's assistant by the name of Lindsey Gouwens (March 21, 2017, Transcript, p. 193) At trial, Petitioner identified Respondent's Exhibit No. 4 as a copy of that document which was entitled "Patient Assessment Update." (March 21, 2017, Transcript, p. 195 and Respondent's Exhibit 4) The Arbitrator notes that Resp. Ex. 4 has a main heading of "History of Present Illness." Under that main heading is a subheading "Where is your pain" located next to which Petitioner wrote "*Left shoulder & upper arm.*" Below that is a question, "Which is your dominant hand?", to which Petitioner checked "RIGHT." Below that is a subheading entitled "Approximate date of onset of present problem" next to which Petitioner wrote, "*App. 4 months ago.*" The patient assessment form has a subsection entitled, "How did the problem occur?", to which Petitioner wrote, "*not sure.*" The form has another subsection entitled, "Any previous problems to this area?", to which Petitioner checked, "Yes," and wrote: "*car accident June 9, 2007.*" Respondent's Exhibit No. 4 has a certification clause immediately above Petitioner's signature which reads in relevant part, "I have reviewed the information which I have submitted and is contained in this Patient Assessment. I certify that all information given is accurate and complete to the best of my knowledge." (Resp. Ex. 4)

Petitioner testified that he was seen by Lindsey Gouwens, a physician's assistant at Hinsdale Orthopaedics on March 31, 2010. The Arbitrator notes that Ms. Gouwens' March 31, 2010, chart notes contain a section entitled "History" which reads in relevant part, the following:

"54-year-old male diesel technician who presents with new left shoulder pain that has been getting worse over the last four months. He is not sure how he injured his shoulder. However, he does remember shoulder pain following a car accident that occurred June 9, 2007 *** He has been noticing progressive weakness and pain at night in the shoulder that has been exacerbated over the last four months." (Resp. Ex. 3, p. 97).

The Arbitrator notes that the typewritten, March 31, 2010, chart notes from Hinsdale Orthopedics, which were dictated by Lindsey Gouwens, makes no mention of any alleged March 22, 2010, accident or, for that matter, any alleged work-related accident. Furthermore, the history portion of Ms. Gouwens typewritten, March 31, 2010, office visit note is consistent with and supported by the history portion of the Patient Assessment Update form, which Petitioner completed and signed that same day.

At the time of the March 31, 2010, office visit, a preliminary diagnosis of left shoulder rotator cuff tear and subscapularis tear was given. A prescription for an MRI arthrogram of his left shoulder was issued "to confirm the diagnosis of rotator cuff tear." The March 31, 2010 chart notes state: "We did discuss in detail what the treatment for full-thickness rotator cuff tears were and the rules of not intervening surgically, if this truly was a full-thickness rotator cuff tear." (Resp. Ex. 3) No restrictions were imposed at that visit. (March 21, 2017, Transcript, p. 204)

The Arbitrator notes that the March 31, 2010 office visit note was offered into evidence by both Petitioner and Respondent as part of the subpoenaed records from Hinsdale Orthopaedics. (Petitioner's Exhibit 10 and Respondent's Exhibit 3)

Petitioner did not call Lindsey Gouwens as a witness at trial and did not take her evidence deposition.

On April 8, 2010, Petitioner underwent a left shoulder MRI arthrogram. He testified he met with Dr. Burra on April 19, 2010. (March 21, 2017, Transcript, p. 205) He testified that at that time, he was told the results of the MRI confirmed a torn rotator cuff and that he would need surgery. Dr. Burra's April 19, 2010, chart notes indicate that the doctor prescribed an arthroscopy of the left shoulder with repair of rotator cuff and subscapularis. (Resp. Ex. 3, p. 94)

The history provided by Petitioner to Dr. Burra on April 19, 2010, states:

"On March 23, 2010, he was lifting a 45-pound turbocharger and was stretching across a tire and his arm lost all his strength and dropped down with a sudden loss of strength, and subsequently as the weight started going downward, he felt significant sharp pain in the left shoulder." (Resp. Ex. 3, p. 93)

At his June 12, 2015, evidence deposition, Dr. Burra testified that the first time Petitioner was seen at Hinsdale Orthopaedics regarding his left shoulder injury was March 31, 2010. He testified Petitioner was seen by his physician's assistant, Lindsey Gouwens. On direct examination, the doctor was asked about the inconsistent documented histories. He testified that he attributed the inconsistencies between the history taken by Ms. Gouwens on March 31, 2010, and the history taken by himself on April 19, 2010, to Ms. Gouwens' inexperience. He testified that she was relatively new to his office in March of 2010. He testified that she was a lot more astute and accurate in her exams in 2015 than she was in 2010. The doctor was asked specifically about the Patient Assessment Update form referenced by Ms. Gouwens in her initial report. Dr. Burra testified that at the time of Petitioner's March 31, 2010, initial visit, new patients "would fill a piece of paper, basically a summary of what caused the injury, how did it come on, the medical history and so on and so forth." He testified that Petitioner's Patient Assessment Update form no longer existed or was nowhere to be found. (Pet. Ex. 5, pp. 10-11)

Prior to beginning cross-examination of Dr. Burra, Respondent's attorney reviewed the doctor's chart that the doctor had been referring to during the deposition. Respondent's attorney located and tabbed the March 31, 2010, Patient Assessment Update form within the doctor's chart. This was the very document that the doctor had just testified "no longer existed or was nowhere to be found." The Arbitrator notes that this document is conspicuously absent from the subpoenaed records from Hinsdale Orthopaedics. (Pet. Ex. 10 and Resp. Ex. 3) Respondent's attorney showed the Patient Assessment Update form to Dr. Burra and the doctor identified it as the part that the Petitioner had filled out. (Pet. Ex. 5, p. 49) He testified that it was dated March 31, 2010, and signed by Mr. Broderick. (Pet. Ex. 5, p. 49) The Arbitrator notes that the Patient Assessment Update form, completed and signed by Petitioner on March 31, 2017, is completely consistent with the history contained in Lindsey Gouwens' March 31, 2010, chart notes, and that Petitioner's history changed on April 19, 2010, when he visited Dr. Burra. The Arbitrator further notes that between March 31, 2010 and April 19, 2010, Petitioner was advised by Lindsey Gouwens that she thought he had a torn rotator cuff and may need surgery. (Resp. Ex. 3) Petitioner had also undergone an MRI/arthrogram of the left shoulder before the history changed.

Petitioner testified at trial that he told a co-worker, Rich Jastrzebski, on the date of the alleged accident that he did something to his shoulder. He testified he considered Mr. Jastrzebski to be his immediate supervisor. (1-19-17 T., p. 27)

Richard Jastrzebski

Mr. Jastrzebski was called to testify by Petitioner. He testified that after he received a subpoena from Petitioner's attorney, he telephoned Petitioner's attorney and was asked to come to the attorney's office. He testified that on April 14, 2015, he traveled to Petitioner's attorney's office and met with Petitioner's attorney. Following that talk, a 3-page Affidavit, typewritten by Petitioner's attorney, was presented to him for his signature. He testified that the Affidavit was created based upon his memory and his conversation with Petitioner's attorney and not on his review of any documents that he had created contemporaneously with the time of the alleged accident. He testified he did not make any written documentation between March 22, 2010 and the date he signed the Affidavit. (1-19-17 T., pp. 33-34) The Arbitrator notes that Mr. Jastrzebski's Affidavit was created and signed over 5 years after the date of the alleged accident.

Mr. Jastrzebski's affidavit indicates he was a "diesel mechanic foreman" at Respondent and was also Petitioner's immediate supervisor. He testified that Dan Burbank told him that he (Jastrzebski) was Petitioner's immediate supervisor. (T. 1-19-17, p. 27) Mr. Jastrzebski testified that he did not see the alleged March 22, 2010, accident. He was asked, "So, you weren't working with him when this allegedly happened?" He responded, "No, I wasn't working with him, no." (T. 1-19-17, p. 36) He testified that his immediate supervisor, Dan Burbank, was not at work on March 22, 2010. When asked how he knew that, he replied "because I didn't see him." He testified a couple of days later, both he and Petitioner told Mr. Burbank together about Petitioner getting hurt at work. (Pet. Ex. 1) Mr. Jastrzebski could not recall where at Freeway Ford this alleged conversation took place with Mr. Burbank. (1-19-17 T., 3-21-17 T., p. 41)

Daniel Burbank

Daniel Burbank testified credibly that in March of 2010, he was employed by Freeway Ford as a Service Manager. (T. 1-19-17, p. 74) He testified in that capacity, he oversaw the day-to-day operations of the Service Department. (T. 1-19-17, p. 75) He testified that at that time there were 23 employees under him in March of 2010 and that Petitioner was one of those employees. (T. 1-19-17, p. 222) He testified that in March of 2010, Petitioner was a Journeyman Technician, also known as a truck mechanic. (T. 1-19-17, p. 223) He testified that in March of 2010, he was Petitioner's immediate

supervisor. (T. 1-19-17, p. 223) Mr. Burbank testified that he was present for all of Mr. Jastrzebski's testimony. He took exception to Mr. Jastrzebski's testimony that he was a foreman and/or that Mr. Burbank ever told him he was a foreman. He testified Jastrzebski was a lead mechanic and that he never told him he was a foreman. (T. 1-19-17, p. 224) He also took exception to Mr. Jastrzebski's testimony that Mr. Jastrzebski was Petitioner's immediate supervisor and testified that Mr. Jastrzebski was never a member of management at Freeway Ford. (T. 1-19-17, p. 247)

Mr. Burbank also took exception to Mr. Jastrzebski's testimony that he (Burbank) was not at work on March 22, 23, or 24, 2010. He testified he was at work those days and neither Mr. Broderick nor Mr. Jastrzebski reported any work-related accident to him on any of those days. (T. 1-19-17, p. 224, 225) He testified that he was not on vacation and did not have any sick days between March 22, 2010, and the last day that Petitioner worked at Freeway Ford, May 28, 2010. (T. 1-19-17, p. 256, 257). He also testified credibly that Mr. Jastrzebski never reported any work-related Broderick injury to him.

Mr. Burbank testified that the first time he received any notice of an alleged, Broderick, work-related injury was on April 22, 2010. (T 1-19-17, p. 226) On that date, Petitioner presented a work status note from Dr. Burra that indicated Petitioner could only lift 5 pounds. This meeting with Petitioner took place in Mr. Burbank's office. He testified that during the meeting, he completed a Workers' Comp Online Claim submission form in Petitioner's presence. He identified Respondent's Exhibit 5 as a true and accurate copy of that form that was created contemporaneously at the time of notice. He testified, and the form shows, that Petitioner gave a history of a March 24, 2010, alleged accident while lifting a turbocharger. He testified that he submitted the form to Hanover Insurance the same day as the meeting with Petitioner. The top line shows that the form was submitted on April 22, 2010, at 2:59 p.m. (Resp. Ex. 5) (T. 1-19-17, pp. 225-231)

Petitioner's attorney asked Mr. Burbank whether he believes what Petitioner told him at the April 22, 2010, meeting. Mr. Burbank testified he does. On further questioning from Respondent's attorney, Mr. Burbank explained that at the time of the April 22, 2010, meeting with Petitioner, he had no reason to doubt Petitioner's allegations of the reported March 24, 2010, alleged accident. (T. 1-19-17, pp. 210, 231)

Post-April 22, 2010, Medical Treatment

On August 11, 2010, Dr. Burra performed left shoulder arthroscopy with rotator cuff repair. On September 15, 2010, Petitioner saw his chiropractor, Dr. Geipel, with complaints of neck stiffness. On September 10, 2010, Dr. Burra administered a steroid injection to the left shoulder. On November 26, 2010, Petitioner underwent an MRI of the cervical spine which showed findings consistent with mild spondylolisthesis and stenosis. On March 21, 2011, Petitioner underwent left shoulder MRI. On March 14, 2011, Dr. Burra reviewed the left shoulder MRI and found no evidence of any loose bodies. He found evidence of a potential re-tear and found that Petitioner will need a revision arthroscopy repair of the rotator cuff.

On March 28, 2011, Petitioner was seen at Respondent's request by Kern Singh, M.D., for a Section 12 examination relative to Petitioner's cervical spine complaints. At that time, Petitioner gave Dr. Singh a history of a March 24, 2010 accident. At that time, unlike March 31, 2010 history to Hinsdale Orthopaedics, Petitioner did not reference any previous automobile accident history or progressive pain at night while sleeping history. The doctor testified at a December 31, 2014, evidence deposition that his physical examination of Petitioner at the time of the Section 12 examination was normal. (Resp. Ex. 7, p. 12) He testified that his diagnosis was cervical muscular strain. He found causal connection between that condition of ill-being and Petitioner's alleged accident *based upon the history provided by Petitioner.* (Emphasis added.) (Resp. Ex. 7, p. 15) He found that Petitioner was at MMI relative to his cervical spine and capable of returning to regular-duty work without restrictions. He testified he did not believe Petitioner suffered from peripheral neuropathy. (Resp. Ex. 7, pp. 18-19) On August 24, 2011, Dr. Burra performed left shoulder arthroscopy with debridement and removal of previous prominent sutures, revision subacromial decompression arthroplasty.

On November 8, 2011, Dr. Burra found that Petitioner had plateaued from a left shoulder perspective. On January 10, 2012, Petitioner underwent an FCE at Athletico Physical Therapy. On January 13, 2012, Dr. Burra found Petitioner could return to modified-duty work per the FCE. He found Petitioner was at MMI for the left shoulder and should return only as needed. Petitioner did not return to Dr. Burra.

Petitioner testified that he applied for a Union Disability Pension in August of 2013 and that he received it in December of 2013. He testified that he receives $1,535.00 a month from that pension. (March 21, 2017, Transcript, p. 212) Petitioner testified that he also began receiving Social Security Disability benefits in August of 2013. He testified that he has received $2,435.00 per month, before taxes, for those disability benefits. (March 21, 2017, Transcript, p. 212). Petitioner testified that he is also a Medicare recipient. (March 21, 2017, Transcript, p. 213)

Petitioner testified he is the owner of a company called Exceptional Management, LLC. The company is in the business of apartment management. He testified he has been an owner since 2004 or 2005 of that company. He testified he has received tax write-offs for that company. (March 21, 2017, Transcript, pp. 214-215)

He testified he is also a partner with his sister in a company called Alsip Management, LLC. He testified that the building was sold in 2015.

Petitioner testified that he was also a partner with his son in a company called Daley Management, LLC, up until about 2 weeks before the date of trial when the apartment building was sold. He testified the sale generated about $70,000.00 between what they owed on the mortgage and what they sold it for and that he and his son would split that money.

Petitioner testified that he conducted a self-directed job search for a period of time after TTD benefits were suspended. He testified it was all done by e-mail or fax and that he did not receive any positive responses. He testified he has not looked for work in maybe 1-1½ years. No job search records were submitted at trial.

Petitioner offered no medical bills at trial.

CONCLUSIONS OF LAW

In support of his decision relating 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 failed to establish by a preponderance of credible evidence that on March 22, 2010, he sustained an accident that arose out of and in the course of his employment with Respondent.

A claimant in a workers' compensation case has the burden of proving, by a preponderance of the evidence, all of the elements of his claim, including proof that he suffered an accident, which arose out of and in the course of his employment. 820 ILCS 305/2 (West 2008). The burden of proof consists of producing sufficient evidence to establish a prima facie case for entitlement to benefits consisting of "evidence on all the necessary elements to establish the underlying cause of action." *City of Chicago v. Illinois Workers' Compensation Commission*, 373 Ill. App.3d 1080, 1090-1091 (1st Dist. 2007).

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. *Mathiessen & Hageler Zinc Co. v. Industrial Board*, 284 Ill. 378, 120 N.E.249 (1918)

The Arbitrator finds that Petitioner lacks credibility. At one time or another, Petitioner has claimed 3 different dates for the alleged turbo-lifting accident: March 22, 2010, March 23, 2010, and March 24, 2010. Ultimately, Petitioner testified he did not know the date of the alleged accident, but knew that it happened at work in the afternoon.

The Arbitrator takes into consideration that Petitioner's alleged March 22, 2010, accident was not seen by anyone. The Arbitrator further notes that Petitioner continued to work regular duty, full shifts, at least 8 hours a day, and did not seek any medical treatment until March 31, 2010, when he presented at Hinsdale Orthopaedics.

The Arbitrator places great weight on Respondent's Exhibit 4, the Patient Assessment Update form (or intake sheet), which Petitioner completed and signed upon his arrival at his treating doctor's office on March 31, 2010. The Arbitrator finds that this exhibit is essentially the "smoking gun" in this case and has much more probative value than any other piece of evidence. As it is the first history Petitioner gave to any medical provider following the alleged work-related accident, the Arbitrator finds it to be reliable, particularly since Petitioner communicated such history in his own hand.

Respondent's Exhibit 4 indicates that Petitioner clearly complained of left shoulder and arm pain. He clearly responded to "Approximate **date** of onset of the present problem" with "*App. 4 months ago.*" In response to the next question, "How did the problem occur?", the Petitioner clearly wrote: "*not sure.*" In response to the nest question, "Any previous problems to this area?", Petitioner checked "Yes," and wrote: "*car accident June 9, 2007.*" He also wrote that he has seen Dr. Giepel, a chiropractor, for this problem.

With regard to Respondent's Exhibit 4, the Arbitrator notes that Petitioner made absolutely no reference whatsoever to any alleged March 22, 2010, work-related accident with a turbocharger. The Arbitrator notes that above Petitioner's signature and date is a certification clause that states: "I have reviewed the information which I have submitted and is contained in this Patient Assessment. I certify that all information given is accurate and complete to the best of my knowledge." (Resp. Ex. 4)

Petitioner attempted to explain the lack of a work-related history in Respondent's Exhibit 4. Petitioner testified that in completing Respondent's Exhibit 4, he was attempting to list anything that was wrong with his left arm before he injured it. However, in Resp. Ex. 4, Petitioner was asked for answers to questions as they related to the "HISTORY OF **PRESENT** ILLNESS." (Emphasis added.) He was asked for the "[a]pproximate date of the onset of the **present** problem." (Emphasis added.) Petitioner attempted to explain his date of onset answer by testifying that 4 months prior to March 31, 2010, he hurt his left shoulder at work when he was using a sledgehammer to knock out a kingpin. (Tr. 3-21-17, p. 70) However, Petitioner did not include this history in Resp. Ex. 4, but instead wrote: "*not sure.*" Moreover, Petitioner is claiming that he sustained a single, traumatic accidental injury on March 22, 2010, not November 22, 2016, and is not claiming a repetitive trauma. Petitioner testified that on March 31, 2010, he had less than 5 minutes to fill out Respondent's Exhibit 4. (Tr. 3-21-17, p. 78) However, on Resp. Ex. 4, Petitioner certified that "all information given is accurate and complete to the best of [his] knowledge.". Petitioner testified that when he phoned Dr. Burra's office on March 23, 2010 to schedule an appointment, he told the person who answered the phone that he hurt his shoulder lifting a turbocharger. However, Petitioner did not know the name of such person, and such history was not documented until April 19, 2010.

The Arbitrator finds none of Petitioner's explanations, as stated above, are persuasive.

The history portion of Respondent's Exhibit 4 is consistent with the typewritten chart notes that Physician's Assistant Lindsey Gouwens recorded on March 31, 2010. (Resp. Ex. 3)

Petitioner testified that while Ms. Gouwens was examining him, she did not ask him questions, write, or type information into a computer. (Tr. 3-21-17, p. 83) Yet, in the PLAN section, Ms. Gouwens wrote, in pertinent part, the following:

"We did discuss in detail what the treatment for full-thickness rotator cuff tears were and the risks of not intervening surgically, if this truly was a full-thickness tear." (Resp. Ex. 3)

Petitioner suggested that these chart notes contain a boiler plate element since they include the following language:

"The new patient assessment form was gone over in detail secondary to the patient's problem being new to our practice. The history of present illness, medical history, surgical and hospitalization history, allergies, family and social history, as well as obstetrical history and a review of systems were all gone over in detail and are located inside the patient's chart." (Resp. Ex. 3)

Dr. Burra testified that Ms. Gouwens was a new physician's assistant at the time she took the March 31, 2010, history and conducted an examination of Petitioner. He attributed the differences between the examination findings Ms. Gouwens recorded on March 31, 2010 and the examination findings he recorded on April 19, 2010, to Ms. Gouwens' lack of experience.

However, at the end of the March 31, 2010 chart notes, both the names of Lindsey Gouwens, P.A.-C. and Giridhar Burra, M.D. are listed. Moreover, as of June 12, 2015, the date of Dr. Durra's deposition, Lindsey Gouwens Cashman, P.A.-C., still works with Dr. Burra.

The Arbitrator notes that the April 19, 2010 history provided by Petitioner is dramatically different than the March 31, 2010 history provided by Petitioner. Rather than saying he was "*not sure*" how he injured his left shoulder and attributing it to a June 9, 2007 automobile accident as he did on March 31, 2010, the Petitioner now gave a very detailed history of an alleged March 23, 2010, work-related accident, while lifting a 45-pound turbocharger. (Resp. Ex. 3, p. 93)

The Arbitrator notes that the April 19, 2010, history was provided by Petitioner after he had undergone a positive MRI arthrogram of the left shoulder that revealed findings consistent with a left torn rotator cuff and after he had been told by Lindsey Gouwens, P.A.-C., that if the study was positive, he would likely need surgery.

The Arbitrator further notes that the March 31, 2010, history was provided by Petitioner only 9 days after the date of alleged accident and yet Petitioner had absolutely no recollection of the alleged event at that time. Petitioner testified on re-direct examination that he believed his recollection would have been fresher in his mind in 2010 than in 2017. (3-21-17 Transcript, p. 228) By this logic, the Arbitrator finds that Petitioner's recollection should have been fresher on March 31, 2010 than on April 19, 2010.

The Arbitrator notes that Petitioner's complaints of pain in the March 31, 2010, chart notes pertain to progressive weakness and pain at night in the shoulder that has been exacerbated over the last 4 months.

The Arbitrator is not impressed by Dr. Burra's testimony regarding the basis for the discrepancy in the two histories documented by his office, especially after Dr. Burra testified that the Patient Assessment Update form referred to in Ms. Gouwens' March 31, 2010, chart notes "no longer existed" or was "nowhere to be found." The record is very clear that this document not only existed but was right under the doctor's nose and contained in his chart at the evidence deposition. (Pet. Ex. 5)

The Arbitrator finds it significant that the March 31, 2010 Patient Assessment Update was conspicuously absent from Hinsdale Orthopaedics' subpoena response. Respondent's Exhibit 4 is consistent with the history stated in Lindsey Gouwens' March 31, 2017, chart notes. Petitioner did not depose Ms. Gouwens or have her testify at trial. There is no evidence in the record that she was unable to testify.

The Arbitrator finds the testimony of Daniel Burbank to be more credible than the testimony of Timothy Broderick or Rich Jastrzebski. The Arbitrator finds that the first time Mr. Burbank received notice of any alleged work accident in this matter was not until April 22, 2010, when Petitioner came to his office with a work restriction note from Dr. Burra. At that time, Petitioner alleged a March 24, 2010, accident at work. Mr. Burbank testified he did, in fact, work on March 22, March 23 and March 24, 2010, which is in direct contradiction to the testimony of Petitioner and Mr. Jabstrzebski.

The Arbitrator also places significance on the Workers' Comp Online Claim submission form that Mr. Burbank created on April 22, 2010, in the presence of Petitioner and in his office. This document was submitted to the workers' comp insurance carrier the same day. The Arbitrator finds the information on Respondent's Exhibit No. 5 to be consistent with Mr. Burbank's testimony at trial.

The Arbitrator is not impressed by the Affidavit or testimony of Mr. Jabstrzebski, who was called by Petitioner. The Arbitrator notes that the Affidavit was prepared

after he was interviewed by Petitioner's attorney in Petitioner's attorney's office 5 years after the alleged accident. Mr. Jabstrzebski's statements were not based upon a review of any written documentation or notes that he had created contemporaneous with the alleged events referred to in the Affidavit. Such statements were based upon only his memory and his interview by Petitioner's attorney more than 5 years after the alleged accident.

Richard Jastrzebski testified to the following:

Q: Does your affidavit say: Towards the end of the day when you were doing own work (sic), Tim came and told me he was trying to lift a turbocharger and hurt his arm. Is that what it says?

A: I witnessed - - when Tim got hurt, he was over there working on the turbo. All right? And he called me over there - - by the time I got there, he was - - the turbo, whatever it did; and he went to grab or whatever he did, and I guess he got hurt. (January 19, 2017 Transcript, p. 35)

After some prompting by Respondent's attorney, and instructions to look at the affidavit, Mr. Jastrzebski revised his testimony by stating that Broderick actually came over to him and told him that he was hurt.

On redirect examination, Mr. Jastrzebski testified to the following:

Q: Okay. Then Mr. Harrington asked you if you witnessed the accident, meaning did you see Tim when he lifted the turbocharger and his arm went numb. You didn't literally see the actual incident?

A: I didn't see the incident, but I - - when I was - -

Q: Immediately after, he came to you?

A: After that, yes.

Q: Okay. Did he walk to you or call you over?

A: No, he called me over because he was there. He had trouble - - I helped him to lift the turbo, because the turbo is - - you know, it's got a little bit of weight. (January 19, 2017 Transcript, p. 45)

Tim Broderick testified to the following:

Q: Okay. Tim, did you - - let's - - I don't know how far back I need to go. You went and told Mr. - - let's talk about after the accident when you went and got Mr. Jastrzebski and asked him to come over and help you, you remember that part?

A: Yes. (March 21, 2017 Transcript, p. 46)

So, Petitioner testified that immediately after the alleged accident, he went over and got Rich Jastrzebski and asked him to help him. Rich Jastrzebski testified that immediately after Petitioner's alleged accident, Petitioner called him over to his bay to help him lift the turbocharger.

Moreover, Rich Jastrzebski could not recall where, at Freeway Ford, the alleged, accident-reporting conversation with Mr. Burbank took place. (1-19-17 T., 3-21-17 T., p. 41)

The Arbitrator concludes that if, on March 22, 2010, Petitioner lifted a turbocharger, reached across to mount it, felt a pinch, felt a zipper open up in his left shoulder, felt a warm feeling then excruciating pain and loss of all strength in his left arm, he would have remembered it 9 days later, he would have written it down on the Patient Assessment Update, and he would have informed Lindsey Gouwens, P.A.-C., of such injury.

The Arbitrator draws the reasonable inference that Petitioner changed his history of injury to his treating doctor after being advised that he had a probable left rotator cuff tear.

Based on the foregoing, the Arbitrator denies accident. All other issues have been rendered moot. Respondent is entitled to a credit for TTD paid in the amount of $111,915.76, as well as a credit for all medical that they have paid.

8-14-17

Brian T. Cronin
Arbitrator

Date

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Stephen Suerth,
Petitioner,

vs. NO: 16 WC 03135

City of Chicago - Department of Water,
Respondent.

19IWCC0323

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed July 5, 2018, is hereby affirmed and adopted.

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

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

DATED: JUN 25 2019
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BNF/mw
045

Barbara Flores

Deborah Simpson

Marc Parker

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

SUERTH, STEPHEN
Employee/Petitioner

Case# **16WC003135**

16WC003136

CITY OF CHICAGO
Employer/Respondent

19IWCC0323

On 7/5/2018, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 2.08% 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:

4564 ARGIONIS & ASSOCIATES LLC
AL KORITSARIS
180 N LASALLE ST SUITE 1925
CHICAGO, IL 60601

0113 CITY OF CHICAGO
STEPHANIE LIPMAN
30 N LASALLE ST SUITE 800
CHICAGO, IL 60602

STATE OF ILLINOIS)
)SS.
COUNTY OF Cook)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
NATURE AND EXTENT ONLY

Stephen Suerth
Employee/Petitioner

v.

City of Chicago
Employer/Respondent

Case # **16** WC **3135**

Consolidated cases: **16 WC 3136**

19IWCC0323

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 Mason**, Arbitrator of the Commission, in the city of **Chicago**, on **June 20, 2018**. By stipulation, the parties agree:

On the date of accident, **7/6/15**, 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 $**97,868.00**, and the average weekly wage was $**1,884.00**.

At the time of injury, Petitioner was **55** [the Request for Hearing form incorrectly states 58] years of age, ***married*** with **1** dependent child.

Necessary medical services and temporary compensation benefits have been provided by Respondent.

The parties agree Petitioner was temporarily totally disabled from October 15, 2016 through April 16, 2017. They further agree Respondent is entitled to credit for temporary total disability payments totaling $33,016.43.

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

For the reasons set forth in the attached decision, the Arbitrator finds that Petitioner established permanency equivalent to 37.5% loss of use of the person as a whole for both his right shoulder and cervical spine injuries. Respondent shall pay Petitioner the sum of **$755.22**/week for a further period of **187.5** weeks, as provided in Section 8(d)2 of the Act.

Respondent shall pay Petitioner compensation that has accrued from **4/15/17** through **6/20/18**, 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.

Molly C Mason

Signature of Arbitrator

Date **7/5/18**

JUL 5 - 2018

Stephen Suerth v. City of Chicago – Department of Water Management
16 WC 3135-6 (consolidated)

Summary of Disputed Issues in Both Cases

The parties agree Petitioner, a hoisting engineer who is now retired, sustained work accidents on July 6, 2015 [16 WC 3135] and December 21, 2015 [16 WC 3136]. Petitioner injured his right shoulder and neck in the first accident and ultimately underwent a cervical spine fusion at C5-C6 on October 11, 2016. He did not require right shoulder surgery. He injured his left shoulder in the second accident and underwent a left rotator cuff repair on March 10, 2016. After being released to full duty, in April 2017, he worked for about 3 ½ months before retiring in late July 2017. He testified he decided to retire because his pain and limited neck mobility made it difficult for him to operate heavy machinery. As of the hearing, he was working part-time at a baseball field maintenance job in Myrtle Beach.

The only issue in dispute in each case is nature and extent. In the second case, the parties stipulated to a temporary total disability overpayment in the amount of $2,512.12. Arb Exh 1-2.

Arbitrator's Findings of Fact

Petitioner testified he began working as a hoisting engineer for Respondent's Department of Water Management in September 1989. He continued to work in this capacity thereafter. His duties included assessing the operating status of various pieces of equipment, fueling and oiling machines and operating various machines, including vacuum trucks, backhoes and "orange peels" at jobsites. He operated these machines manually.

Petitioner testified that, as of the July 6, 2015 accident, he performed full duty and was not subject to any restrictions. In 2005, he fell at work, injuring his right shoulder. He underwent a right rotator cuff repair thereafter. He testified he filed a claim [05 WC 7116] for this injury.

Petitioner testified he performed a double shift on July 6, 2015. He was about 12 to 15 hours into his workday and was operating a backhoe when the injury occurred. The doors to the cab opened outward. He reached over with his right arm to close the door to his right. The latch on this door was old and worn. From prior experience, he knew he would have to use force to get the door to close. He gave a "good tug" on the door and felt pain in his right shoulder.

Petitioner testified he underwent treatment at MercyWorks, a medical facility used by Respondent, following the July 6, 2015 accident. No records concerning this treatment are in evidence.

Petitioner testified he saw Dr. Nora, his personal care physician, after undergoing a right shoulder MRI at the direction of MercyWorks. Petitioner underwent this MRI on July 24, 2015. The radiologist interpreting the MRI noted operative changes related to an acromioplasty, evidence of the prior supraspinatus tendon repair, no recurrent tear, mild thinning of the supraspinatus tendon, "consistent with attritional wear," mild infraspinatus tendinosis with articular surface fraying and a "low to moderate grade partial-thickness articular sided tear of the subscapularis." The radiologist described the biceps as intact. He did not identify any labral tear or paralabral cyst. PX 1.

On August 8, 2015, Petitioner saw Dr. Nora's certified nurse practitioner, Allison Kinder. Kinder noted a complaint of right shoulder pain "with radiating tingling down the arm" and right thumb

numbness. She indicated that Petitioner reported feeling a "pop" in his right shoulder when he closed a door while "working one day in July in a machine." She also indicated that Petitioner reported going to an immediate care clinic following this incident and being started on a Medrol Dosepak "with no relief in pain."

On right arm examination, Kinder noted decreased sensation, tenderness to palpation in the anterior shoulder, pain and mild weakness with external rotation against resistance and pain with GERBER testing. After reviewing the MRI, she assessed Petitioner as having shoulder pain with neuropathy, "likely [secondary] to a small, low to moderate grade partial-thickness articular-sided tear of the subscapularis." She prescribed Meloxicam and ice applications. She referred Petitioner to Dr. Rubinstein, an orthopedic surgeon affiliated with Illinois Bone & Joint Institute, for further management. PX 1.

Petitioner saw Dr. Rubinstein on August 24, 2015. The doctor wrote to Dr. Nora the same day, acknowledging the referral. He referenced both the 2005 right rotator cuff repair and the July 6, 2015 work accident. He noted that, while some of Petitioner's right shoulder pain had "settled down" since the accident, Petitioner was still complaining of anterior shoulder discomfort, significant numbness in his right thumb and cold sensitivity. He also noted that Petitioner reported deriving some relief from the previously prescribed Medrol Dosepak and Meloxicam.

On examination, Dr. Rubinstein noted a good range of neck motion, a full range of shoulder motion, a slightly positive impingement sign, a little bit of pain with abduction and external rotation, some decreased sensation along the thumb and cold sensitivity in the forearm.

Dr. Rubinstein viewed Petitioner's symptoms as more consistent with subtle cervical radiculopathy than anything else. He indicated that, while the recent right shoulder MRI might show a small tear, he was uncertain whether this was a true entity due to "multiple screw artifacts" from the prior rotator cuff repair. He prescribed a cervical spine MRI and an EMG. PX 1.

The cervical spine MRI, performed without contrast on September 16, 2015, showed a mild posterior disc osteophyte complex at C5-C6 with a "constellation of findings resulting in moderate central canal and moderate bilateral foraminal stenosis" along with a "minimal left paracentral posterior disc osteophyte complex at C3-C4 without central canal stenosis. PX 3, 4.

Petitioner returned to Dr. Rubinstein on October 19, 2015. The doctor interpreted the cervical spine MRI images as showing a herniation at C5-C6 causing compression on the spinal cord. He "suspect[ed] that the disc herniation is acute and happened at the time of [Petitioner's] injury on July 6." He noted that Petitioner was still complaining of thumb numbness. He referred Petitioner to Dr. Chang, a pain management specialist, for purposes of a cervical epidural steroid injection. He indicated Petitioner might require a surgical evaluation if the injection was not effective. PX 1, 3.

Dr. Chang administered cervical epidural steroid injections at C6-C7 on November 12, 2015 and December 17, 2015. PX 3.

Petitioner testified he continued working throughout this period. On December 21, 2015, he was attempting to pump water out of a flooded area. He stepped over a curb that was below the surface of the water. The surface was icy or muddy. He fell, initially landing on his left elbow. He heard a "pop" in his left shoulder.

Records in PX 2 reflect Petitioner initially underwent treatment at Physicians Immediate Care the same day, December 21, 2015. Petitioner testified that Respondent directed him to this facility. The examining provider recorded a consistent history of the work fall occurring four hours earlier. He noted that Petitioner described adducting his left arm against him when he fell, hearing a pop and experiencing "instant pain in the shoulder." He further noted that Petitioner denied any prior left shoulder injuries. On left shoulder examination, he noted positive "drop arm" testing, a reduced range of flexion and abduction and tenderness to palpation. He obtained left shoulder X-rays, which showed no fractures or dislocations. He diagnosed a left shoulder sprain, prescribed pain medication and ice applications and imposed various lifting-related restrictions. PX 2.

Petitioner returned to Physicians Immediate Care on December 26, 2015 and saw a physician's assistant. She noted that Petitioner was performing light duty and home exercises but remained symptomatic. She dispensed Nabumetone and continued the work restrictions. PX 2.

Petitioner returned to Physicians Immediate Care on January 6, 2016 and saw Dr. Magana, who noted no left shoulder improvement. She prescribed a left shoulder MRI and continued the work restrictions. PX 2.

Petitioner returned to Dr. Chang on January 7, 2016. The doctor noted the recent work fall and left shoulder treatment. He indicated that the first two cervical injections provided only temporary relief of Petitioner's right hand numbness. He prescribed a third injection, increased Petitioner's Lyrica dosage and continued the Diclofenac. PX 3. It is not clear whether Petitioner underwent the third injection. He testified that, overall, the injections Dr. Chang administered did not relieve his symptoms.

On January 20, 2016, Petitioner returned to Physicians Immediate Care and saw a nurse practitioner, who noted that the left shoulder MRI had not yet been approved. She prescribed physical therapy and continued the work restrictions. PX 2.

The left shoulder MRI, performed without contrast on February 11, 2016, showed full-thickness, full-width tears of the supraspinatus and infraspinatus tendons with tendon retraction, superior migration of the humeral head secondary to these tears, a moderate joint effusion and degeneration and fraying of the superoposterior glenoid labrum. The interpreting radiologist did not identify any detached labral tear. PX 3.

Following the MRI, Physicians Immediate Care referred Petitioner to Dr. Rubinstein.

Dr. Rubinstein operated on Petitioner's left shoulder on March 10, 2016. In his operative report, he documented a "full detachment of the rotator cuff of both the supraspinatus and anterior portion of the infraspinatus." He described the biceps tendon and glenohumeral joint surfaces as normal. PX 3.

At the first post-operative visit, on March 23, 2016, Dr. Rubinstein removed the sutures. He described his surgical findings as follows:

> "[A]t the time of surgery [he] was noted to have a very significant, complete rotator cuff tear, some of which was significantly scarred down. {W]hile I was able to perform a reasonable repair of some of the muscles, we were unable to get it completely down and he may

continue to have some difficulty with his rotator cuff depending on how it scars down."

Dr. Rubinstein recommended that Petitioner continue immobilization and begin some passive range of motion exercises. He directed Petitioner to remain off work. PX 3.

Petitioner returned to Dr. Chang on March 31, 2016, with the doctor noting complaints of posterior neck pain radiating to the right arm and right hand numbness. The doctor directed Petitioner to continue taking Lyrica and Diclofenac for these symptoms as well as his left shoulder pain. He also recommended that Petitioner see Dr. Fisher for a surgical consultation. PX 4.

On April 18, 2016, Dr. Rubinstein noted left shoulder stiffness. He directed Petitioner to wean out of the sling and start formal therapy. He continued to keep Petitioner off work. PX 3.

Petitioner began a course of physical therapy at Athletico on April 20, 2016. The evaluating therapist, David French, PT, DPT, noted a history of the December 21, 2015 fall and March 10, 2016 left shoulder surgery. He noted that Petitioner had recently discontinued the sling and was "very limited with reaching upwards, lifting anything, pulling up his underwear, cooking and using the left arm for driving." PX 5.

On June 6, 2016, Dr. Rubinstein noted that Petitioner was progressing in therapy but would probably require an additional eight to ten weeks, based on the therapist's recommendations and "the severity of [the] rotator cuff tear." The doctor directed Petitioner to continue therapy and remain off work. PX 3.

On June 24, 2016, Dr. Rubinstein noted additional left shoulder progress but indicated that Petitioner had developed some right shoulder pain during therapy. PX 5. He administered an injection. He directed Petitioner to stay off work and continue therapy. PX 3.

Petitioner testified that Dr. Rubinstein referred him to his partner, Dr. Fisher, a spine surgeon, for a cervical spine evaluation. Petitioner first saw Dr. Fisher on July 27, 2016. In his note of that date, Dr. Fisher recorded a consistent history of the July 6, 2015 and December 21, 2015 work accidents and subsequent care. He noted that Petitioner's right shoulder had recently "flared" during rehabilitation following the left rotator cuff surgery. He indicated that, since the July 6, 2015 accident, Petitioner had been experiencing numbness extending down the right arm into the forearm and thumb.

On cervical spine examination, Dr. Fisher noted tenderness to the paraspinous muscles from C4 to the bilateral trapezius muscle, right greater than left, and positive Spurling's to the right. On bilateral upper extremity examination, he noted 5/5 strength with the exception of the left rotator cuff musculature, which was 4/5. He also noted decreased sensation in the forearm and thumb.

Dr. Fisher interpreted the September 16, 2015 cervical spine MRI images as showing a "broad-based disc herniation at C5-C6, both anteriorly and posteriorly, with resultant spinal stenosis." He discussed various treatment options with Petitioner, ultimately recommending a C5-C6 anterior cervical discectomy and fusion. PX 3.

On August 15, 2016, Dr. Rubinstein noted Dr. Fisher's findings and surgical recommendation. He also noted that Petitioner was off work for both the shoulder and the neck. He recommended four

more weeks of shoulder therapy. PX 3. A therapy progress note dated September 26, 2016 reflects that Petitioner had attended 68 sessions to date and was still limited with reaching overhead and behind his back. PX 5.

On September 21, 2016, Dr. Fisher re-examined Petitioner and again recommended a C5-C6 anterior cervical discectomy and fusion. He performed this surgery on October 11, 2016. Ten days later, he described Petitioner as reporting improvement of his radicular symptoms but still experiencing mild posterior neck discomfort and "some residual numbness in the thumb, index and part of the middle finger of the right hand." He obtained cervical spine X-rays and interpreted the films as showing good positioning of the fusion hardware. He directed Petitioner to gradually wean out of his cervical collar during the day, start Skelaxin and return in five weeks. PX 3.

On November 30, 2016, Dr. Fisher obtained repeat cervical spine X-rays. He interpreted the films as showing no evidence of hardware failure or loosening. He also obtained lumbar spine X-rays and recommended a lumbar spine MRI. [Dr. Fisher later recommended and performed a microdiscectomy at L4-L5. Petitioner is not claiming any lumbar spine condition relative to either work accident.]

On January 13, 2017, Dr. Fisher noted persistent numbness in the first and second fingers as well as left shoulder pain. He directed Petitioner to begin formal therapy for his neck. PX 3.

Petitioner returned to Athletico on January 17, 2017, with therapist David French, PT, DPT, noting a history of the recent cervical fusion.

Petitioner last saw Dr. Rubinstein for his left shoulder on February 22, 2017. The doctor wrote to Coventry Workers' Comp Services the same day, indicating that Petitioner was still experiencing numbness, which was likely neck-related, but had "pretty much regained 90% of his [shoulder] range of motion." He noted "reasonable strength against resistance" but described Petitioner as "not fully 100%." He found this to be "not surprising," again referencing the cervical spine issues. He found Petitioner to be at maximum medical improvement with respect to the shoulder and released him from care on a PRN basis. PX 3.

Petitioner also saw Dr. Fisher on February 22, 2017, with the doctor noting the upcoming L4-L5 discectomy. The doctor noted complaints of severe low back pain radiating into the lower extremity but indicated that Petitioner described his neck as "feeling much better." He also indicated that Petitioner denied any current neck pain. On cervical spine re-examination, he noted 80% full range of motion in all planes, negative Spurling's bilaterally and negative Lhermitte's. He recommended a continued exercise program for the neck. PX 3.

The last therapy note, dated March 22, 2017, reflects ongoing limitations with respect to cervical left side bending. The therapist described Petitioner as having plateaued with his progress, both subjectively and objectively. He noted that Petitioner had not met his goal of bilateral cervical rotation to 75 degrees. He also noted that Petitioner reported moderate difficulty lifting and carrying a heavy suitcase and a little difficulty with placing a 25-pound box on an overhead shelf, turning to look behind him, carrying a small object on his shoulders and using a shovel to dig a hole. He indicated Petitioner might be a good candidate for a functional capacity evaluation. PX 5.

Petitioner returned to Dr. Fisher on April 7, 2017. With respect to the cervical spine condition, the doctor noted a complaint of "slight numbness to the first and second fingers of the right hand" which was, according to Petitioner, "slowly improving." On re-examination, he noted a full range of cervical spine motion in all planes, negative Spurling's bilaterally and negative Lhermitte's. On bilateral upper extremity examination, he noted 5/5 strength, normal reflexes and "subjective decreased sensation to the first and second fingers." He described sensation as "grossly intact." He obtained new cervical spine X-rays. He interpreted the films as showing evidence of the fusion and "no evidence of hardware failure or loosening." He released Petitioner to work "a week from Monday" and recommended he return to his office in six months for repeat cervical spine X-rays. PX 3.

Petitioner testified he returned to Dr. Fisher as directed, and underwent additional X-rays. The note concerning this final visit is not in evidence.

Petitioner testified he resumed his regular hoisting engineer duties for Respondent after being released by Dr. Fisher on April 7, 2017. He found it difficult to operate heavy machinery. When he moved the controls with his hands, his shoulder throbbed. The job required him to move his head in a 200-degree arc. It was difficult for him to do this because he lacked mobility in his neck. Over time, he found it "harder and harder" to continue working. This prompted him to retire in late July 2017. He subsequently moved to Myrtle Beach, where he obtained a "very part-time" job with the park district, working on baseball fields. He testified he works 15 to 20 hours per week. His duties include lifting a chalk-marking machine off of an ATV. He continues to experience pain. His neck pain is the worst. He deals with his symptoms by taking Aleve once daily.

Petitioner testified he is left-handed.

Under cross-examination, Petitioner testified his prior right shoulder injury was work-related. He filed a claim for this injury. The claim went to hearing. He believes he received an award of 45% loss of use of the right arm. [The Commission main frame reflects an award of 10% loss of use of the left arm, by former Arbitrator Gomora, in 05 WC 7116, and a subsequent review, with the Commission apparently affirming and adopting the award. The Arbitrator was unable to access the decisions but it appears the reference to the left arm is an error.] As of his July 2017 retirement, he was vested but not fully. Both Dr. Rubinstein and Dr. Fisher released him to full duty. He has had no neck or left arm reinjuries. He denied injuring his neck before the July 6, 2015 accident. He has no pending medical appointments relating to his shoulder or neck.

Respondent did not call any witnesses. Respondent offered into evidence print-outs of the temporary total disability and medical benefits it paid in both claims. RX 1-2.

Arbitrator's Credibility Assessment

Petitioner worked for Respondent for almost twenty-eight years, a factor that weighs in his favor, credibility-wise. Petitioner answered questions directly and without hesitation. His testimony concerning his persistent symptoms and decision to retire was detailed and believable.

Arbitrator's Conclusions of Law Relative to Both Cases

<u>What is the nature and extent of the injury?</u>

Because both accidents occurred after September 1, 2011, the Arbitrator looks to Section 8.1b of the Act for guidance in determining the nature and extent of Petitioner's shoulder and cervical spine injuries. That section sets forth five factors to be considered in assessing permanency, with no single factor to be given more weight than any other. The Arbitrator views the first factor, i.e., any AMA Guides impairment rating, as not relevant since neither party offered such a rating in either case. The Arbitrator assigns significant weight to the second and third factors, Petitioner's occupation and age at the time of the accidents. Petitioner's occupation at the time of the accidents involved maintenance and manual operation of different pieces of heavy equipment. Petitioner's surgeons, Drs. Rubinstein and Fisher, released Petitioner to full duty. Petitioner testified he resumed his typical duties in April 2017, per the doctors' releases, but found it difficult to continue working due to his pain and inability to turn his head easily. He opted to retire after working several months and then moved south, where he began performing a part-time baseball field maintenance job. The Arbitrator assigns weight to the full duty releases of the surgeons, neither of whom was chosen by Petitioner, but finds it believable, based on the operative findings and residual symptoms, that Petitioner would have had some difficulty manipulating controls and turning his head in a 200-degree arc. As for Petitioner's age at the time of the accidents, the Request for Hearing forms incorrectly describe Petitioner as 58. Based on the birth date in the treatment records, January 11, 1960, Petitioner was in fact 55 as of July 6 and December 21, 2015. The Arbitrator views him as an individual who could have readily anticipated performing his hoisting engineer trade another ten years. He opted to retire in July 2017, two years before his 30-year anniversary. He credibly testified he found it difficult to operate heavy equipment following his surgeries. The Arbitrator also assigns significant weight to the fourth factor, future earning capacity. Petitioner was released to full duty and resumed his former job. He did not testify to being paid less during the 3 ½ months he worked before retiring. He was working only part-time, at a different job, as of the hearing but there is no evidence indicating any physician restricted his hours. As for the fifth and final factor, evidence of disability corroborated by the treatment records, the Arbitrator initially notes there is some uncertainty as to whether the first accident resulted in new right shoulder pathology. The radiologist interpreted the right shoulder MRI as showing a small tear but Dr. Rubinstein thought the images might show multiple screw artifacts from the prior surgery rather than new tearing. He viewed Petitioner's symptoms as emanating from the cervical spine, not the shoulder. Dr. Fisher interpreted the cervical spine MRI as showing a broad-based herniation at C5-C6 causing stenosis. While he noted some improvement of Petitioner's pre-operative radicular symptoms following the fusion, he consistently documented right hand numbness. The final therapy note of March 22, 2017 (PX 5) supports Petitioner's testimony that he has difficulty turning his head. The second accident resulted in substantial left shoulder pathology, i.e., full-thickness supraspinatus and infraspinatus tendons tears, with retraction, documented on MRI and intraoperatively. In his first post-operative note of March 23, 2016, Dr. Rubinstein described the tearing as very significant and "scarred down."

The Arbitrator has considered the foregoing, along with Petitioner's left hand dominance and his credible testimony concerning his persistent symptoms and limitations. In **16 WC 3135**, the Arbitrator finds that Petitioner established permanency equivalent to 37.5% loss of use of the person as a whole for both his cervical spine and right shoulder injuries, representing 187.5 weeks of benefits under Section 8(d)2. In **16 WC 3136**, the Arbitrator finds that Petitioner established permanency equivalent to 12.5% loss of use of the person as a whole, representing 62.5 weeks of benefits under Section 8(d)2 of the Act. Based on the parties' wage stipulations, the Arbitrator utilizes the maximum applicable weekly permanency rate of $755.22 in each case.

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Stephen Suerth,
Petitioner,

vs. NO: 16 WC 03136

City of Chicago - Department of Water,
Respondent.

19IWCC0324

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed July 5, 2018, is hereby affirmed and adopted.

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

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

DATED: JUN 25 2019
o062019
BNF/mw
045

Barbara Flores

Deborah Simpson

Marc Parker

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

SUERTH, STEPHEN
Employee/Petitioner

Case# **16WC003136**

16WC003135

CITY OF CHICAGO
Employer/Respondent

19IWCC0324

On 7/5/2018, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 2.08% 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:

4564 ARGIONIS & ASSOCIATES LLC
AL KORITSARIS
180 N LASALLE ST SUITE 1925
CHICAGO, IL 60601

0113 CITY OF CHICAGO
STEPHANIE LIPMAN
30 N LASALLE ST SUITE 800
CHICAGO, IL 60602

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

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
NATURE AND EXTENT ONLY

Stephen Suerth
Employee/Petitioner

v.

City of Chicago
Employer/Respondent

Case # **16** WC **3136**

Consolidated cases: **16 WC 3135**

19IWCC0324

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 Mason**, Arbitrator of the Commission, in the city of **Chicago**, on **June 20, 2018**. By stipulation, the parties agree:

On the date of accident, **12/21/15**, 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 $**98,925.37**, and the average weekly wage was $**1,902.41**.

At the time of injury, Petitioner was **55** years of age, ***married*** with **1** dependent child.

Necessary medical services and temporary compensation benefits have been provided by Respondent.

Respondent shall be given a credit of $46,203.81 for TTD (inclusive of a stipulated $2,512.12 credit for a TTD overpayment), $**0** for TPD, $**0** for maintenance, and $**0** for other benefits, for a total credit of $46,203.81.

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 **$755.22**/week for a further period of **62.5** weeks, as provided in Section **8(d)(2)** of the Act, because the injuries sustained caused **12.5% loss of use of the person as a whole.** As noted on the preceding page, Respondent is entitled to a credit in the amount of $2,512.12 due to an overpayment of temporary total disability benefits. Arb Exh 2.

Respondent shall pay Petitioner compensation that has accrued from **4/15/17** through **6/20/18**, 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.

Molly C Mason

Signature of Arbitrator

7/5/18
Date

JUL 5 - 2018

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

Jose Ferrer,
Petitioner,

vs. NO: 16 WC 17298

Bubbles Window Washing,
Respondent.

19IWCC0325

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of accident, temporary disability, permanent disability, medical expenses, notice and 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 1, 2018, 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: JUN 25 2019
o052319
BNF/mw
045

Barbara Flores

Deborah Simpson

Marc Parker

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

FERRER, JOSE Case# **16WC017298**
Employee/Petitioner

BUBBLE WINDOW WASHING
Employer/Respondent

19IWCC0325

On 10/1/2018, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 2.32% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

4998 LAW OFFICES OF HUGO A ORTIZ PC
4440 S ASHLAND AVE
CHICAGO, IL 60609

1408 HEYL ROYSTER VOELKER & ALLEN
BRAD ANTONACCI
33 N DEARBORN ST 7TH FL
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

JOSE FERRER
Employee/Petitioner

Case # **16** WC **17298**

v.

BUBBLES WINDOW WASHING
Employer/Respondent

19IWCC0325

An *Application for Adjustment 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 T. Cronin**, Arbitrator of the Commission, in the city of **Chicago**, on **05/22/2018** and **05/23/2018**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

19IWCC0325

FINDINGS

On **04/09/2016**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

In the year preceding the injury, Petitioner earned an average weekly wage of $**1,005.00**.

On the date of accident, Petitioner was **40** years of age, ***married*** with **1** dependent child.

Respondent shall be given a credit of $**25,793.23** for TTD, $**0.00** for TPD, $**0.00** for maintenance, and $**31,448.23** for other benefits, for a total credit of $**57,241.46**.

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

ORDER

Denial of benefits

Because Petitioner failed to prove he sustained an accident that arose out of and in the course of his employment by Respondent, the Arbitrator denies all benefits.

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

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

Signature of Arbitrator

9-29-2018
Date

OCT 1 - 2018

ARBITRATION DECISION ATTACHMENT

Jose Ferrer v. Bubbles Window Washing
16 WC 17298

FINDINGS OF FACT

On April 9, 2016, Petitioner was employed by Respondent as a technician. He performed window washing, gutter cleaning, and power washing. (Respondent's Exhibit No. 7) Although he had worked for Respondent years prior, his most recent employment with Respondent began April 1, 2016. Petitioner testified to an alleged work injury occurring on April 6, 2016 in Glenview at a private residence, although he noted that accident date to be April 9, 2016 on the Request for Hearing. (Arbitrator's Exhibit No. 1) He was about to begin pressure washing a garage floor. He testified he walked to the house to determine if the spigot was frozen. On his way back to his truck, he slipped, hitting his left knee on "the floor." He testified he experienced immediate, significant pain. Petitioner testified the owner of the home told him to be careful after Petitioner slipped. Petitioner indicated in his recorded statement that he slipped right in front of Ron Mayer, the homeowner. (Respondent's Exhibit No. 2) Petitioner testified that Ron Mayer witnessed his slip and fall. Petitioner completed the power washing at the residence in Glenview.

Petitioner also testified the temperature was "40 below." He testified that it had snowed the morning of his accident and there was frozen ice. Tom Oplawski, Petitioner's supervisor, testified that window washing and power washing cannot be performed unless the temperature is above freezing. Records from the National Oceanic & Atmospheric Administration (NOAA) indicate no precipitation occurred the morning of April 9, 2016. (Respondent's Exhibit No. 12) The temperature also rose to above freezing on April 9, 2016.

When asked if he felt pain in any other body part on the date of the alleged accident, Petitioner testified he extended his left arm to break his fall. He testified he did not feel symptoms in his left arm because his body was frozen due to the cold temperatures.

Petitioner provided a recorded statement on May 6, 2016 to Jace Fletcher. (Respondent's Exhibit No. 2) When asked if he suffered any other injuries, besides his left knee, Petitioner only mentioned experiencing symptoms on his hamstring.

Petitioner testified that he asked Tom Oplawski during the next week what would happen if he had an accident, but testified he did not report his alleged accident at that time. Tom Oplawski denied that this conversation ever took place. Petitioner testified he first reported the alleged accident to Tom Oplawksi on April 22, 2016, 13 days later, during a dispute about his paycheck, despite speaking with someone from the Respondent every single day from April 9 through April 22, 2016.

Tom Oplawski testified that he was a dispatcher/supervisor for Respondent in April 2016. He was Petitioner's supervisor at that time. Petitioner was to report any work injury as soon as it happened but did not report the work accident to Tom Oplawski until April 22, 2016. Tom Oplawski confirmed that Petitioner called him on April 22, 2016, complaining that he was supposed to be paid at a higher commission rate, and at that point, he brought up the alleged accident from April 9, 2016. Petitioner never mentioned falling to the ground during the accident and never mentioned his left shoulder.

Tom Oplawski also testified that on April 22, 2016 he spoke with Ron Mayer, the homeowner where the accident allegedly occurred. Tom Oplawski testified that Ron Meyer stated he did not witness Petitioner's alleged accident. He also advised Tom Oplawski that he was outside the entire time Petitioner was performing the power washing.

Ron Mayer testified at trial that he did not recall witnessing Petitioner slipping and falling on his property on April 9, 2016. He confirmed during cross-examination that he did not witness Petitioner slipping. Ron Mayer did not recall he, himself slipping on his driveway on that date. In Petitioner's recorded statement, he said that Mayer almost slipped too. (Respondent's Exhibit No. 2) Ron Mayer testified that the Petitioner never indicated to him that he had injured himself. On cross-examination, Ron Mayer testified he did not believe there was any ice on the concrete or the walkway.

After the alleged accident, Petitioner continued working, performing his regular work duties with no indication he was having any issues performing those work duties. (Respondent's Exhibit No. 9) He did not seek medical treatment until April 25, 2016, with Dr. Castillo at Advocate Occupational Health (Petitioner's Exhibit No. 1). Dr. Castillo diagnosed a left knee sprain/strain and eventually referred the Petitioner to an orthopedic physician. According to Petitioner's testimony, Dr. Castillo provided no work restrictions. Petitioner never mentioned his left shoulder symptoms to Dr. Castillo, according to Petitioner's testimony. Dr. Castillo's records do not reference the left shoulder.

Petitioner first presented to Dr. Hennessy, an orthopedic surgeon, on May 11, 2016. (Petitioner's Exhibit No. 3) An MRI revealed degenerative intrasubstance signal within the posterior horn of the medial meniscus and patellar tendinopathy. In a patient questionnaire form of the same date, Petitioner never mentioned any injuries besides his left knee. (Respondent's Exhibit No. 15)

At Petitioner's second appointment with Dr. Hennessy on June 3, 2016, for the first time, Petitioner mentioned to Dr. Hennessy a left shoulder injury. Dr. Hennessy performed an injection into the left shoulder for tendinitis. Dr. Hennessy also provided an injection to Petitioner's left knee. Petitioner claimed that the injection only provided a minimal decrease in his pain for a few days.

Petitioner began physical therapy at NovaCare Rehabilitation on June 30, 2016 for two sessions and was noncompliant, claiming the physical therapist was intentionally attempting to hurt him. (Respondent's Exhibit No. 6) The physical therapist noted inconsistent effort. Despite significant complaints of pain, the therapist noted Petitioner was able to get into his vehicle without difficulty. Petitioner refused to schedule follow-up appointments and requested a switch to a different physical therapist, which was authorized, to Athletico. (Petitioner's Exhibit No. 5) Dr. Hennessy then recommended a left knee arthroscopy on July 15, 2016. (Petitioner's Exhibit No. 3)

Following a July 20, 2016 IME with Dr. Verma in which Dr. Verma agreed with the surgical recommendation (Respondent's Exhibit No. 3), Dr. Hennessy performed a left knee arthroscopy, partial medial and lateral meniscectomy, partial synovectomy and medial femoral

chondroplasty on August 23, 2016. (Petitioner's Exhibit No. 2) Following surgery, Dr. Hennessy aspirated the Petitioner's left knee due to fluid build-up on September 2, 2016. He recommended physical therapy. Petitioner began physical therapy again at Athletico after surgery. (Petitioner's Exhibit No. 5) The physical therapist noted very slow progress and symptom magnification. The physical therapist noted Petitioner was inconsistent with describing causes of his pain. (Petitioner's Exhibit No. 5, pp. 300, 296)

Petitioner claimed the physical therapist at Athletico was also attempting to intentionally hurt him. According to his testimony, "the lady stuck her hand behind my left knee, causing me a lot of pain, making me cry and yell or scream." He refused to attend additional physical therapy. Petitioner last attended physical therapy on November 9, 2016. (Petitioner's Exhibit No. 5, p. 286) Auto-Owners Insurance advised Petitioner they were terminating his TTD benefits due to his failure to attend physical therapy and non-compliance with medical care. (Respondent's Exhibit No. 11)

In October of 2016, in follow-up with Dr. Hennessy, Petitioner's knee was again swollen and Dr. Hennessy again performed aspiration. (Petitioner's Exhibit No. 3) Petitioner began making complaints with respect to his right knee and claimed the right knee did not start bothering him until physical therapy started. At another point, the Petitioner claimed that he injured his right knee from improperly using his crutches. Dr. Hennessy recommended another left knee MRI.

The November 14, 2016 left knee MRI was essentially normal. (Petitioner's Exhibit No. 3) In follow-up on that same date, Dr. Hennessy recommended a left knee revision surgery despite the negative MRI findings. Petitioner now also claimed that he injured his lower back in physical therapy. Dr. Hennessy recommended a right knee MRI and a lumbar spine MRI. He discussed a left shoulder arthroscopy as well.

Petitioner also treated with Dr. Dorodi on one occasion on November 17, 2016. (Petitioner's Exhibit No. 2) Dr. Dorodi's note is unclear at best but notes Petitioner's complaints of left knee pain, right knee pain, left shoulder pain and back pain.

Dr. Verma then conducted a second IME of Petitioner on November 21, 2016. (Respondent's Exhibit No. 4) He found signs of symptom magnification and complaints that were out of proportion to the objective findings. He noted another left knee surgery was not necessary and rather recommended a left knee injection and four weeks of physical therapy, followed by a functional capacity evaluation.

On December 9, 2016, Dr. Hennessy noted Petitioner was to discontinue his left knee physical therapy due to his lumbar spine strain. Petitioner had not been to physical therapy since November 9, 2016. Dr. Hennessy reviewed Dr. Verma's IME report and essentially agreed with Dr. Verma's opinions. (Petitioner's Exhibit No. 3) He recommended work conditioning followed by an FCE. He also noted Petitioner should put the treatment of his right knee and low back through private insurance.

In follow-up with Dr. Hennessy on March 20, 2017, Petitioner stated he had only attended one work conditioning session and had to stop after 2 hours because of pain. (Petitioner's Exhibit No. 3) Petitioner claimed the work conditioning was "torture." Petitioner then began performing rehabilitation on his own and noted he felt markedly better. He noted he felt he had "fixed himself." (Petitioner's Exhibit No. 3, p. 054) Petitioner reported very minimal pain. He also stated he might have fixed his back pain as well. Dr. Hennessy noted full lumbar motion, bilateral knee motion and left shoulder motion. Dr. Hennessy allowed Petitioner to return to work without restrictions on a trial basis as of March 23, 2017.

Dr. Hennessy last provided medical treatment to Petitioner on May 1, 2017. (Petitioner's Exhibit No. 3) Petitioner again reported feeling much better with respect to his left knee. Petitioner only stated that he had some pain after running about a mile. Petitioner also stated that rehab in the gym "has made all the difference." Petitioner reported that he was feeling much better with respect to all injuries. (Petitioner's Exhibit No. 3, p. 053) Dr. Hennessy's examination was essentially normal. He released Petitioner to return to full-duty work and also placed the Petitioner at maximum medical improvement.

Dr. Verma examined Petitioner and prepared a third report dated March 5, 2018. (Respondent's Exhibit No. 5) With respect to Petitioner's left knee, Dr. Verma diagnosed subjective pain only. He did not believe there was any current causal connection with respect to

Petitioner's subjective symptoms and the alleged work accident. He found no basis for Petitioner's ongoing complaints on examination. Dr. Verma placed Petitioner at MMI for the left knee on May 1, 2017. With respect to the left shoulder, Dr. Verma diagnosed subjective pain only. He found no causal connection to the alleged work accident due to the delay in reported symptoms and fairly normal objective examination. Dr. Verma noted Petitioner could return to full-duty work as evidenced by his full-duty return to work in 2017. Petitioner did not require any additional medical treatment, according to Dr. Verma. He noted Petitioner's prognosis was fair based on his ongoing subjective complaints that have no objective support.

Dr. Verma also performed an AMA impairment rating for the left knee injury in the report. He detailed his calculation of the impairment rating at 8% of the left lower extremity, which translates to 3% whole-person impairment.

Petitioner has had no further medical treatment since May 2017. Petitioner testified that his left shoulder felt much better in May of 2017. He testified that his back was doing much better in May of 2017. He claimed that he was still experiencing symptoms in his left knee. Petitioner currently has no work restrictions from any doctor.

Petitioner testified he is currently unemployed. He claimed he attempted to work in 2017 but that it was "horrible." He claimed he almost fell when he attempted to climb a ladder again. He confirmed that he worked full-time, full duty in the year 2017. He testified that he avoided using his left shoulder during work activities in 2017 due to pain, and also testified he walked with a limp. He claimed that he experiences pain every single day in his left knee and left shoulder that has affected his mobility.

Respondent introduced into evidence a surveillance video (Respondent's Exhibit No. 13) and surveillance report (Respondent's Exhibit No. 14) from surveillance performed in October and November 2017. The Arbitrator notes the Petitioner was very active on November 6, 2017, with no signs of being impaired or disabled. Petitioner washed windows located at the top of a door with his left arm extended above his head, moving his left arm back and forth with no apparent difficulties (10:31 into video). He stepped off a ladder with no apparent difficulty (10:40 and 10:51 into video). He carried a ladder in his left hand (14:32 into video). Finally, he

carried three ladders with his left arm with no apparent difficulties (15:22 into video). The Arbitrator notes the Petitioner is not limping at any point in the video.

CONCLUSIONS OF LAW

In support of the Arbitrator's decision relating to (C), whether an accident occurred that arose out of and in the course of Petitioner's employment by Respondent, the Arbitrator finds as follows:

Pursuant to Section 1(d) of the Act, to obtain compensation under the Workers' Compensation Act, an employee bears the burden of showing, by a preponderance of the evidence, that he has sustained accidental injuries arising out of and in the course of employment. In the case at hand, Petitioner has failed to prove by a preponderance of the evidence that he has sustained accidental injuries arising out of and in the course of employment.

Petitioner testified that he slipped and fell in the presence of the homeowner, Ron Mayer, and he testified that Ron Mayer witnessed his slip and fall. Ron Mayer, the only independent witness to testify, confirmed that he never witnessed Petitioner slipping at his property on April 9, 2016. Not only did he not recall Petitioner slipping and falling on his property, he also confirmed Petitioner never indicated to him that he had injured himself. Ron Mayer's testimony was confirmed by the testimony of Tom Oplawski, the Petitioner's supervisor. Tom Oplawski spoke with Ron Mayer on April 22, 2016, and Ron Mayer advised Tom Oplawski that he did not witness Petitioner's alleged accident. He also advised Tom Oplawski that he was outside the entire time Petitioner was performing the power washing. The independent witness' testimony contradicts Petitioner's testimony and confirms no accident took place.

Petitioner's testimony regarding the weather conditions on the date of accident was entirely inaccurate and not supported by the evidence. The records from the NOAA indicate the temperature rose to above freezing on April 9, 2016. (Respondent's Exhibit No. 12) At no point was the temperature 40° below zero, as Petitioner testified. Further, the NOAA records indicate there was no precipitation the morning of April 9, 2016, contrary to Petitioner's testimony. Tom Oplawski testified credibly that power washing can't even be performed unless the temperature is above freezing. Finally, Ron Mayer testified he did not believe there was any ice on the concrete

or walkway on his property. The records and testimony regarding the weather conditions do not support Petitioner's claim that he slipped on ice or snow.

If the Petitioner had injured himself as badly as claimed, the Arbitrator would expect that he would not have been able to continue to perform his regular work duties. To the contrary, Petitioner continued to work, performing his regular work duties and working full time for two weeks. (Respondent's Exhibit No. 9) He gave no indication that he was having any difficulties performing those work duties following the alleged work accident. If Petitioner had injured himself as badly as claimed on April 9, 2016, one would expect that he would have sought medical treatment immediately rather than waiting until April 25, 2016.

Finally, the Arbitrator notes numerous, other pieces of evidence that illustrate Petitioner's lack of veracity or credibility. Petitioner claimed he extended his left arm to break his fall and did not feel symptoms in his left arm on the date of accident due to the extremely cold temperatures. As noted above, the temperatures were nowhere near his low as Petitioner claimed. Further, Petitioner made no left shoulder complaints in multiple medical records until approximately two months after the alleged accident, when Petitioner's body was not "frozen" due to cold temperatures. Petitioner never mentioned the left shoulder injury in his recorded statement to Jace Fletcher on May 6, 2016. (Respondent's Exhibit No. 2) He never advised Tom Oplawski on April 22, 2016 of any alleged left shoulder symptoms. Dr. Verma credibly opined that the left shoulder was in no way causally related to the alleged work accident based on the delayed symptoms and essentially normal objective examination. (Respondent's Exhibit No. 5) Petitioner's attempt to relate his alleged other injuries to the alleged accident, including the alleged left shoulder symptoms, right knee symptoms, and back symptoms is entirely inconsistent with the evidence.

Petitioner's lack of credibility was further demonstrated in the medical records, including the physical therapy records. Petitioner claimed the physical therapist at NovaCare Rehabilitation was intentionally attempting to hurt him. That physical therapist noted Petitioner's inconsistent effort during physical therapy. (Respondent's Exhibit No. 6) As an example, the physical therapist pointed out that Petitioner was able to enter his vehicle without difficulty despite extreme complaints of pain during physical therapy. The same symptom

magnification and lack of effort was noted by the physical therapist at Athletico. (Petitioner's Exhibit No. 5) That therapist documented Petitioner's inconsistencies in describing the causes of his pain along with symptom magnification. (Petitioner's Exhibit No. 5, pp. 300, 296) Petitioner then claimed that the Athletico physical therapist was also intentionally attempting to hurt him. The Arbitrator finds no truth in Petitioner's statements that multiple physical therapists were intentionally attempting to hurt him. Dr. Verma additionally found signs of symptom magnification and complaints that were out of proportion the objective findings. (Respondent's Exhibit No. 4) Dr. Verma's findings corroborate the findings of both physical therapists.

Petitioner lacks credibility based on his testimony regarding his return to work in 2017. He claimed he avoided using his left shoulder during work activities. Respondent's surveillance video from November 2017 illustrated Petitioner carrying three ladders with his left arm, all at once, with no apparent difficulties. (Respondent's Exhibit Nos. 13 and 14) He extensively used his left upper extremity to wash windows, with his left arm extended above his head. Petitioner testified he walked with a limp during his work activities in 2017. At no point in the surveillance video does Petitioner walk with a limp. His gait appears to be normal. Petitioner showed no signs of being impaired or disabled in the surveillance.

The Arbitrator finds that the evidence, which includes the testimony of an independent witness, fails to support his claim of a work injury on April 9, 2016.

Based on the foregoing, the Arbitrator finds that Petitioner failed to prove by a preponderance of the evidence that he suffered an accident that arose out of and in the course of employment by Respondent.

Compensation is hereby denied. All other issues have been rendered moot.

[signature] 9-29-18

Brian T. Cronin, Arbitrator — 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	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Mary Jane Menne,
Petitioner,

vs. NO: 16 WC 25178

Graham Hospital Association,
Respondent.

19IWCC0326

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 disability, permanent 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 August 30, 2018, 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.

19IWCC0326

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $60,500.00. 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: JUN 2 6 2019
o050919
BNF/mw
045

Barbara Flores

Marc Parker

Concurrence in Part and Dissent in Part

Petitioner is a medical records transcriber. She testified that she used a keyboard and mouse constantly for at least seven hours every workday. Her testimony was not rebutted. The Arbitrator found that Petitioner sustained her burden of proving that her bilateral carpal tunnel syndrome and right ring trigger finger were caused by her work activities. He awarded Petitioner 44.75 weeks of permanent partial disability benefits representing loss of 10% of each hand and loss of 25% of the right ring finger. The majority affirmed and adopted the Decision of the Arbitrator.

I concur with the majority that the Arbitrator was correct in finding that Petitioner sustained her burden of proving that the condition of bilateral carpal tunnel syndrome was causally connected to her work-related activities. However, I respectfully dissent from the majority in affirming the Decision of the Arbitrator finding that Petitioner sustained her burden of proving that her right ring trigger finger was causally related to her work activities.

The Arbitrator, and through it affirmance the majority, based the finding on the testimony of Petitioner's treating orthopedic surgeon, Anane-Sefah, who was found more persuasive than Respondent's Section 12 medical examiner, Dr. Rotman. Dr. Anane-Sefah testified that keyboarding can in and of itself cause carpal tunnel syndrome, and in this instance actually caused or at least aggravated Petitioner's bilateral carpal tunnel syndrome. Dr. Rotman opined that keyboarding alone cannot alone cause either carpal tunnel syndrome or trigger finger.

Given the extraordinary amount of keyboarding Petitioner performed, and Dr. Anane-Sefah's testimony, I accept the Arbitrator's conclusion that her bilateral carpal tunnel was causally related to her work activities. However, in looking at Dr. Anane-Sefah's deposition, he never specifically opined that Petitioner's right ring trigger finger was caused by Petitioner's keyboarding activities. In the absence of such opinion, the only expert opinion before the

Commission is that of Dr. Rotman, who testified that the condition of trigger-finger is not caused by keyboarding.

Therefore, I respectfully dissent from the majority in affirming the Arbitrator's finding that Petitioner's right ring trigger finger was causally related to her work activities. Accordingly, I would have vacated the portion of the permanent partial disability award for Petitioner's right ring finger. In addition, the record indicates that Petitioner's left carpal tunnel syndrome was mild and her symptoms in the right (dominant) hand/wrist were greater than on the left. Looking at the record as a whole I would have awarded Petitioner a permanent partial disability award of 36.9 weeks representing loss of 10% of the right hand and loss of 8% of the left hand.

Deborah L. Simpson

Deborah L. Simpson

DLS/dw
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ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

MENNE, MARY JANE Case# **16WC025178**

Employee/Petitioner

GRAHAM HOSPITAL ASSOCIATION

Employer/Respondent

19IWCC0326

On 8/30/2018, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 2.21% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

2249 HARVEY & STUCKEL CHTD
DAVID W STUCKEL
101 S W ADAMS ST SUITE 600
PEORIA, IL 61602

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

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

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Mary Jane Menne
Employee/Petitioner

v.

Graham Hospital Association
Employer/Respondent

Case # **16** WC **25178**

Consolidated cases: **N/A**

19IWCC0326

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Michael Nowak**, Arbitrator of the Commission, in the city of **Peoria**, on **12/18/17**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **8/1/16**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

On this date, 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 $**34,015.63**; the average weekly wage was $**654.15**.

On the date of accident, Petitioner was **66** years of age, ***married*** with **no** dependent children.

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

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

Respondent shall be given a credit of $**0** for TTD, $**0** for TPD, $**0** for maintenance, and $**3,317.21** for other benefits, for a total credit of $**3,317.21**.

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 $**19,735.20**, as set forth in Petitioner's exhibit 5, as provided in Sections 8(a) and 8.2 of the Act.

Respondent shall pay Petitioner temporary total disability benefits of $**436.10**/week for **13 5/7** weeks, commencing **10/7/16** through **11/28/16 (7 4/7 weeks)** and **12/27/17** through **2/7/17 (6 1/7 weeks)**,as provided in Section 8(b) of the Act.

Based on the factors enumerated in §8.1b of the Act, which the Arbitrator addressed in the attached findings of fact and conclusions of law, and the record taken as a whole, Respondent shall pay Petitioner the sum of $**392.46**/week for a further period of **44.75** weeks, as provided in Section **8(e)** of the Act, because the injuries sustained caused **10% loss of use of the right hand (19 weeks), 10% loss of use of the left hand (19 weeks), and 25 % loss of use of the right ring finger (6.75 weeks)**.

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

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

Michael K. Nowak, Arbitrator

8/23/18
Date

FINDINGS OF FACT

Petitioner testified that she was first hired at Graham Hospital in 1985 on a part-time basis working in several positions. She became a full-time transcriptionist in the medical records department in 1992. She then left the hospital in 2002, returning to work in 2009. She worked from 2009 through July 2016 as a transcriptionist. She was home based working 7:00 a.m. to 3:30 p.m., Monday through Friday. She had no other jobs and no other hobbies which involved repetitive use of her hands.

Petitioner testified that her job duties involved transcribing records for Dr. Krock and Dr. Savegnago. She stated that she transcribed nursing home records and provided examples of the nursing home history and physical which she would have typed as identified by Petitioner's Exhibit 6. She noted that the records from Dr. Krock were done pursuant to eClinical Works program which involved filling multiple fields. She stated that you would work through an electronic medical record by clicking on the field and then typing in the information provided by the physician. It involved both use of the mouse and typing. She stated that the physicians would visit the nursing home monthly and may see 45 patients. She also noted that there were other facilities where she would type the records from 25 to 45 different patients. She said that it was typical for a physician to see 40-45 patients a day.

Pet. Ex. 6, 7 and 8 exemplify the transcription work. For nursing home records she prepares a document as shown in Pet. Ex. 6 for each patient based on the physician's dictation . Pet. Ex. 7 and 8 are instruction forms prepared by Respondent which show the extent of medical records prepared for each patient visit with Dr. Savegnago and Dr. Krock which was the bulk of Petitioner's work. Each record is multiple pages and require Petitioner to use a mouse to navigate between fields and the keyboard to enter text. She performed this work all day.

Petitioner testified that her work station was in her home and was never evaluated by Respondent for ergonomic conditions. Her keyboard is a split style board. The volume of work requires her to enter information as fast as possible to keep up with the workload.

In 2012 or 2013, Petitioner noticed problems with her hands. Those problems increased and became worse in 2016.She noticed she was having tingling and numbness in her hands and was having difficulty performing her job duties. By 2016 her hands hurt at night and she had increased symptoms while performing her job. In July 2016 she consulted Dr. Jason Anane-Sefah, an orthopedic surgeon, who ordered an EMG. His clinical findings are contained in Pet. Ex. 2 and include positive Tinel, Phalen and carpal compression tests on both wrists. The EMG was performed by Dr. Russo (Pet. Ex. 1) and on August 1, 2016, Dr. Anane-Sefah informed Petitioner she had carpal tunnel syndrome with right ring trigger finger and needed surgery on both hands. Petitioner testified that this date was the first time Petitioner had a diagnosis of her condition and its relationship to her work.

Dr. Anane-Sefah Performed surgery on her right upper extremity for carpal tunnel syndrome and right ring trigger finger October 7, 2016, (Pet. Ex. 3) and on December 27, 2016, for left carpal tunnel syndrome. (Pet. Ex. 1).

Dr. Anane-Sefah testified by way of deposition. He opined that Petitioner's carpal tunnel syndrome was either caused or aggravated by her work activities since her paresthesia worsened while performing her work.

(Pet. Ex. 4, p. 12). She had no other conditions or activities which were risk factors for the development of carpal tunnel syndrome. (Pet. Ex. 4, p. 13). On cross-examination Dr. Anane-Sefah was asked about Mayo Clinic studies which examine the correlation between keyboard work and the occurrence of carpal tunnel syndrome. Dr. Anane-Sefah completed a Mayo Clinic hand surgical fellowship and was familiar with the Clinic studies on carpal tunnel. He testified that there is more than one Mayo Clinic study and they reach different conclusions concerning the relation of keyboard work to carpal tunnel syndrome. (Pet. Ex. 4, p. 15). Dr. Anane-Sefah noted that his practice experience found persons who do intensive keyboard work had carpal tunnel syndrome at a higher rate than the general population. (Pet. Ex. 4, p. 19).

Dr. Mitchell Rotman performed a Section 12 examination on behalf of Respondent and testified by deposition as well. Dr. Rotman, like Dr. Anane-Sefah, is a board certified orthopedic surgeon. Dr. Rotman agreed with the diagnosis of bilateral carpal tunnel syndrome with right ring trigger finger and the need for treatment, but disagreed with Dr. Anane-Sefah's opinion that these conditions were related to Ms. Menne's work. Dr. Rotman opined that keyboard work does not cause carpal tunnel syndrome or trigger finger although the two conditions do proceed together. (Resp. Ex. 1, p. 10-12, 15).

On cross examination Dr. Rotman testified that there are hand surgeons who disagree with his opinions on the cause or aggravation of carpal tunnel syndrome by key boarding. (Resp. Ex. 1, p. 14). Dr. Rotman is a member of the American Academy of Orthopedic Surgeons and agreed that the Academy has published studies which link keyboard and mouse work with the development of carpal tunnel syndrome and trigger finger. (Resp. Ex. 1, p. 17). He agreed that the publications of the Academy are relied upon by orthopedic physicians in the care and treatment of patients.

Dr. Rotman opined that ergonomic keyboards and wrist rests are not necessary and do not alleviate hand and wrist problems. His conclusion about Ms. Menne's condition is that it is idiopathic in origin. (Resp. Ex. 1, p. 20). He felt that her age was part of the reason for her condition because increased age means more time for thickening of the ligament to occur. He also agreed that age also means more time for work activities to cause thickening of the ligament that leads to carpal tunnel syndrome. He agreed that Petitioner did not have any other risk factors in her health history to account for development of the syndrome.

Petitioner was off work from October 7, 2016 through November 28, 2016 (7 4/7 weeks) and December 27, 2016 through February 7, 2017 (6 1/7 weeks). Petitioner submitted medical bills totaling $19,735.20 (Pet. Ex. 5). Respondent disputes its liability for TTD and medical benefits based upon the issues of accident and causal connection but does not dispute the period of incapacity or the reasonableness or necessity of the treatment received and the charges for that treatment.

CONCLUSIONS

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

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

The Arbitrator found the Petitioner to be forthright and credible in all regards. As indicated above there appears to be a split in the medical literature concerning the existence of a relationship between the development of carpal tunnel syndrome and keyboarding.

Dr. Anane-Sefah testified that Petitioner's carpal tunnel syndrome was either caused or aggravated by her work activities since her paresthesia worsened while performing her work. She had no other conditions or activities which accounted for the development of carpal tunnel syndrome. Dr. Anane-Sefah noted that his practice experience found persons who do intensive keyboard work had carpal tunnel syndrome at a higher rate than the general population. Dr. Rotman disagreed with Dr. Anane-Sefah's opinion that these conditions were related to Ms. Menne's work. Dr. Rotman opined that keyboard work does not cause carpal tunnel syndrome or trigger finger. He felt Petitioners condition is idiopathic in origin. He felt that her age was part of the reason for her condition. He agreed that Petitioner did not have any other risk factors in her health history to account for development of the carpal tunnel syndrome.

An injury is accidental within the meaning of the Act if "a workman's existing physical structure, whatever it may be, gives way under the stress of his usual labor." *Laclede Steel. Co. v. Industrial Commission*, 128 N.E.2d 718, 720 (Ill. 1955); *General Electric Co. v. Industrial Commission*, 433 N.E.2d 671, 672 (Ill. 1982). In a repetitive trauma case, issues of accident and causation are intertwined. *Elizabeth Boettcher v. Spectrum Property Group and First Merit Venture,* 99 I.I.C. 0961 (1999). Accidental injury need not be the sole causative factor, nor even the primary causative factor, as long as it is a causative factor in the resulting condition of ill-being. *Sisbro, Inc. v. Indus. Comm'n*, 797 N.E.2d 665, 672-73 (Ill. 2003) (emphasis added). As in establishing accident, to show causal connection Petitioner need only show that some act or phase of the employment was a causative factor of the resulting injury. *Fierke v. Industrial Commission*, 723 N.E.2d 846 (3rd Dist. 2000).

In *Edward Hines Precision Components v. Indus. Comm'n,* 825 N.E.2d 773, (2nd Dist. 2005). the Court expressly stated, "There is no legal requirement that a certain percentage of the workday be spent on a task in order to support a finding of repetitive trauma." *Id.* at N.E.2d 780. Similarly, the Commission noted in *Dorhesca Randell v. St. Alexius Medical Center*, 13 I.W.C.C. 0135 (2013), a repetitive trauma claim, a claimant must show that work activities are a cause of his or her condition; the claimant does not have to establish that the work activities are the sole or primary cause, and there is no requirement that a claimant must spend a certain amount of time each day on a specific task before a finding of repetitive trauma can be made. *Randell* citing *All Steel, Inc. v. Indus. Comm'n*, 582 N.E.2d 240 (2nd Dist. 1991) and *Edward Hines supra.*

The Arbitrator notes that the Commission has recognized that keyboard work can be a cause or aggravating factor in the development of carpal tunnel syndrome and trigger finger. See, *Price v. City of Peoria*, 13 I.W.C.C. 0095 (February 14, 2017). In this case, Petitioner's duties are not varied and she performs keyboard and mouse work for the entire work day. Petitioner provided direct and unrebutted testimony about the frequency, duration and manner of performing her work and satisfies the standard of proof required for a repetitive trauma claim. See, *Shanklin v. Illinois Worker's Compensation Commission*, 2017 IL App (4th) 160440WC-U 4th District Appellate Court, IL No. 4-16-0440WC (unpublished decision).

Further, the Arbitrator finds the testimony and opinions of Dr, Anane-Sefah more persuasive than those of Dr. Rotman in this case.

Based upon the foregoing and the record taken as a whole, the Arbitrator finds Petitioner has met her burden of establishing that she sustained accidental injuries which arose out of an in the course of her employment with Respondent and that her condition(s) of ill-being are causally related to the 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?**
Issue (K): **What temporary benefits are in dispute?**

As indicated above, Respondent disputes its liability for TTD and medical benefits based upon the issues of accident and causal connection but does not dispute the period of incapacity or the reasonableness or necessity of the treatment received and the charges for that treatment.

Having found in favor of Petitioner with regard to issues C and F above, the Arbitrator finds Respondent is liable for payment of TTD benefits and medical expenses as claimed by Petitioner.

Respondent shall pay reasonable and necessary medical services of $19,735.20, as set forth in Petitioner's exhibit 5, as provided in Sections 8(a) and 8.2 of the Act. Respondent shall be given a credit for medical benefits that have been paid, and Respondent shall hold petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act.

Respondent shall also pay Petitioner temporary total disability benefits of $436.10/week for 13 5/7 weeks, commencing 10/7/16 through 11/28/16 (7 4/7 weeks) and 12/27/17 through 2/7/17 (6 1/7 weeks),as provided in Section 8(b) of the Act.

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

Pursuant to §8.1b of the Act, permanent partial disability from injuries that occur after September 1, 2011 is to be established using the following criteria: (i) the reported level of impairment pursuant to subsection (a) of §8.1b of the Act; (ii) the occupation of the injured employee; (iii) the age of the employee at the time of the injury; (iv) the employee's future earning capacity; and (v) evidence of disability corroborated by the treating medical records. 820 ILCS 305/8.1b. The Act provides that, "No single enumerated factor shall be the sole determinant of disability." 820 ILCS 305/8.1b(b)(v).

With regard to subsection (i) of §8.1b(b), the Arbitrator notes that neither party submitted an impairment rating. The Arbitrator therefore gives *no* weight to this factor.

With regard to subsection (ii) of §8.1b(b), the occupation of the employee, the Arbitrator notes that Petitioner continues to work as a medical transcriptionist using her upper extremities. Petitioner testified that after returning to work her symptoms have begun to return. The Arbitrator therefore gives *greater* weight to this factor.

With regard to subsection (iii) of §8.1b(b), the Arbitrator notes that Petitioner was 66 years old at the time of her injuries. Petitioner has diminished healing capacity and a low threshold for future injury as a result thereof. Furthermore, Petitioner has hand and arm intensive employment as a medical transcriptionist. The Arbitrator therefore gives *some* weight to this factor.

With regard to subsection (iv) of §8.1b(b), Petitioner's future earnings capacity, the Arbitrator notes there is no direct evidence of reduced earning capacity contained in the record. The Arbitrator therefore gives *no* weight to this factor.

With regard to subsection (v) of §8.1b(b), evidence of disability corroborated by the treating medical records, the Arbitrator notes the Petitioner was a credible witness. As a result of her intensive, repetitive employment, Petitioner developed bilateral carpal tunnel syndrome right ring trigger finger which required bilateral carpal tunnel releases as well as a trigger finger release. Petitioner testified at Arbitration that despite the improvement resulting from surgery, she continues to experience symptoms in her hands. Because the medical records and evidence taken as a whole corroborate the Petitioner's complaints of pain, weakness and loss of function in her hands, the Arbitrator therefore gives *greater* weight to this factor.

Based on the above factors, and the record taken as a whole, the Arbitrator finds that Petitioner sustained permanent partial disability to the extent of 10% loss of use of each hand and 25% loss of use of the ring finger pursuant to §8(e) of the Act.

Respondent shall pay Petitioner the sum of $392.46/week for a further period of 44.75 weeks, as provided in Section 8(e) of the Act, because the injuries sustained caused 10% loss of use of the right hand (19 weeks), 10% loss of use of the left hand (19 weeks), and 25 % loss of use of the right ring finger (6.75 weeks).

STATE OF ILLINOIS)
) SS.
COUNTY OF ST. CLAIR)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Ricky A. Duncan,
Petitioner,

vs.

NO: 13 WC 31742
17 WC 27834

19IWCC0327

Ameren Illinois,
Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of accident, temporary disability, permanent disability, medical expenses and 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 14, 2018, is hereby affirmed and adopted.

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

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

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

DATED: JUN 2 6 2019
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BNF/mw
045

Barbara Flores

Deborah Simpson

Marc Parker

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

DUNCAN, RICKY A
Employee/Petitioner

Case# **13WC031742**
17WC027834

AMEREN IL
Employer/Respondent

19IWCC0327

On 8/14/2018, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 2.18% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0384 NELSON & NELSON
DAVID NELSON
420 N HIGH ST PO BOX Y
BELLEVILLE, IL 62220

1241 LEMP &MURPHY PC
DONALD MURPHY
8045 BIG BEND BLVD STE 202
WEBSTER GROVES, MO 63119

STATE OF ILLINOIS)
)SS.
COUNTY OF St. Clair)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Ricky Duncan
Employee/Petitioner

Case # 13 WC 031742

v.

Consolidated cases: 17-WC-027834

Ameren, IL
Employer/Respondent

19IWCC0327

An *Application for Adjustment 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 **Tuesday, June 26, 2018**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. [ ] Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. [ ] Was there an employee-employer relationship?
C. [ ] Did an accident occur that arose out of and in the course of 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 [x] Maintenance [x] TTD
L. [x] What is the nature and extent of the injury?
M. [ ] Should penalties or fees be imposed upon Respondent?
N. [ ] Is Respondent due any credit?
O. [ ] Other ______

FINDINGS

On **09/04/13 and 10/08/14**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**103,833.60**; the average weekly wage was $**1,996.80**.

On the date of accident, Petitioner was **61/62** years of age, *married* with **0** dependent children.

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

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

Respondent shall be given a credit of $**18,954.97** for TTD, $ for TPD, $ for maintenance, and $ for other benefits, for a total credit of $**18,954.97**.

Respondent is entitled to a credit of $**84,415.61** under Section 8(j) of the Act.

ORDER

THE ARBITRATOR DENIES PPD BENEFITS AND ANY ADDITIONAL TTD OR MEDICAL BENEFITS. SEE ATTACHED.

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

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

Signature of Arbitrator

8/11/18

Date

AUG 14 2018

STATE OF ILLINOIS)

)SS.

COUNTY OF St. Clair)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Ricky Duncan
Employee/Petitioner

Case # 13 WC 031742

v.

Consolidated cases: 17-WC-027834

Ameren, IL
Employer/Respondent

STATEMENT OF FACTS

I. Testimony at Trial

19IWCC0327

The initial witness was Annette Duncan, wife of Petitioner, Ricky Duncan. At the time of trial, they had been married 43 years. She testified that prior to the initial exposure on 09/04/13 he had no trouble breathing, no coughing, wheezing, or the like. Further, that he was not taking any types of medication, such as Albuterol inhaler or steroids. (Tr. 13-15).

Annette Duncan did testify that there were three occasions of breathing symptoms prior to the exposure on 09/04/13, which she described as episodes of bronchitis and pneumonia. (Tr. 15).

Annette Duncan testified that prior to 09/04/13 her husband had no issues with doing work around the house, taking vacations, burning leaves, exposure to detergents or cleaning items around the house. (Tr. 18-20).

Annette Duncan testified that between the initial exposure on 09/04/13 and the subsequent exposure on 10/08/14 her husband did not want to leave the house, was concerned he would have attacks and was depressed. (Tr. 23-24).

There was discussion as to surveillance which was undertaken following the initial exposure (on 08/30/14), which Annette Duncan had reviewed. This involved a charity event at an Elks Lodge, to which both she and her husband belong. She admitted this showed her husband near a BBQ grill, allegedly though away from the smoke. (Tr. 21-23).

Allegedly after the exposures, Annette Duncan started changing filters in the house, removing soap powders, deodorants, lotions, or similar items, to avoid her husband having any triggers. (Tr. 26-29).

Allegedly after the two exposures, Petitioner's symptoms never returned to baseline, getting worse. (Tr. 33-34).

On cross-examination, Annette Duncan testified she was aware that her husband was seeing Dr. Roth at Illini Family Medicine prior to both exposures. Further, that prior to both exposures, he had been prescribed Flonase, Addair (an inhaler), the latter allegedly given with pneumonia, statements as to wheezing, statements as to possibility of asthma, prescriptions of Biaxin and Albuterol. (Tr. 36-38).

Annette Duncan was not aware that on 01/28/13, prior to the initial or either exposure, Dr. Roth had diagnosed her husband with asthma. Further, that there was reference by Dr. Roth to her husband having a frequency of asthma attacks about once a year. Finally, that on 08/24/13, two weeks prior to the initial exposure, her husband was reporting fatigue and difficulty sleeping. (Tr. 38-41).

The second witness at trial was Corey Duncan, Petitioner's son. Both have been employed over the years at Ameren as gas journeymen. He was not present at the initial exposure on 09/04/13. However, he did testify as to growing up with his father, going hunting, shooting guns, wearing cologne with no issues, his father not having any reactions to orders, perfumes or the like. (Tr. 49-51). However, that after the second exposure, he would cough excessively, wheeze and the like. (Tr. 51-52).

Prior to the exposures, Corey Duncan testified that his father and he would go to drag races, where they would be exposure to fluids and fumes. However, that after the exposures, they have not been able to do so. (Tr. 53-55).

Corey Duncan testified that when his father visits (after the exposure) he has to make sure there are no cleaners, "smelly stuff", perfumes or the like, for fear of reaction. (Tr. 62-63). Further, that he had no such problems prior to the exposure. (Tr. 63-64).

On cross-examination, Corey Duncan confirmed he was not aware of any emergency room visits involving his father in terms of pulmonary problems other than on the exposure of 09/04/13 and 10/08/14. Further that after the exposures, his father would wear a mask when it was cold but that in terms of smells, but that the mask "didn't really block a whole lot out". (Tr. 65-66).

The third witness was Petitioner, Ricky Duncan. At trial, he was 66 years old. He testified his voice was different, because of having walked into the building where the trial took place. (Tr. 69-70).

There was a discussion as to the initial exposure on 09/04/13, when Petitioner and another employee were cutting a four inch cast iron line. Water came out, then some type of liquid. It emptied into a nearby ditch, and it was noticed the water was turning red and foamy. (Tr. 70-72).

Allegedly after this exposure, Petitioner had a tight chest, with difficulty breathing. He called his supervisor, who took him to the emergency room. (Tr. 74).

At the time of trial, Petitioner testified he was using an inhaler every four to six hours as needed, or if he would be involved with triggers. He was also carrying oxygen. On the date of trial, he had already used one bottle of oxygen, greater than usual. (Tr. 79-80).

Petitioner talked about various triggers, including paint, perfumes and the like. (Tr. 81).

Petitioner only missed a couple of days off work after the initial exposure. He did not begin missing time from work until 05/12/14, approximately seven months thereafter. He was paid TTD from 05/12/14 through 09/21/14. He then returned to work on 09/22/14. (Tr. 83-84).

Following the return to work on 09/22/14, there was the subsequent exposure on 10/08/14. Petitioner was in the crew room, when he smelled a very strong order of gas. He stated there was limited ventilation, and he again experienced chest pain and difficulty breathing (Tr. 88-90). He was taken by ambulance to the hospital. He was admitted overnight and then discharged the second day. (Tr. 92-93).

After the subsequent exposure, Petitioner returned to Dr. Tuteur, who authorized lost time. (Tr. 101-102). Since then, Dr. Tuteur never released Petitioner back to work. (Tr. 104).

Petitioner testified as to a job search log with approximately 500 contacts, further his evaluation with a vocational specialist, June Blaine (at the request of Respondent) and with Stephen Dolan (at the request of his attorney). There has been no vocational rehabilitation effort. (Tr. 107-108).

On cross-examination, there was a discretion with Petitioner as to his extensive prior treatment with Dr. Roth. That began in October of 1998 with a history of trouble breathing and chest pain. Then in July of 1999, shortness of breath and a referral to Dr. West for pulmonary function testing. Petitioner did not remember Dr. West suggesting obstructive airways disease as far back as August of 1999. Nor did he remember Dr. West talking about the possibility of a work up for asthma. Petitioner testified to knowledge, he was never diagnosed with asthma. (Tr. 129-131).

There was discussion as to excessive fatigue in May of 2001, shortness of breath and coughing in December of 2001, bronchospasm and being prescribed an Albuterol inhaler in June of 2003, prescribed Flonase in October of 2004, Advair in November of 2005, wheezing and a prescription of Biaxin and Albuterol in February of 2009, chest tightness and wheezing in May of 2001. (Tr. 131-135).

Petitioner was confronted with a history from Dr. Roth on 01/23/13, approximately 7 ½ months prior to the initial exposure of 09/04/13, referencing asthma. Petitioner again stated he was not diagnosed with asthma. Further, that he did not understand the discussion as to frequency of attacks as being approximately once a year, as reflected in the records from Dr. Roth. (Tr. 136-137).

Petitioner indicated that the co-employee who was with him at the time of the initial exposure on 09/04/13 was Al Hoernis. Mr. Horenis and Petitioner were in the same spot when the material came out. They both cut their pipe. Petitioner did not know whether Mr. Horenis had any symptoms with this exposure or had any treatment. (Tr. 140-141).

Petitioner admitted returning to work a couple of days after the initial exposure on 09/04/13 until being taken off again in May of 2014, approximately eight months. During that time frame, he was a gas journeyman lead man, and would work in the field. He did try to control his environment during that time frame. (Tr. 142-143).

There was a discussion as to the surveillance and BBQ at the Elks Lodge on 08/30/14. Petitioner had reviewed the video. He admitted to being in the vicinity of the BBQ and fumes, also an individual smoking a cigarette. However, allegedly that he was upwind. (Tr. 143-144).

Petitioner admitted that after the initial exposure on 09/04/13 and the return to work a couple of days after, he did not wear a mask during that time frame, up until the subsequent exposure on 10/08/14. (Tr. 154). Further, that thereafter, he would wear the mask only if it was cold or if there was dust flying. As of the date of trial, he was no longer wearing the mask, being on oxygen. (Tr. 155).

Petitioner was never prescribed the mask, rather he just went to the store to buy a mask. He admitted that the masks identified on surveillance did not hold back fumes. (Tr. 156).

Petitioner testified that other than an emergency room for a bee sting, there have been no emergency room visits since 10/08/14. Specifically, no emergency room visits thereafter based on breathing or lung issues. (Tr. 157-158).

As of the trial date, Petitioner still had group insurance through Ameren, with that policy honoring treatment relating to pulmonary issues. (Tr. 160).

As to the job search log, Petitioner admitted that the vast majority, 90% to 95% indicated the employers were not hiring or no jobs were open. (Tr. 150).

II. Medical Records and Deposition Testimony of Dr. Roth

Dr. Roth is Petitioner's family physician, and has been since the late 1990's. She discussed Petitioner's pulmonary symptoms over the years, including after the two exposures. It was her opinion that "I do not think he has returned to baseline after those exposures." (Tr. 31).

On cross-examination, there was a discussion as to Petitioner's history of pulmonary or arguably asthma, dating back to 1999. She admitted that as far back on 07/28/99 she referred Petitioner to Dr. West, with a history of shortness of breath on exertion. (Tr. 34). Further, that his oxygen level that date was 68, whereas she would usually "like to see them between 80 and 100". Thus, that the oxygen level as of that date was below normal. (Tr. 35). Dr. Roth admitted that on 08/08/99 there was a discussion as to potential obstructive airways disease. Further, that

in August of 1999 there was a statement as to the possibility of a diagnosis of asthma. (Tr. 35-36).

Dr. Roth prescribed Albuterol on 06/18/03, designed to open up the airways and relax the spasm in the airways. She admitted an Albuterol inhaler is sometimes prescribed for asthma. (Tr. 41).

On 11/23/05 Dr. Roth prescribed Advair 250/50. (Tr. 41-42).

On 02/16/09 there was reference to Petitioner having reported wheezing, with a questionable history of asthma. (Tr. 42-43).

Dr. Roth admitted that as far back as February of 2009 there was concern as to a potential diagnosis of asthma. Further, that wheezing would be consistent with a diagnosis of asthma. Finally, noting that as of 01/23/13 there was a specific discussion as to "asthma first diagnosed in adulthood . . . to be conceived as attacks once per year". (Tr. 43-44).

There was a visit on 08/15/13, less than a month prior to the initial claimed exposure. Therein, reference to the Petitioner having fatigue for the last five years or so. (Tr. 44-45).

III. Medical Records and Deposition Testimony of Dr. Tuteur

Dr. Tuteur initially saw Petitioner on 11/06/13. He noted the Petitioner had never smoked cigarettes. Further, with a history of pneumonia and chest discomfort over the years. He also made reference to the prior evaluation with Dr. West "which is the only date I have", with reference to the possibility of asthma dating back to 2002. (Tr. 8-10).

Dr. Tuteur had a history of the Petitioner cutting a pipe, with exposure to materials thereafter. He talked about the return to work in May of 2014, recommending environmental control. He then discussed the subsequent exposure on 10/08/14. (Tr. 12-16).

Dr. Tuteur talked about every exposure being an exacerbation, involving remodeling of the airways. Further, that this would be irreversible. (Tr. 17).

In discussing references to the possibility of pre-existing asthma or asthma in general, Dr. Tuteur advised "I view use of the term asthma – and I will give you an anecdote that will explain this – as very much of the concept of the blind man – the multiple blind men assessing the camel". He then went into his view as to why only specialists such as he had would be qualified to make or discuss the diagnoses. (Tr. 24-26).

Dr. Tuteur testified that the exposures on 09/04/13 and 10/08/14 made Petitioner worse, that he would not get better, that condition would be permanent and irreversible. (Tr. 28-30).

As of the date of his deposition on 01/26/15, Dr. Tuteur admitted that he last seen the Petitioner in October of 2014. (Tr. 35). He admitted that there is no way he could testify as to what Petitioner had been doing since October of 2014, since he had not seen him since then.

Dr. Tuteur did admit on cross-examination that "not everybody gets remodeling every time you have an exacerbation". Further, that pulmonary function can remain the same. Further, that that would be no way to objectively indicate whether there had in fact been remodeling. (Tr. 36-37).

Dr. Tuteur indicated that he knew Dr. Hyers in a professional capacity. Further, that he had no reason to question his integrity or qualifications as a pulmonary specialist. (Tr. 38).

As to the degree of disability, Dr. Tuteur admitted that he did not recommend Petitioner be home bound and not capable of going to any type of work environment. Further, "I strongly feel that for total global health, for persons with this condition, that some form of remunerative activity, as long as it is safe from a pulmonary stand point should be attempted". He then discussed the possibility of a work place home environment, environmental control, ventilation, etc. (Tr. 40-41).

In discussing potential irritants, such as perfume, Dr. Tuteur admitted that there was no evidence in the record as to Petitioner needing to seek additional treatment when he was allegedly exposure to any such triggers. (Tr. 46).

IV. IME Reports and Deposition Testimony of Dr. Hyers

Dr. Hyers is a board certified pulmonary specialist, who took an initial evaluation of Petitioner on 09/09/13. His diagnosis was asthma. He indicated that if the exposure on 09/04/13 in any way impacted the asthma, it was transient. He noted that the acute problems seem to have resolved by the time of a follow up with Dr. Roth at Illini Family Medicine within a couple of weeks thereafter. He did not feel Petitioner had sustained any permanent impairment as a result of the industrial exposure on 09/04/13.

An initial deposition of Dr. Hyers took place on 11/24/14. Therein, he reiterated his findings and conclusions that Petitioner had an acute exposure on 09/04/13, but had returned to baseline within several weeks thereafter, as documented in a follow up visit to Dr. Roth at Illini Family Medicine.

On cross-examination, Dr. Hyers noted Petitioner had a history of wheezing for 10 to 12 years prior to the exposure on 09/04/13. (Tr. 25-26). He disagreed with Dr. Tuteur as to the diagnosis of irritant induced asthma. He stated this diagnoses would be based on somebody who developed asthma without a prior history, noting Petitioner had a prior history of asthma. (Tr. 27).

Dr. Hyers went into background in terms of diagnosed asthma. He stated it is consistent with shortness of breath, chest tightness, coughing and wheezing here with a stethoscope. (Tr. 29). He also noted spirometry testing, though he was not aware Petitioner had any such testing prior to the initial exposure on 09/04/13. (Tr. 29).

Dr. Hyers noted the 01/21/13 report from Dr. Roth (prior to the initial exposure) with reference to medical problems to be addressed that date, including asthma. (Tr. 34).

Dr. Hyers also noted reference to a diagnosis of asthma as far back as to 02/16/09, including recurrent wheezing and cough. (Tr. 35).

In discussing references in Dr. Roth's records and diagnosis of bronchitis, Dr. Hyers noted that it is often a substitute from a general practitioner or non-specialist for asthma. (Tr. 43-44). Dr. Hyers admitted Petitioner would be susceptible to flare-ups of asthma, and medical treatment relating thereto. (Tr. 56).

Dr. Hyers testified that a prescription for Addair is typically for asthma or COPD – with no indication Petitioner had COPD. Further, that this was prescribed as far back as 11/23/05. (Tr. 64).

Dr. Hyers' initial deposition on 11/24/14 was soon after the subsequent exposure on 10/08/14, and he did not have sufficient information to reply to the impact of that event.

Thus, there was a second evaluation with Dr. Hyers on 12/08/14. That incorporated a history of the subsequent event on 10/08/14 and treatment with Dr. Tuteur thereafter. Dr. Hyers reiterated his previous opinion that Petitioner did not suffer from irritant induced asthma or irritant induced bronchoreactivity; rather, noting a history of asthma dating back over 10 years. He did not feel any exposure at Ameren would increase the risk of asthma attack more than any exposure away from the work place. He advised Petitioner had no permanent partial disability as the result of the exposures on 09/04/13 and/or 10/08/14. Further, that he did agree with Dr. Tuteur that Petitioner should take common sense precautions to avoid and mitigate exposure to fumes, smokes, molds, sense and other irritants, "this is advice that is appropriate for all asthmatics".

Dr. Hyers' supplemental deposition took place on 03/18/15.

Dr. Hyers testified that the subsequent visit on 12/08/14 there was an attempt at another spirometry. However, that Petitioner did not give a reproducible effort. He thought that was based on lack of effort. (Tr. 11). He noted everything else was normal with regard to the evaluation on 12/08/14, specifically, that Petitioner was in no distress, lung exam was normal, he moved about the office normally. (Tr. 11).

Dr. Hyers noted the Petitioner had pre-existing asthma, dating ten years prior to any claimed exposure at Ameren. He did not feel that any exposure at Ameren would be any more risky than his moving about in the general environment. He did not believe that Petitioner sustained any permanent partial disability as the result of either the exposure on 09/04/13 or 10/08/14. (Tr. 12-13).

Dr. Hyers noted that after the initial exposure of 09/04/13 and a visit at Dr. Roth/Illini Family Medicine a week or two later the findings had returned to baseline. Similarly, after the subsequent exposure on 10/08/14 and a return to Dr. Tuteur, within a couple of weeks, the findings had returned to baseline. (Tr. 16).

V. Surveillance

Surveillance on 08/30/14 revealed Petitioner to be in the area of a BBQ, also an individual smoking, with no apparent distress. He was able to move some bicycles out of the back of a pickup truck.

Subsequent surveillance over many years revealed Petitioner sometimes wearing a mask around at a gas station, sometimes not wearing a mask.

VI. Martin Upchurch/SEA Limited.

Mr. Upchurch is an engineer. He reviewed surveillance, identifying the different types of masks Petitioner was earning over the years. It is was his opinion that neither would have been protective of gas fumes or related odors.

VII. Vocational Assessment of June Blaine

June Blaine testified regardless of the causation, he was restricted in his job opportunities. She indicated that he would be employable, but at a reduced earnings, in the range of $10.00 to $12.00 per hour.

VIII. Stephen Dolan

Mr. Dolan examined the Petitioner at the request of his attorney. It was Mr. Dolan's opinion that Petitioner would be permanency and totally disabled as the result of his pulmonary condition.

FINDINGS OF FACT

It is found Petitioner has symptoms comparable with the diagnosis of asthma dating back to the late 1990's. Further, that there was several specific references to a potential diagnoses of asthma, along with inhaler prescribed on different dates prior to the exposures on 09/04/13 and 10/05/14.

At a follow up with Dr. Roth on 09/09/13 there was a reference to the exposure on 09/04/13, with acute symptoms.

At a follow up with Dr. Roth on 09/19/13 there was an essentially negative evaluation. On that date, diagnoses were cough and acute sinusitis. Petitioner was advised to avoid cigarette smoke.

At a time when Petitioner was claiming reactivity to different exposures and problems with exposures at work, surveillance revealed that he was capable of being outdoors, in the vicinity of a BBQ, in the vicinity of an individual smoking cigarettes, able to engage in exertional activity, all without apparent distress.

There was a subsequent exposure on 10/08/14. There was no objective testimony from Dr. Tuteur or otherwise as to Petitioner's clinical findings or symptoms having materially changed thereafter.

Dr. Tuteur did not have all records from Dr. Roth/Illini Family Medicine. Nevertheless he refuted any diagnosis of asthma prior to the 09/04/13 and 10/08/14, suggesting only a pulmonary specialist such as he would be capable of making that diagnoses.

Dr. Hyers evaluated Petitioner on two occasions, one after the initial exposure, and one after the subsequent exposure. He did review the records from Dr. Roth/Illini Family Medicine. He documented references to diagnosis of asthma and medications (Advair and Albuterol) prior to either exposure that would be consistent with a diagnosis of asthma.

Dr. Hyers testified credibly that shortly after both exposures, Petitioner's symptoms abated, at least with regard to objective findings.

Dr. Hyers did not dispute that Petitioner, having asthma, would be susceptible to further aggravations, as would be the case will all asthmatics. However, he did not feel that either exposure of 09/04/13 and 10/08/14 resulted in any permanent impact on Petitioner's underlying asthma.

It is found that Dr. Hyers' testimony is more compelling than that from Dr. Tuteur, given that Dr. Hyers had all relevant documentation and testified accordingly as to Petitioner's pre-existing asthma and symptoms in accord therewith; further with Dr. Hyers noting after both exposures, a relevantly prompt return to similar objective findings.

CONCLUSIONS OF LAW

It is found Petitioner sustained temporary aggravations of his pre-existing asthma via the exposures on 09/04/13 and 10/08/14.

It is noted at trial that Petitioner testified as to significant and permanent exacerbations after the initial exposure of 09/04/13 and the subsequent exposure of 10/08/14. However, his credibility is undermined by the fact that after what was alleged to the most significant event on 09/04/13, he returned to work within a couple of days thereafter. Further, at a time when he was claiming significant and unabated symptoms, he was found on surveillance to be quite active outdoors, exposed to multiple fumes, without any evident of impairment or difficulty relating thereto.

It is not disputed Petitioner has a significant condition of asthma. In fact, that is documented by references to asthma and symptoms compatible to asthma for more than 10 years prior to either claimed exposure.

Petitioner has the burden of proof on all issues, including medical causation.

It is found that Petitioner has only sustained his burden of proof in determining that there was a temporary aggregation of underlying asthma as the result of the exposures on 09/04/13 and 10/08/14; failing to meet his burden of proof as to any indication of permanent aggravation or permanent partial disability relating thereto in terms of the underlying asthma – rather, that any perceived progression of symptoms would be compatible with his ten plus year history of symptoms compatible with asthma.

All other issues are rendered moot.

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

David Kapanowski,

Petitioner,

vs. NO: 14 WC 21160

Village of Merrionette Park Police Department,

Respondent.

19IWCC0328

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by Petitioner herein and notice provided to all parties, the Commission, after considering the issues of accident, causal relationship, nature and extent of permanent disability and medical expenses and being advised of the facts and the law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof with further analysis and correction of clerical error.

Conclusions of Law

On the threshold issue of accident, the Commission affirms the Arbitrator's finding Petitioner failed to prove he sustained an accidental injury arising out of his employment on May 31, 2014. Petitioner bears the burden of establishing his injury arose out of and in the course of his employment. *Shafer v. Illinois Workers' Compensation Commission*, 2011 IL App (4th) 100505WC, ¶ 35. "In the course of" speaks to the time, place, and circumstances of the occurrence of the injury. *Caterpillar Tractor Co. v. Industrial Commission*, 129 Ill. 52, 57, 541 N.E.2d 665 (1989). "Arising out of" speaks to risk. "A risk is incidental to the employment where it belongs to or is connected with what an employee has to do in fulfilling his duties. [citation omitted]." *Id.* at 58.

19IWCC0328

A. In the Course of

Petitioner proved the fall occurred in the course of his employment with Respondent. Petitioner was on a sanctioned break during his normal work hours in a place he might reasonably be expected to be. See *Caterpillar Tractor Co. v. Industrial Commission*, 129 Ill. 52, 57, 541 N.E.2d 665 (1989). Moreover, during such break, Petitioner was on Respondent's premises engaging in incidental work activities. T. 16. Even such, Petitioner must prove his injury arose out of his employment.

B. Arising Out of

Petitioner failed to prove his injury arose out of his employment. As the Arbitrator noted: "There are three types of risk an employee might be exposed to, namely: 1) risks distinctly associated with the employment; 2) risks which are personal to the employee; and 3) 'neutral risks which have no particular employment or personal characteristics.' [citation omitted]." *Potenzo v. Illinois Workers' Compensation Commission*, 378 Ill. App. 3d 113, 116, 881 N.E.2d 523 (2007). Petitioner exposed himself to a personal risk when he chose to step off the paved sidewalk onto the grassy area. This matter is similar to the facts presented in both *Dodson v. Industrial Commission*, 308 Ill. App. 3d 572, 720 N.E.2d 275 (1999) and *Hanson v. Trinity Express Care*, 09 WC 7350- affirmed by appellate court in Rule 23 Order.

In *Dodson*, claimant after completing her shift fell en route to her car located in the employee parking lot. Claimant left the paved sidewalk instead opting to utilize a grassy slope due to the inclement weather. The Commission denied compensation benefits. In affirming the Commission's denial, the Appellate Court held claimant was in the course of her employment, but she failed to prove her injury arose out of her employment. In so holding, the Court found "an injury does not arise out of the employment where an employee voluntarily exposes himself or herself to an unnecessary personal danger solely for his own convenience. *Orsini, 117 Ill. 2d at 47.*" *Dodson* at 576.

In *Hanson*, claimant, a front desk clerk, arrived at work and realized she forgot her computer login credentials in her car. Claimant was en route to her car located in the employee parking lot when she deviated from the paved sidewalk onto a grassy area further negotiating a retaining wall to reach her vehicle. The Commission denied compensation benefits finding claimant failed to prove her injuries arose out of her employment as the risk encountered was a personal risk. The Appellate Court affirmed the Commission in a Rule 23 Order dated December 18, 2013.

As the claimants in both *Dodson* and *Hanson*, Petitioner chose to expose himself to an unnecessary risk purely for his own convenience. Petitioner testified he was en route to his squad car which was parked in the lot provided by Respondent. T. 14. Petitioner testified he decided to cut across a grass area to the north of the sidewalk. T. 18-19. Petitioner did so for his own convenience in order to access his squad car faster. T. 70. There was no evidence presented that such haste was necessitated by Petitioner's job duties. Petitioner testified a

sidewalk which was unobstructed was available for access to his squad car. T. 66-67. Detective Sergeant Cavazos confirmed an unobstructed paved sidewalk was available to Petitioner in order to access his squad car. T. 93. Petitioner was performing a voluntary act- stepping into the grass for his own personal convenience- a shorter route to his car. Petitioner chose to step into the grass. It is grass; by its nature it is uneven which is why Respondent provided a paved parking lot and paved sidewalks.

The Commission finds Petitioner's choice to use this short cut was personal in nature, designed to serve his own convenience and not the interests of his employer. Therefore, his claim is not compensable. See *Dodson v. Industrial Commission*, 308 Ill.App.3d 572, 720 N.E.2d 275 (1999).

The Commission corrects the clerical error on Page 7 to reflect the claimed date of accident of May 31, 2014. The Commission affirms and adopts the Arbitrator's Decision with this analysis and correction.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed on December 7, 2017 is clarified and corrected for the reasons stated herein and otherwise affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that since Petitioner failed to prove he sustained accidental injuries arising out of his employment on May 31, 2014, his claim for compensation and medical expenses is hereby denied.

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

DATED: JUN 27 2019
LEC/maw
o06/19/19
43

L. Elizabeth Coppoletti

Stephen J. Mathis

D. Douglas McCarthy

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

KAPANOWSKI, DAVID
Employee/Petitioner

Case# **14WC021160**

VLG OF MERRIONETTE PARK POLICE DEPT
Employer/Respondent

19IWCC0328

On 12/7/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.45% 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:

0290 KARCHMAR & STONE
ADAM T KARCHMAR
111 W WASHINGTON ST SUITE 1030
CHICAGO, IL 60602

0507 RUSIN & MACIOROWSKI LTD
KISA P STHANKIYA
10 S RIVERSIDE PLZ SUITE 1925
CHICAGO, IL 60606

STATE OF ILLINOIS)
)SS.
COUNTY OF COOK)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

David Kapanowski
Employee/Petitioner

Case # 14 WC 21160

v.

Village of Merrionette Park Police Department
Employer/Respondent

19IWCC0328

An *Application for Adjustment 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 David Kane, Arbitrator of the Commission, in the city of Chicago, on 10/26/17 and 11/28/17. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. [ ] Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?

B. [ ] Was there an employee-employer relationship?

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

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

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

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

G. [ ] What were Petitioner's earnings?

H. [ ] What was Petitioner's age at the time of the accident?

I. [ ] What was Petitioner's marital status at the time of the accident?

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

K. [x] What temporary benefits are in dispute?
[x] TPD [ ] Maintenance [x] TTD

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

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

N. [ ] Is Respondent due any credit?

O. [ ] Other ____________

FINDINGS

On 5-31-14, Respondent was operating under and subject to the provisions of the Act.

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

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

Timely notice of this accident was given to Respondent.

In the year preceding the injury, Petitioner earned $60,091.72; the average weekly wage was $1,155.61.

On the date of accident, Petitioner was 48 years of age, single, with 2 children under 18.

Petitioner has received all reasonable and necessary medical services.

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

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

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

ORDER

Petitioner did not sustain an accident that arose out of and in the course of employment.

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 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.

David A. Kane
Signature of arbitrator

December 7, 2017
Date

DEC 7 - 2017

I. FINDINGS OF FACTS

Petitioner testified that he worked part time as a police officer for the Merrionette Park Police Department ("Police Department") and full time for VCNA Prairie. (T.9) His job as a police officer included patrolling the Village, enforcing the ordinances of the Village, the laws of the State of Illinois and to see that no laws were broken. (T. 10)

On May 31, 2014, Petitioner reported to his job as a police officer at 6:00 am. (T. 11) He came into the station and talked to the shift that was coming off duty and they did not report anything of significance. (T. 11-12) He then went to get his patrol radio and vehicle inspection forms and roll call. (T. 11-12) After roll call, he went out and inspected his squad car. (T. 13) He testified that he then assumed mobile patrol by himself. (T. 13)

His squad car was parked in the rear of the station in an uncovered parking lot. (T. 14) The parking lot had a sign prohibiting the general public from parking in the lot. (T. 14)

Petitioner returned to the Police Department in the mid-morning from mobile patrol. (T. 15) He spoke to one of his sergeants and did a desk relief for the dispatcher. (T. 16)

He then exited through the rear door of the Police Department with Sergeant Murray. (T. 16) The door had a simplex locking unit with access to only members of the department. (T. 17) He testified that once you left the rear door, there was a sidewalk that led to the parking lot. (T. 18) There was a grassy area to the north and a stone area to the south. (T. 19) When he exited with Sergeant Murray, his squad car was facing the building to the north of where the sidewalk would end. (T. 18-19) He denied carrying anything at the time. (T. 59) He denied that he was answering a call over the radio. (T. 59) He took two to three steps on the sidewalk and then entered the grassy area to cut over to the driver's side of the squad car. (T. 19) He admitted that the path was a paved walkway. T. 65) He admitted that there was nothing obstructing his use of the paved walkway on the date of the incident. (T. 67) He admitted that the walkway is sloped into the parking lot. (T. 67) He admitted that there was no curb at the end of the walkways. (T. 67) Instead of using the walkway into the parking lot, petitioner admitted he took a shortcut. (T. 70) He testified that he then

proceeded to walk on the grass. (T. 19) He admitted he took the short cut so he could get to his squad car faster as a matter of convenience. (T. 70) He testified it was common practice to cut across to go to the north side. (T. 20) There were no signs posted telling people to stay off the grass. (T. 83) He had witnessed other colleagues of the police force taking the same path numerous times. (T. 83) He testified that he was neve reprimanded for taking a specific path. (T. 83)

Petitioner testified that as he was nearing the edge of the grass line and the beginning of the curb line, there was a dip in between the grass and the top of the curb line. (T. 23) He testified that Petitioner's Exhibit 1 were taken by him and depicted the dip in the curb line. (T. 24) The dip was 4.5 to 5 inches. (T. 24) He claimed that the photograph depicted an area of the grass that was brown because it was a common pathway that the officers took. (T. 28)

He claimed that as he was crossing the curb line, he tripped over the space in the curb. (T. 23) His left foot stubbed into the dip and caused his momentum to carry him over the curb line. (T. 26) He claimed that as he was trying to steady himself, his right ankle came down onto the curb and rolled underneath. (T. 26) However, upon further questioning he indicated that his left foot went into the dip and he couldn't remember what happened to his right foot. (T. 87) He never made it to his squad car. (T. 35)

He testified that he was wearing a police uniform at the time of the injury. (T. 29) He was wearing a ballistic bullet proof vest, keys, pens, note pads, radio (T. 29-31). He testified he was also wearing a utility belt with two extra magazines, a side arm, flashlight, handcuffs, keepers and ASP impact weapon. (T. 31-32) He was wearing tactical boots on the day of the accident. (T. 34) He testified that the only requirement for shoes is that they are black. (T. 68) He never attributed his fall to the shoes he was wearing. (T. 68) He estimated that all of his gear weighed approximately 20-26 pounds. (T. 34) He admitted that he didn't believe his uniform was the reason he fell but it could have contributed to the fall. (T. 69) He admitted he never reported this to any physician or put it on a Form 45. (T. 69) The first time he attributed his uniform to contributing to his fall was his testimony that day. (T. 69)

After the incident, petitioner testified that Sergeant Murray helped him into the radio room. (T. 35) He filled out an accident report that reflects the

cause of injury to be a curb. (PX9; T. 38) An ambulance came to the station and took petitioner to Metro South Hospital (T. 36-37) At Metro South, petitioner was given x-rays and pain medication. (T. 38)

Thereafter, he saw orthopedic specialist, Dr. DeBartolo. (T. 39) She diagnosed petitioner with a bad sprain and recommended physical therapy. (T. 40) He underwent physical therapy at ATI. (T. 40) Petitioner returned to work light duty at VCNA Prairie. (T. 41 and 44). He saw Dr. Leonard for a second opinion. (T. 41)

By July 14, 2104, Petitioner testified that he was released to return to work full duty. (T. 46)

By October 13, 2014, petitioner was released to maximum medical improvement by Dr. DeBartolo. (T. 48) Dr. DeBartolo had not recommended any further medical treatment. (T. 74) He had not recommended any medication, assistive devices or accommodations for petitioner's right ankle since October of 2014. (T. 75)

Petitioner testified that at the time of trial, he had returned back to work full duty since July of 2014 at Prairie Material in a heavy duty job as a truck driver. (T. 73) He admitted to working full duty as a police officer since July of 2014. (t. 74) He had not taken any time off of work due to his right ankle. (T. 74) He admitted that he was working available overtime since his work injury. (T. 75) Nonetheless, petitioner felt that every day there was some degree of pain. (T. 48-49) His ankle was permanently swollen and it throbbed. (T. 49) He testified he had issues with walking and that he really couldn't do as much as he used to without it really hurting. (T. 49)

Petitioner admitted that he had an injury prior to this injury date in the late 90s. (T. 50) On direct examination, he denied any other issues with his right foot until the May 2014 incident. (T. 50) On cross examination, after subsequent questioning he admitted that he had a right ankle injury in June of 2011. (T. 54) VCNA records reflect treatment for his right ankle from Jun 1, 2011 to June 10, 2011. (RX3)

He admitted a right ankle injury on October 27, 2003. (T. 58) He also didn't recall a July 18, 2013 right ankle sprain. (T. 57) Petitioner ultimately admitted that he had had treatment for his right ankle from 1997 to May 31, 2014. (T. 58)

Petitioner recalled giving a recorded statement on June 2, 2014 only three days after the incident. (T. 61; RX 9). He couldn't recall if this was before or after he went to take pictures with a ruler. (T. 62) He admitted that his memory was note as clear as it was three years before. (T. 63) He believed the recorded statement would be more clear than his testimony on the day of trial. (T. 63) The recorded statement indicates that "Petitioner didn't know how it happened. All I know is that when I stepped over the curb line, I—I went down. I felt my ankle roll under me. Like I said, I don't know if it was from a rock that may have been there. I don't know if it was from a rock that may have been there. I don't know if it was because I sat my foot down the wrong way. I really couldn't answer that." (RX9) Petitioner did not disagree that three years prior and only two days after the work injury, he had no idea how he actually tripped and fell. (T. 64)

Petitioner admitted he underwent an IME with Dr. Vinci. (T. 76) He admitted he was honest about his history and complaints. (T. 76)

Petitioner saw Dr. Samuel Vinci for an IME on November 25, 2014. . Petitioner reported that he rolled his right ankle while walking on patrol to his squad car. Upon examination, Dr. Vinci noted an unremarkable exam other than the right ankle had a slight increase when compared to the left. Dr. Vinci reviewed x-rays and noted old chronic changes that seemed to be consistent with injuries that pre-date petitioner's May 31, 2014 injury. He noted a pre-existing degenerative condition on the x-ray of the right ankle. He also noted coronation syndrome of flat footedness bilaterally. He also noted petitioner was obese weighing 260 pounds. He opined that petitioner's right foot condition was related to an ankle sprain that was currently totally resolved as a result of the May 31, 2014 work related accident. Further, Dr. Vinci noted that the petitioner reported good and bad days. He believed that the bad days were the result of the non work related diagnoses, including degenerative changes from old previous injuries, petitioner's biomechanics of flat footedness, which causes strain upon the ankle joint, and his obesity. Dr. Vinci opined that the medical records did not support that the May 31, 2014 work injury resulted in anything more significant than a simple ankle sprain which had resolved as expected by October 13, 2014 when petitioner was released to unrestricted work by his treating physician. Dr. Vinci opined that petitioner's medical care, after his supposed injury on May 31, 2014 was reasonable and necessary. He agreed with the MMI date of October 13, 2014. Dr. Vinci

performed a PPI rating and provided petitioner with a PPI rating of 0%. He opined that petitioner could continue to work full duty as a police officer without any restrictions as he had been doing prior to this examination.

Petitioner saw Dr. Vinci again for an IME on May 4, 2016. Petitioner reported to Dr. Vinci that his ongoing medical treatment is related back to his original injury that took place on May 31, 2014. Dr. Vinci noted that since the evaluation petitioner had treated with multiple medical providers.. Petitioner reported subjective complaints of ongoing discomfort in his foot. He pointed to the instep area both on the dorsal aspect and the lateral and medial aspects. He did not point to any difficulties in the ankle area. He was pointing to areas anatomically of the foot, dorsally, medially and laterally. Dr. Vinci noted that his clinical examination was no different than his last evaluation. Dr. Vinci opined that petitioner was status post ankle sprain of the right foot which had completely resolved. Petitioner was at MMI. Dr. Vinci continued to estimate MMI at October 13, 2014. Pre-existing degenerative changes were noted on the x-rays and well documented on multiple MRIs that were taken on August 12, 2014 and August 19, 2015. Petitioner had personal conditions including pronation syndrome of flat-footedness was bilateral and obesity. He noted that his review of the MRI films was consistent with the radiologist and Dr. DeBartolo. Dr. Vinci also noted that in November of 2014, when he last examined the petitioner, petitioner had no complaints regarding the right ankle. He was under no medication. He complained of no discomfort. Now petitioner is complaining of discomfort in his foot and not really his ankle. He pointed specifically, as noted in the body of the report, to his foot and not his ankle. This was important as petitioner was initially diagnosed with an ankle sprain.

Det. Sgt. Juan Cavazos

Detective Sergeant Juan Cavazos testified on behalf of the Respondent. (T. 91) He testified he had worked with the Village of Merrionette Park for 29 years. (T. 91) He was being paid his regular salary to appear to testify in court and was not coerced to testify. (T. 91) He worked with petitioner from time to time. (T. 91) He had a good professional relationship with the petitioner. (T. 100) He had no reason to think he was dishonest. (T. 100)

He testified that he was familiar with the parking lot with respect to the incident. (T. 91) The parking lot was not open to the general public. (T. 92)

He testified that there was paved walkway that leads from the police station to the parking lot. (T. 92) He testified that the walkway feeds into the parking lot which is an apron and there is a curb on each side. (T. 93) He testified that the paved path was made available by the Village to access the parking lot. (T. 93) He testified that people take shortcuts on each side of the path. (T. 94) This shortcut was for their own convenience. (T. 94) He testified that he had never told any colleague not to walk on the grass. (T. 101)

II. CONCLUSIONS OF LAW

In support of the Arbitrator's decision with respect to C (accident), the Arbitrator finds as follows:

The Arbitrator finds that petitioner did not meet their burden of proving that an accident arose out of and in the course of his employment. It is undisputed that petitioner's accident occurred in the course of his employment. He was walking back to his squad car after a break during his work day.

However, the Arbitrator finds that petitioner's injuries did not arise out of his employment.

The Arbitrator notes that in order for an injury to arise out of one's employment, the risk must be: (1) a risk to which the public is generally not exposed but that is peculiar to the employee's work, or (2) a risk to which the general public is exposed but the employee is exposed to a greater degree. A peculiar risk is one that is peculiar to a line of work and not common to other kinds of work. *Karastamatis v. Industrial Comm'n*, 306 Ill. App. 3d 206; 713 N.E. 2d 161 (1st Dist. 1999); *Orsini v. Industrial Comm'n*, 117 Ill. 2d 38; 509 N.E. 2d 1005 (1987). The case law establishes that an injury does not arise out of the employment where an employee voluntarily exposes himself to an unnecessary personal danger solely for his own convenience. *Dodson v. Industrial Comm'n*, 308 Ill.App.3d 572 , 720 N.E.2d, 241 Ill.Dec. 820 (5th Dist. 1999) Further, the Respondent's knowledge or failure to stop does not convert a personal risk into an employment risk. *Hatfill v. Industrial Comm'n*, 202 Ill.App.3d 547, 560 N.E.2d 369 (1990)

In the instant case, Petitioner testified that he the Village provided a paved walkway to access the parking lot that was sloped into the parking lot. He admitted that the paved walkway was unobstructed. He admitted he was not in a rush or responding to a call. Det. Sgt. Cavazos testified that this was the walkway provided by the Village to enter the parking lot. If he had taken this route, he would not have encountered a curb. He admitted that he was aware of the dip in the grass by the curb and that other officers took the route all the time. He admitted that instead of using the paved walkway, he took a shortcut through the grass and encountered the dip in the grass on the way to his squad car. He admitted that he took the shortcut for his own personal convenience. There was no benefit conferred on the Respondent by taking the shortcut. Petitioner's claim does not arise out of his employment. Petitioner's claim was a personal risk he assumed when he took a detour through the grass instead of the paved walkway. There is no increased risk to Petitioner.

Petitioner failed to prove that he sustained accidental injuries arising out of and in the course of his employment with Respondent on May 31, 2014. Petitioner's accident did not arise out of his employment. The Arbitrator finds that petitioner's injuries results from exposure to an increased personal risk. Therefore, after carefully reviewing all of the testimony, medical records and cases cited above, the Arbitrator finds that petitioner failed to meet his burden of proving he sustained accidental injuries which arose out of his employment with Respondent. Accordingly, petitioner's accident is not compensable. All claims for compensation are denied.

In support of the Arbitrator's decision with respect to F (causal connection), the Arbitrator finds as follows:

In light of the Arbitrator's finding that Petitioner failed to prove an accident arising out of his employment, the Arbitrator need not find that Petitioner sustained any condition causally connected to said alleged accident of November 3, 2012.

The Arbitrator further notes that petitioner sustained an ankle sprain that resolved as of October 13, 2014. Any treatment thereafter would be related to petitioner's personal ankle condition as opined by Dr. Vinci.

Due to the Arbitrator's findings on the issues of accident and causation, all other issues are rendered moot.

Therefore, compensation is hereby denied.

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

JOSE TORRES,

Petitioner,

vs. NO: 18 WC 6198

WASTE CONNECTIONS,

Respondent.

19IWCC0329

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

The Commission affirms and adopts the Decision of the Arbitrator in all respects except as to the award of temporary partial disability.

The parties completed the Request for Hearing form prior to the start of the June 18, 2018 hearing. The Petitioner alleged an entitlement to TPD benefits from January 4, 2018 through June 18, 2018. The Respondent disputed Petitioner's entitlement to said TPD benefits.

During the arbitration hearing, the Petitioner testified that he presented to Physicians Immediate Care following the undisputed January 4, 2018 work accident and was given work restrictions. He then presented said restrictions to the general manager and was informed that light

duty work was not available. Petitioner has not worked since the accident date.

The Arbitrator awarded Petitioner TPD benefits from January 4, 2018 through June 18, 2018 as the Respondent did not accommodate Petitioner's light duty work restrictions.

Section 8(a) provides, in relevant part: when the employee is working light duty on a part-time basis or full-time basis and earns less than he or she would be earning if employed in the full capacity of the job or jobs, then the employee shall be entitled to temporary partial disability benefits. *820 ILCS 305/8(a)*.

The Commission notes that the Petitioner selected TPD and not TTD on the Request for Hearing form. Respondent disputed the issue of TPD. Respondent subsequently appealed the Arbitrator's Decision and wrote temporary partial disability on the Petition for Review. Section 19(b) provides, in part: "[t]he jurisdiction of the Commission to review the decision of the arbitrator shall not be limited to the exceptions stated in the Petition for Review." *820 ILCS 305/19(b)*. Further, Section 19(e) states: "If a petition for review and agreed statement of facts or transcript of evidence is filed *** the Commission shall promptly review the decision of the Arbitrator and all questions of law or fact which appear from the statement of facts or transcript of evidence." *820 ILCS 305/19(e)*.

The Commission finds that no stipulation existed between the parties as Respondent disputed the issue of TPD on the Request for Hearing. The evidence establishes that the Respondent was unable to accommodate the Petitioner's work restrictions resulting in Petitioner being temporarily and totally disabled, and not temporarily partially disabled, from January 4, 2018 through June 18, 2018.

An employee is temporarily totally incapacitated from the time an injury incapacitates him from work until such time as he is as far recovered or restored as the permanent character of injury will permit. *Archer Daniels Midland Co. v. Industrial Comm'n*, 138 Ill. 2d 107 (1990); *Shafer v. Illinois Workers' Compensation Comm'n*, 2011 IL App (4th) 100505WC. To be entitled to TTD benefits, it is the claimant's burden to prove not only that he did not work but also that he was unable to work. *Shafer*, 2011 IL App (4th) 100505WC, ¶ 45.

As the Commission is tasked with reviewing all questions of law or fact which appear from the statement of facts or transcript of evidence, the Commission finds that Petitioner was unable to work in any capacity following the work-related accident. Therefore, the Commission modifies the Decision of the Arbitrator and finds that the Petitioner is entitled to TTD benefits from January 4, 2018 through June 18, 2018.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed August 22, 2018, is hereby modified as stated above, and otherwise affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay to the Petitioner the sum of $733.37 per week for a period of 23-5/7 weeks, January 4, 2018 through June 18, 2018, that being the period of temporary total incapacity for work under §8(b), and that as

provided in §19(b) of the Act, this award in no instance shall be a bar to a further hearing and determination of a further amount of temporary total compensation or of compensation for permanent disability, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $8,873.14 for medical expenses under §8(a) of the Act, and subject to the medical fee schedule.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay for Petitioner's bilateral EMG.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall continue to pay for Petitioner's reasonable and necessary medical services, as provided in Section 8(a) 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 this case be remanded to the Arbitrator for further proceedings consistent with this Decision, but only after the latter of expiration of the time for filing a written request for Summons to the Circuit Court has expired without the filing of such a written request, or after the time of completion of any judicial proceedings, if such a written request has been filed.

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $24,300.00. 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: JUN 27 2019

Douglas McCarthy

DDM/tdm
O: 6/19/19
052

L. Elizabeth Coppoletti

Stephen Mathis

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

TORRES, JOSE
Employee/Petitioner

Case# **18WC006198**

WASTE CONNECTIONS
Employer/Respondent

19IWCC0329

On 8/22/2018, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 2.18% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

5888 LAW OFFICE OF ADRIAN MURATI
6090 STRATHMOOR DR
ROCKFORD, IL 61107

1120 BRADY CONNOLLY & MASUDA PC
MARK VIZZA
10 S LASALLE ST SUITE 900
CHICAGO, IL 60603

STATE OF ILLINOIS)

COUNTY OF LAKE)

19IWCC0329

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

JOSE TORRES
Employee/Petitioner

Case # **2018 WC 006198**

v.

Consolidated cases: **N/A**

WASTE CONNECTIONS
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 A. Jessica Hegarty**, Arbitrator of the Commission, in the city of **Waukegan**, on **June 18, 2018**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below and attaches those findings to this document.

DISPUTED ISSUES

A. [ ] Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?

B. [ ] Was there an employee-employer relationship?

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

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

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

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

G. [ ] What were Petitioner's earnings?

H. [ ] What was Petitioner's age at the time of the accident?

I. [ ] What was Petitioner's marital status at the time of the accident?

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

K. [x] Is Petitioner entitled to any prospective medical care?

L. [x] What temporary benefits are in dispute?
[x] TPD [ ] Maintenance [ ] TTD

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

N. [ ] Is Respondent due any credit?

O. [ ] Other **Prospective Medical Care**

19IWCC0329

FINDINGS

On the date of accident, **Januay 4, 2018**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

On this date, 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 **$57,200**; the average weekly wage was **$1,100**.

On the date of accident, Petitioner was **36** 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** 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 **$2,110.77** under Section 8(j) of the Act.

ORDER

Respondent shall pay reasonable and necessary medical services of $8,873.14, as provided in Section 8(a) of the Act.

Respondent shall pay for Petitioner's Bilateral EMG.

Respondent shall continue to pay for Petitioner's reasonable and necessary medical services, as provided in Section 8(a) of the Act.

Respondent shall pay Petitioner temporary partial disability benefits of $733.37/week for 23.5 weeks, commencing 01/04/2018 through 06/18/2018, as provided in Section 8(a) of the Act.

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

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

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

Signature of Arbitrator

8/17/18
Date

ICArbDec19(b)

AUG 2 2 2018

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

JOSE TORRES
Employee/Petitioner

v. Case # **2018 WC 6198**

WASTE CONNECTIONS
Employer/Respondent

ADDENDUM TO THE DECISION OF THE ARBITRATOR FINDINGS OF FACT

The parties stipulated that Petitioner sustained accidental injuries that arose out of and in the course of his employment with Respondent on January 4, 2018 when he was 36 years old. (Arb. 1). Petitioner had been employed by Respondent for three years, ten months as a trash hauler/truck driver.

Respondent disputes causal connection, medical bills and Petitioner's entitlement to prospective medical care in the form of an EMG exam. (Id.).

Regarding the accident, Petitioner testified he was tossing the contents of a recycle bin into his truck when he felt pain in his shoulder. Petitioner reported the accident to Respondent and presented to Physicians Immediate Care reporting the sudden onset of sharp right shoulder pain accompanied by numbness in his middle, ring and little fingers after lifting a container of empty bottles. (PX 2). He was diagnosed with a right shoulder joint sprain and restricted from work involving the use of his right arm. (Id.).

Petitioner testified when he advised his general manager about the aforementioned work restrictions he was told he could not return to work unless he was 100% .

On January 16, 2018 Petitioner followed-up at Physicians Immediate Care where he reported shooting right shoulder pain with numbness in his middle, ring and little fingers. (Id.). Dr. Terry Buzzard diagnosed a right rotator cuff capsule sprain, ordered a right shoulder MRI, continued the prior work restrictions and advised Petitioner to follow-up on January 22, 2018. (Id.).

A right shoulder MRI without contrast performed on January 30, 2018 at Forest City Diagnostic Imaging noted rotator cuff tendinosis with mild AC joint degenerative changes. (Id.).

Petitioner followed up at Physicians Immediate Care on February 5, 2018 at which time he reported persistent right shoulder pain at a 7/10 with intermittent tingling in his fingers. (Id.). He further complained of tightness in his shoulder and neck. Dr. Buzzard reviewed the recent MRI noting "RTC tendinosis of supra and infraspinatus". (Id.). The doctor noted that physical therapy was still pending approval by Respondent's carrier. Mobic and Cyclobenzaprine was dispensed to Petitioner and his prior wok restrictions were continued

On February 8, 2018, Petitioner presented for initial consult with Dr. Michael Birman at Hand to Shoulder Associates on referral from Dr. Buzzard. (PX 4). Dr. Birman noted a history of a work-related accident 4½ weeks prior when Petitioner grabbed a 32 gallon can that was particularly heavy following the recent New Year's holiday. Petitioner reported lifting the can with both hands, his right arm raised higher overhead when

he felt immediate pain at the right shoulder followed by numbness and tingling in the fingers. Since the accident, Petitioner noted persistent right shoulder pain with occasional numbness and tingling in his middle, ring and small fingers worsened when his right arm hangs at his side. Petitioner has been unable to work in the interim due to restrictions. (Id.). Dr. Birman noted the prior right shoulder MRI was relatively unremarkable except for some mild rotator cuff tendinitis. For diagnostic and therapeutic purposes, a steroid injection was administered. (Id.). Physical therapy was ordered and work restrictions of no overhead lifting were noted. Petitioner reportedly had not been offered light duty work. (Id.).

On March 9, 2018 Dr. Birman noted Petitioner's report that his symptoms remained unchanged following the prior steroid injection. (Id.). Petitioner complained that physical therapy worsened his numbness and tingling in his right upper extremity. Dr. Birman noted some focal tenderness and findings at the shoulder which could correlate with the MRI finding of right rotator cuff tendinitis. The doctor further noted increasing concern that Petitioner's primary symptoms may originate at the cervical spine. (Id.). The doctor noted no definite surgical indication to the right shoulder after again reviewing the MRI. Dr. Birman anticipated referring Petitioner for a neurosurgery consult if significant findings were noted on the pending cervical MRI. If no such findings occurred, the doctor anticipated aiming toward further nonoperative treatment to address Petitioner's symptoms. (Id.).

MRI of Petitioner's cervical spine was performed on March 14, 2018 which was negative.

On March 17, 2018 Dr. Birman noted Petitioner's complaints of persistent right upper extremity pain with intermittent numbness and tingling into the ulnar hand and fingers. (Id.). Dr. Birman reviewed the recent cervical MRI noting no significant findings. Petitioner voiced his frustration with his persistent right arm symptoms which had not changed significantly since their onset. (Id.). Dr. Birman noted concern with the extent of radiating pain and numbness and tingling in the right upper extremity. The doctor further noted, in light of some focal symptoms localized to the right shoulder, continued non-operative treatment was being recommended.

On April 26, 2018 Dr. Birman testified via evidence deposition consistent with his medical records documenting Petitioner's treatment through March 17, 2018. (PX 5). Dr. Birman testified that Petitioner next presented on April 12, 2018 with persistent right upper extremity complaints. (Id., pp. 22). Petitoner further reported that his physical therapy sessions were accompanied by spasms, pain, tingling and numbness. (Id., pp. 23). In light of Petitioner's persistent complaints along with some focal findings at the shoulder, surgery was discussed. The doctor was concerned with the extent of numbness and tingling reported which would not typically be attributed to rotator cuff tendinitis. (Id.). As a result, the doctor ordered electrodiagnostic studies before determining Petitioner's treatment plan. (Id., pp. 23-24). Dr. Birman held therapy pending further evaluation and continued Petitioner's work restrictions. (Id., pp.24). The doctor testified that as of Petitioner's last appointment on April 26, 2018, the recommended EMG was still pending approval by Respondent's carrier. (Id. pp. 25). Dr. Birman opined that Petitioner's work activities at the time of his accident, more likely than not, are related to his right upper extremity injury (Id. pp. 27). He further opined that Petitioner's work duties could have been a factor in aggravating Petitioners rotator cuff tendinitis. (Id. pp. 28).

CONCLUSIONS OF LAW

Petitioner's current condition of ill-being is causally related to the uncontested work-related accident at issue

Based on a preponderance of the evidence contained in the record, the Arbitrator finds Petitioner's current condition of ill-being is related to the uncontested accident at issue.

The Arbitrator notes the following in support:

1. Petitioner's testimony at the hearing concerning the work-related accident and his subsequent right upper extremity complaints and treatment is uncontradicted and corroborated by the treating medical records in evidence;

2. There is no evidence that Petitioner had any right upper extremity complaints or treatment prior to the uncontested accident at issue.

3. The right shoulder MRI performed on January 30, 2018 noted rotator cuff tendinosis with mild AC joint degenerative changes. (Id.).

4. Dr. Birman's credible testimony.

Petitioner is entitled to temporary partial disability payments

The Arbitrator bases this finding on the records contained in evidence noting the following:

On the accident date, Dr. Buzzard at Physicians Immediate Care issued work restrictions of "left-handed duty only". On February 8, 2018, Petitioner presented for initial consult with Dr. Michael Birman at Hand to Shoulder Associates at which time Dr. Birman ordered work restrictions of no overhead lifting. Dr. Birman noted Petitioner's report that he had not been offered light duty work. Dr. Birman's medical records and his testimony indicate the aforementioned restrictions were continued as of Petitioner's last appointment in April of 2018. The Arbitrator further notes Repsondent's IME physician agreed with Petitioner's work resticrions as of February 22, 2018. Lastly, Petitioner credibly testified when he advised his general manager about the aforementioned work restrictions he was told he could not return to work unless he was 100% .

Based on the credible evidence contained in the record, the Arbitrator finds that Petitioner is entitled to TPD benefits from January 4, 2018 until the date of the arbitration hearing, June 18, 2018.

The medical services provided to the Petitioner were reasonable and necessary

The Arbitrator finds that the Petitioner is entitled to medical expenses in the amount of $8,873.14 as provided in Section 8(a) and 8.2 of the Act. The Respondent is entitled to credit for $2,110.77 paid under Section 8(j) of the Act. The Arbitrator finds that the medical bills submitted into evidence by the Petitioner as part of Petitioner's Exhibit 2, Exhibit 3, and Exhibit 4 are the responsibility of the Respondent and payable pursuant to the Illinois Fee Schedule.

Penalties or fees

The Petitioner's petition for penalties and attorneys' fees is hereby denied as no evidence was presented concerning this issue.

Prospective medical care

The Arbitrator has found that Petitioner's current condition of ill-being is causally related to the uncontested accident at issue. Based on the credible evidence contained in the record, including the treating records and testimony of Petitioner's treating phsyican, Dr. Birman, the Arbitrator finds Petitioner is entitled to prospective medical treatment consistent with Dr. Birman's recommendation for EMG testing.

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

Wade Chan,
Petitioner,

vs.

NO: 14WC 20069

City of Chicago ,
Respondent.

19IWCC0330

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, benefit rates, medical expenses, notice, penalties, fees, permanent disability, temporary total disability, causal connection, motion to reopen proofs and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed September 26, 2018, 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: JUN 27 2019

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DDM/jrc
052

Douglas McCarthy

L. Elizabeth Coppoletti

Stephen Mathis

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

CHAN, WADE
Employee/Petitioner

Case# **14WC020069**

CITY OF CHICAGO
Employer/Respondent

19IWCC0330

On 9/26/2018, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 2.32% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0786 BRUSTIN & LUNDBLAD LTD
CHARLES E WEBSTER
10 N DEARBORN ST 7TH FL
CHICAGO, IL 60602

0766 HENNESSY & ROACH PC
ERICA A LEVIN
140 S DEARBORN ST 7TH FL
CHICAGO, IL 60603

19IWCC0330

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

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Wade Chan
Employee/Petitioner

Case # **14** WC **20069**

v.

Consolidated cases: **D/N/A**

City of Chicago
Employer/Respondent

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Molly Mason**, Arbitrator of the Commission, in the city of **Chicago**, on **August 17, 2018**. Proofs were closed on said date. Petitioner filed an Emergency Motion to Re-Open Proofs on August 21, 2018. The Arbitrator denied this motion on September 17, 2018, after conducting a hearing. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below and attaches those findings to this document.

DISPUTED ISSUES

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. [x] What were Petitioner's earnings?
H. [ ] What was Petitioner's age at the time of the accident?
I. [ ] What was Petitioner's marital status at the time of the accident?
J. [x] Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. [x] What temporary benefits are in dispute?
[ ] TPD [ ] Maintenance [x] TTD
L. [x] What is the nature and extent of the injury?
M. [x] Should penalties or fees be imposed upon Respondent?
N. [ ] Is Respondent due any credit?
O. [ ] Other _____

FINDINGS

On **September 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.

For the reasons set forth in the attached decision, the Arbitrator finds Petitioner lacked credibility and failed to meet his burden of proof on the issues of accident and notice. The Arbitrator views the remaining disputed issues as moot and makes no findings as to those issues.

On the date of accident, Petitioner was **43** years of age, ***married*** with **3** dependent children.

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

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

ORDER

For the reasons set forth in the attached decision, the Arbitrator finds that Petitioner lacked credibility and failed to meet his burden of proof on the issues of accident and notice. The Arbitrator views the remaining disputed issues as moot and makes no findings as to those issues. Compensation is denied.

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

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

Molly C Mason

Signature of Arbitrator

9/26/18

Date

SEP 26 2018

Wade Chan v. City of Chicago
14 WC 20069

Summary of Disputed Issues/Denial of Petitioner's Emergency Motion to Re-Open Proofs

Petitioner worked in Respondent's office of special projects and events between 2011 and his termination in 2013. On June 23, 2014, he filed an Application for Adjustment of Claim alleging a work accident of September 21, 2011. He testified the accident occurred when he lifted a box of work equipment out of the trunk of his car.

At the August 17, 2018, hearing, the parties placed the following issues in dispute: accident, notice, causal connection, earnings (with Petitioner claiming an average weekly wage of $1,000), medical expenses, temporary total disability between Petitioner's August 23, 2013 termination and June 24, 2014, nature and extent and penalties/fees. Arb Exh 1. Petitioner did not testify to his earnings. He offered into evidence joint tax returns for the years 2012 through 2014. PX 20.

Petitioner's counsel filed an emergency motion to re-open proofs (Arb Exh 1) on August 21, 2018. The Arbitrator conducted a hearing on this motion on September 17, 2018. A record was made. Respondent raised an objection, correctly noting that wage was clearly a matter of dispute at the August 17, 2018 hearing, that Petitioner agreed to close proofs at the conclusion of that hearing and that the evidence Petitioner now wanted to present was available years earlier. The Arbitrator denied the motion to re-open proofs but, in anticipation of a review, allowed Petitioner to testify for the purpose of identifying several wage-related documents, including two W2 forms. The Arbitrator marked these documents (PX 21-24) as rejected exhibits.

Arbitrator's Findings of Fact

Petitioner testified he was born on February 1, 1968. He holds a bachelor's degree and was one class short of obtaining his master's.

Petitioner testified he started working in Respondent's City Clerk office on May 17, 2011. His job title was assistant director of special projects and events. His supervisor was Ed Kantor, Deputy City Clerk.

Petitioner testified he worked in City Hall between his hire date and July 2011, helping with lines of people who were applying for city stickers. After the application period ended, he started traveling to various public schools and senior homes to help students and senior citizens obtain photo I.D.s. He drove his own car to the schools and senior homes. His office provided him with a box so that he could transport the equipment and supplies he needed, including a laptop computer, a printer, a camera, I.D. film and cards. Petitioner testified the box was oddly shaped. It weighed between 20 and 27 pounds when full.

Petitioner testified his health was "pretty good" before his accident of September 21, 2011. On that date, he drove to a church or town hall to help senior citizens obtain I.D. cards. The building was on East 111th, near the Indiana border. He was working alone. As he reached into the trunk of his car to remove the box, he felt a "twinge" in his right shoulder and neck. He testified he never felt a twinge like this before. He finished the workday despite the accident because the building was in a remote area and there was no one to substitute for him.

19IWCC0330

Petitioner testified he mentioned the accident to Ed Kantor "in passing" in the men's restroom.

Petitioner offered into evidence, with no objection from Respondent, an affidavit signed by Edmund Kantor on February 26, 2016. The affidavit was filed in connection with a retaliatory discharge action Petitioner filed against Respondent in the Circuit Court of Cook County. In the affidavit, Kantor attested he served as Respondent's Deputy City Clerk from June 16, 2004 to October 19, 2012, with his duties including selling vehicle stickers and administering "kids' ID and medical ID programs." He further attested he met Petitioner after Petitioner began working in the City Clerk's office but "did not directly supervise" Petitioner. He recalled one conversation with Petitioner "which took place at the end of the workday in the men's washroom during city vehicle sticker season in 2011 or 2012." He indicated that, during this conversation, Petitioner told him he "wrenched his back while lifting office equipment." He went on to say that he advised Petitioner to speak with Loretta Flores that evening or the next day about completing an "injury on duty report" with Petitioner responding that he "would wait a few days to see if his back got better." Kantor indicated he did not inform any employee of the City Clerk's office of this conversation. He also indicated he had no personal knowledge concerning Petitioner's termination from that office. PX 14.

Petitioner testified that, a week or so after the accident, he saw his personal care physician, Dr. Lawler, with this physician referring him to a specialist, Dr. Heller. Petitioner further testified he saw Dr. Heller on October 10, 2011 and complained of his neck. He indicated that Dr. Heller injected his left elbow due to tingling in his left arm, prescribed physical therapy and referred him to Dr. Fisher.

Records in PX 5 reflect Petitioner saw Dr. Lawler on September 30, 2011 for a "re-check" due to bilateral arm tingling. The doctor noted that Petitioner "had lat[eral] epicond[ylitis] on left" and was now experiencing somewhat different right-sided symptoms radiating up to his shoulder. The note contains no mention of work activities or a work accident. The doctor recommended that Petitioner see an orthopedic specialist for a steroid injection. PX 5.

Records in PX 3 reflect Petitioner saw Dr. Heller of Midland Orthopedics on October 10, 2011. The records include a completed medical history form which appears to bear Petitioner's signature. The form is dated October 10, 2011. On the form, Petitioner identified Dr. Lawler as the referring physician. He described his problem as follows:

> "left elbow has sharp pains – physician diagnosis as tennis elbow.
> R arm has tingling sensation that runs up from my hand all the way
> up to my shoulder."

A section of the form asks for an explanation of how the problem happened. Petitioner responded as follows: "unknown." In another section, Petitioner identified June 2011 as the date of onset. In response to a question asking what makes the problem worsen, Petitioner wrote: "just happens out of the blue." PX 3.

Dr. Heller's narrative note of October 10, 2011 documents complaints of left elbow pain with all everyday activities as well as occasional right periscapular pain and paresthesias radiating to the hand. The doctor described Petitioner as working in a sedentary capacity. He indicated that Petitioner "denies any recent trauma." The note contains no mention of an accident or lifting-related event. After examining Petitioner and obtaining cervical spine X-rays, Dr. Heller diagnosed left elbow lateral

epicondylitis and mild radiculopathy of the cervical spine. He injected the left elbow and provided Petitioner with a wrist brace. He prescribed therapy for the cervical spine problem and indicated Petitioner should see a spinal specialist if his problems persisted. PX 3.

Petitioner underwent an initial physical therapy evaluation at Mercy Hospital on October 26, 2011. The evaluating therapist recorded the following history:

> "Pt attempted to lift a suitcase about 1.5 months ago and since then he is feeling pain in neck and rt. arm. Pt feels occasional pins and needles. Pain is on and off. He feels twinges in outer side (radial side) of arm. Certain neck movements increase symptoms."

Physical therapy notes from November 8 and 10, 2011 indicate Petitioner was "not satisfied" with the services he was receiving and "felt he is still doing the same thing he was doing for his neck 5 years ago." PX 10.

Petitioner returned to Dr. Lawler on January 5, 2012 "for a re-check L elbow pain and R shoulder X-ray results." The doctor noted that Petitioner was "very upset" with the physical therapy he underwent. On examination, the doctor noted forearm tenderness consistent with epicondylitis and a decreased range of lateral neck motion with some tenderness in the trapezius paraspinal area. He recommended that Petitioner see Dr. Slack for his neck and return to Dr. Heller for his elbow. PX 5.

Petitioner returned to Dr. Heller on January 9, 2012, with the doctor noting that the injection provided two months of left elbow relief. The doctor also noted that Petitioner was seeing Dr. Fisher and undergoing therapy for his neck but remained symptomatic. The doctor administered another left elbow injection and advised Petitioner to use the brace. PX 3.

Petitioner saw Dr. Fisher, an orthopedic surgeon, on January 23, 2012, with the doctor recording the following history:

> "Mr. Chan reports neck pain and bilateral trapezius pain, right side greater than left, without specific inciting event although he has a new job with more computer work and believes it was aggravated when he lifted a suitcase."

On initial examination, Dr. Fisher noted tenderness over the paraspinal muscles from C6 to the trapezius muscle, left side greater than right. He also noted a full range of cervical spine motion with pain with extremes of range of motion. He documented negative Spurling's bilaterally and negative Lhermitte. He interpreted the October 11, 2012 cervical spine X-rays as showing small posterior osteophytes at several levels and no evidence of spondylolisthesis, fracture or tumor. He diagnosed cervicalgia. He recommended a cervical spine MRI, non-steroidal anti-inflammatory medication and home exercises. PX 12.

The cervical spine MRI, performed without contrast on February 13, 2012, showed a right paracentral herniation at C5-C6, a broad-based right paracentral disc protrusion at C4-C5 and a small central disc protrusion at C6-C7. PX 12.

Petitioner returned to Dr. Fisher on March 19, 2012, with the doctor recording the following interval history:

> "Mr. Chan returns to my office today with continued complaints of right-sided neck pain, right trapezius pain, and right scapular pain. He has had an MRI scan of his cervical spine since his last visit. Aggravating factors include activity while alleviating factors include traction, medications and exercises. He denies any left upper extremity symptoms with the exception of previous forearm pain that he attributes to carrying his daughter, which was improved after the injection near the elbow and wrist. He denies any lower extremity symptoms or bowel or bladder dysfunction. He denies any constitutional symptoms. He believes his pain started approximately three months ago when he was lifting a machine out of his trunk for work and felt pain in that area."

After re-examining Petitioner and viewing the MRI, Dr. Fisher prescribed Flexeril and home exercises. He also recommended an epidural steroid injection. He did not comment on work status. PX 12.

Petitioner testified he saw Dr. Cupic thereafter, with the doctor administering three cervical epidural steroid injections. Petitioner testified these injections provided only temporary relief.

Petitioner saw Dr. Heller again on May 15, 2012. The doctor noted ongoing left elbow complaints. He administered a third injection and directed Petitioner to use the wrist brace. He indicated Petitioner might eventually need surgery for the epicondylitis. PX 3.

Petitioner went to the Emergency Room at Mercy Hospital on June 13, 2013. Hospital personnel recorded a complaint of left upper extremity tingling at work at 3:45 PM that day. They noted a history of a cervical disc herniation with radiculopathy on the right. They described Petitioner as denying injury, heavy lifting or repetitive stress. An EKG showed no significant changes from an EKG performed in March 2012. Cervical spine X-rays showed mild narrowing of the C5-C6 intervertebral disc space with mild osteophytes. The Emergency Room physician prescribed Motrin, Flexeril and Tylenol with Codeine and directed Petitioner to follow up with Dr. Lawler. PX 10.

Petitioner returned to Dr. Fisher on July 18, 2013 and reported "significant exacerbation of his pain symptoms with numbness extending down the left upper extremity to all fingers." He also reported improvement following the injections "until June 2013." The doctor interpreted the recent repeat MRI as showing an increase in the size of the herniation at C5-C6 compared with the MRI performed in 2012. He recommended a C5-C6 anterior cervical discectomy and fusion along with cervical spine X-rays. PX 12.

On August 21, 2013, Petitioner underwent a thyroid-related procedure.

Petitioner testified that Respondent fired him on August 23, 2013, at which point he was still under treatment and subject to restrictions per Dr. Fisher. He lost his health insurance when he was fired. He used his wife's coverage to get neck surgery at UIC. Dr. Engelhard performed this surgery on November 7, 2013, following a repeat MRI.

Petitioner first saw Dr. Engelhard on October 9, 2013. In his note of that date, the doctor described Petitioner as a "45-year-old gentleman who started having problems in September 2011. He was lifting his work suitcase out of a trunk and started having neck and shoulder pain." The doctor indicated he reviewed two MRIs and various treatment records. He interpreted the most recent MRI of July 2, 2013 as showing a large herniated disc at C5-C6 with compression of the spinal cord more on the right side and effacement of the nerve root." He recommended an anterior cervical discectomy and fusion. PX 1, pp. 253-254 of 572.

Dr. Engelhard performed the recommended discectomy and fusion at UIC on November 7, 2013.

Petitioner underwent an initial physical therapy evaluation at UIC on November 8, 2013. The therapist noted that the fusion was performed "for ongoing sh/neck pain since 2011 from lifting heavy object." PX 1, p. 298 of 572.

On December 18, 2013, Dr. Engelhard noted that Petitioner was doing "extremely well" and was no longer experiencing any neck or arm symptoms. He indicated that Petitioner was still wearing a soft cervical collar and was not yet ready to return to work. He recommended range of motion exercises. PX 1, p. 245 of 572.

Petitioner returned to Dr. Engelhard on March 25, 2014 and complained of some numbness and pain running down his left arm. Petitioner requested an MRI and the doctor agreed. Petitioner returned to the doctor on April 17, 2014, following the MRI. The doctor described the MRI as negative. He also described Petitioner's neurological examination as negative. He noted that Petitioner was having issues with "anxiety, sweating and neck and chest pain." He discussed symptom management with Petitioner. PX 1, p. 240 of 572. A repeat EMG performed on May 14, 2014 was negative. PX 1, pp. 120-123 of 572.

On September 17, 2014, Petitioner saw several neurologists at UIC. Petitioner complained of left arm tingling, starting in the palm of his left hand, and right shoulder pain when typing. The doctors recommended a repeat EMG and started Petitioner on Gabapentin. They noted a high probability of Petitioner's symptoms being anxiety-related. PX 1, p. 236 of 572. A repeat EMG performed on September 29, 2014 was normal. PX 1, pp. 116-119. On November 7, 2014, neurologists at the clinic noted ongoing left-sided symptoms. They indicated these symptoms were "likely related to cervical irritation." They increased the Gabapentin dosage and prescribed a brain MRI to look for a possible thalamic lesion. PX 1, pp. 233-234 of 572. Petitioner returned to the neurology clinic on April 29, 2015 and complained of left leg as well as left arm symptoms. The doctors noted that all of the objective testing, including a recent brain MRI, was negative. They adjusted the Gabapentin dosage and recommended physical therapy, acupuncture and stress and anxiety control. PX 1, pp. 230-231.

Petitioner testified that Dr. Engelhard released him to work within four to six months of the surgery. He started a new job at an alderman's office about ten months after Respondent fired him. The job consisted of responding to telephone inquiries and typing. He experienced neck pain due to the constant sitting and typing.

Petitioner testified he saw Dr. Rhode at the request of his attorney. Dr. Rhode, a fellowship-trained orthopedic surgeon, examined Petitioner on March 28, 2017. In his report of the same date, he recorded a history of the claimed work accident and subsequent treatment. On examination, he noted a

left-sided cervical scar consistent with an anterior cervical discectomy with fusion, pain over the paraspinous muscle, a limited range of neck motion and positive Spurling's testing on the right. He found Petitioner to be at maximum medical improvement but indicated he might require physical therapy in the future. He provided an AMA Guides impairment rating of 10% of the whole person. PX 15-16.

Dr. Engelhard testified by way of evidence deposition on March 15, 2018. PX 19. Dr. Engelhard testified he obtained board certification in neurosurgery in 1992. He is affiliated with the University of Illinois Hospital and teaches residents there. PX 19, p. 5. He has operated on about 3,000 discs, performing about 2800 operations total, in his career. PX 19, p. 6.

Dr. Engelhard testified he first saw Petitioner on October 9, 2013. Petitioner indicated his neck and arm problems started in September 2011, when he lifted a work suitcase out of a trunk. Petitioner presented him with multiple records and a July 2, 2013 cervical spine MRI. PX 19, pp. 6-7. Petitioner told him his pain was intermittent but could be quite severe.

Dr. Engelhard testified his initial examination revealed right-sided neck pain radiating in the direction of the thumb, slight weakness of the right biceps, a decreased reflex in the right biceps and no left-sided problems. PX 19, p. 8. He interpreted the MRI as showing a large herniated disc at C5-C6 with compression of the spinal cord more on the right side and a bulge at C3-C4. The MRI did not permit him to determine how old this pathology was. PX 19, p. 9. He opined that the pathology was "traumatic more than degenerative due to the absence of chronic changes." The C3-C4 bulge could have been of longstanding, since a spur had formed, but the C5-C6 disc had the "appearance of being more recent and more consistent with something more acute." PX 19, p. 9. There was no spurring at C5-C6. PX 19, p. 10. He recommended surgery, knowing that Petitioner had already undergone conservative care, including three injections. PX 19, p. 10. He performed an anterior cervical discectomy and fusion on November 7, 2013, removing the C5-C6 disc and inserting a cage, plate and screws. PX 19, p. 11. The surgery was successful. PX 19, p. 12. Petitioner did well postoperatively and made a "pretty typical recovery." PX 19, p. 13. On March 25, 2014, Petitioner reported some numbness and pain radiating down his left arm. He ordered an MRI which was negative. On April 17, 2014, he described Petitioner as having "mild left cervical radiculopathy." Right after the surgery, he placed Petitioner in a plastic collar but ultimately allowed him to resume all normal activities. PX 19, p. 15. Most likely, he would have released Petitioner to work by March 25, 2014. Preoperatively, he would have restricted Petitioner to refrain from any activities that aggravated his neck pain. With a patient such as Petitioner, who had a "significant large ruptured disc hitting [his] spinal cord," he is "pretty strict about restricting activities." PX 19, pp. 16-17. He does not specifically recall restricting Petitioner from office work before the surgery but, if Petitioner was having a lot of pain and could not function, he would support that. PX 19, p. 17.

Dr. Engelhard testified that reviewing an earlier MRI performed on February 17, 2012 "helped [him] to determine that the onset of the problem, namely the ruptured disc, was going back to September 2011." This MRI was performed within four months of the accident. PX 19, p. 18.

Dr. Engelhard testified he reviewed records from Drs. Lawler, Fisher and Heller, as well as records from Mercy Hospital, prior to the deposition. Those records influenced his thinking in that "the story is consistent with the problem beginning in September." With an event such as Petitioner described, radicular symptoms do not always start right away. The initial injury can be just to the outer annulus. As more of the inner nucleus comes out, or extrudes, and starts hitting the nerve root, pain

and numbness can start. The rupture of the inner nucleus is not necessarily immediate. PX 19, p. 20. Based on Petitioner's history, the September 2011 work accident brought about the need for the surgery he performed. The act of lifting a suitcase out of the trunk of a car can cause the type of disc herniation he saw on Petitioner's MRI, "especially if there is any sort of a twisting or jerking motion." PX 19, p. 20. Based on a reasonable degree of medical and surgical certainty, he believes the work accident caused the disc herniation. Pressure on the nerve root can cause neck pain but, characteristically, it is the radicular pain that goes down in the location Petitioner described, toward his thumb. "So it's the appropriate dermatome, namely C6, that corresponds to a C5-C5 herniation with impingement upon this nerve root." PX 19, p. 22.

Under cross-examination, Dr. Engelhard testified he has been licensed in Illinois since 1981. In September 2016, he was reprimanded and fined by the Illinois Department of Financial and Professional Responsibility. PX 19, pp. 22-23. He understands Petitioner was injured in September 2011 but he did not examine Petitioner until October 2013. PX 19, p. 23. He is not sure how Petitioner came to see him. He is not sure exactly what records he reviewed at the time of Petitioner's initial visit. PX 19, pp. 24-25. As of that visit, he was not aware of any cervical spine or arm complaints predating September 2011. PX 19, p. 24. He believes his interaction with Petitioner was direct, with no resident or medical student acting as an intermediary. PX 19, p. 26. He does not know what Petitioner's job duties were as of September 2011. Nor does he know what type of equipment Petitioner handled. He did not record the weight of the suitcase Petitioner lifted out of the trunk. He does not know which arm Petitioner used. PX 19, p. 27. If Petitioner was performing sedentary work as of October 2013 it is possible he would have allowed Petitioner to continue performing that work. PX 19, pp. 27-28. He does not know whether Petitioner saw any other physicians between the office visit of December 2013 and the visit of March 2014. He did not note whether Petitioner was working as of March 2014. PX 19, pp. 28-29. When Petitioner came back to him in March 2014, it was because he developed left arm symptoms, after a period of doing well, and "they had made sure it wasn't a heart attack." It was reasonable for Petitioner to return to him at that point since he had operated on Petitioner's neck. Dr. Rossman, who he wrote to at one point, is a primary care physician. He does not know what care Dr. Rossman was providing to Petitioner. PX 19, pp. 30-31. When Petitioner returned to him in March 2014, it was due to left-sided symptoms. He recommended an MRI which was negative. He discharged Petitioner from care in April 2014. He did not know that Petitioner underwent EMG testing during that time frame. PX 19, p. 32. He is not aware of the hospital's policy in terms of producing medical records pursuant to a subpoena. PX 19, pp. 32-33. It could be that the hospital produced only the records concerning the care he rendered to Petitioner. PX 19, pp. 32-33.

Dr. Engelhard acknowledged his causation opinion could possibly change if, prior to October 2013, Petitioner told a doctor that he had a random onset of symptoms with no triggering activity. It would be possibly significant if Petitioner reported in October 2011 that his symptoms were not due to any recent accident or injury. PX 19, p. 34. A degenerated cervical disc can herniate absent any trauma. PX 19, p. 34. He has not seen Petitioner since April 2014. He does not know whether Petitioner has undergone treatment since that time. PX 19, p. 34. He has no information concerning Petitioner's current state of health. PX 19, p. 34.

On redirect, Dr. Engelhard testified that the cervical fusion is certainly permanent. As of Petitioner's last visit, the radiculopathy was "mild and residual." PX 19, p. 35. He has no additional information. The exact weight of the suitcase would not be important, in terms of his causation opinion. He did not see any records concerning "random events." PX 19, p. 35.

Petitioner testified he now works full-time for the Chicago Park District. He works in the field, overseeing groups of volunteers. He performs less typing than he did while working in the alderman's office. He uses rakes and shovels and moves wheelbarrows. He feels twinges with these activities.

Petitioner testified his ongoing symptoms make it difficult for him to carry his two youngest children, who weigh 33 and 40 pounds. His shoulder pulls a little when he tries to carry one of them.

Petitioner testified his wife's group carrier paid his medical bills and has asserted a lien.

Under cross-examination, Petitioner acknowledged he was alone at the time of his claimed accident. His direct supervisor at that time was Luisa Keefe. He has not read Edmund Kantor's affidavit. He provided a complete and accurate history to Dr. Heller when he first saw the doctor in October 2011. He also provided an accurate history to Dr. Fisher in January 2012. He filed a retaliatory discharge claim against Respondent in 2014. He is not sure of the exact date on which his attorneys filed his Application for Adjustment of Claim. He underwent a cervical fusion in November 2013.

No witnesses testified on behalf of Respondent. Respondent offered into evidence a consent order entered into by the Illinois Department of Financial and Professional Regulation and Dr. Engelhard in September 2016, with the doctor agreeing to a reprimand against his license to practice medicine and a fine in the amount of $2,500. RX 1.

Arbitrator's Credibility Assessment

Petitioner testified to a specific, work-related lifting event of September 21, 2011, involving his neck and right shoulder. Following this event, Petitioner saw his primary care physician, Dr. Lawler, on September 30, 2011. The doctor's note of that date describes the visit as a "re-check." The note contains no mention of a lifting-related incident. It documents a prior diagnosis of left lateral epicondylitis and new right-sided complaints. At Dr. Lawler's recommendation, Petitioner saw Dr. Heller, an orthopedic surgeon, on October 10, 2011. Petitioner offered Dr. Heller's records into evidence. Those records include a medical history form bearing Petitioner's signature and the date October 10, 2011. The handwritten sections of this form contain no mention of a lifting-related incident. Petitioner identified left elbow and right arm symptoms dating back to about June 2011. In response to a question asking for an explanation as to how the symptoms developed, Petitioner wrote "unknown." The <u>first</u> medical record to mention a lifting-related event is a therapy evaluation note of October 26, 2011. This note describes Petitioner as lifting a suitcase a month and a half earlier. The time frame fits with Petitioner's testimony but the note contains no mention of work. Subsequent therapy notes clearly reference prior neck-related treatment. Petitioner did not testify to this treatment.

Simply put, Petitioner's account of the accident finds no support in the earliest post-accident records.

Petitioner's notice-related evidence was vague at best. Petitioner testified he mentioned the lifting incident to Respondent's Deputy City Clerk, Ed Kantor, "in passing" in a men's restroom. Petitioner did not testify as to when this conversation occurred. Kantor referenced this conversation in his 2016 affidavit but simply indicated it took place sometime during city vehicle sticker season in either 2011 or 2012. Kantor described Petitioner as telling him he "wrenched his back while lifting office equipment." Petitioner's claimed injury does not involve his back.

Petitioner testified his health was "pretty good" prior to the claimed lifting incident. Significantly, however, he did not deny having neck or arm issues before this incident. Dr. Lawler's note of September 30, 2011 describes Petitioner's visit as a "re-check." Therapy records from November 2011 clearly reference neck treatment occurring five years earlier. Petitioner was not forthright concerning potentially relevant pre-accident treatment.

Arbitrator's Conclusions of Law

Did Petitioner sustain an accident on September 21, 2011 arising out of and in the course of his employment? Did Petitioner establish timely notice?

As noted above, the earliest medical records contain no mention of the claimed, unwitnessed lifting-related incident of September 21, 2011. Those records include a detailed history form that Petitioner completed at Dr. Heller's office on October 10, 2011, less than three weeks after the claimed incident. Petitioner did not mention the incident on the form and indicated his upper extremity symptoms started in June 2011. He described the cause of the symptoms as "unknown." The Arbitrator assigns significant weight to this form and the histories recorded by Dr. Lawler and Dr. Heller on September 30 and October 10, 2011.

The Arbitrator finds that Petitioner lacked credibility and that he failed to establish a work accident of September 21, 2011.

The Arbitrator further finds that Petitioner failed to provide notice of his claimed accident to Respondent within the statutory 45-day period. Petitioner testified he mentioned the lifting incident to Ed Kantor, Respondent's Deputy City Clerk, but he did not testify when this conversation occurred. In his 2016 affidavit, Kantor was unable to pinpoint a specific time frame. He merely stated that, sometime during city vehicle sticker season in 2011 or 2012, Petitioner told him he "wrenched his back lifting office equipment." This claim does not involve a back injury. Petitioner failed to meet his burden of proving that he provided Respondent with notice of his claimed accident within 45 days of September 21, 2011.

The Arbitrator views the remaining disputed issues as moot and makes no findings as to those issues. Compensation 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	☐ Second Injury Fund (§8(e)18)
			☐ PTD/Fatal denied
		☐ Modify	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Michael Strode,
Petitioner,

vs. NO: 17WC 36099

National Express Corp.,
Respondent.

19IWCC0331

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed September 24, 2018, is hereby affirmed and adopted.

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

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

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

DATED: JUN 27 2019
o061919
DDM/jrc
052

Douglas McCarthy

L. Elizabeth Coppoletti

Stephen Mathis

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION
19(K) 19(L).16

STRODE, MICHAEL
Employee/Petitioner

Case# **17WC036099**

NATIONAL EXPRESS CORP
Employer/Respondent

19IWCC0331

On 9/24/2018, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 2.29% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in 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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5001 GAIDO & FINTZEN
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STATE OF ILLINOIS)
)SS.
COUNTY OF COOK)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(K), 19(L), 16

MICHAEL STRODE,
Employee/Petitioner,

v.

NATIONAL EXPRESS CORP.,
Employer/Respondent

Case # **17 WC 36099**

Consolidated cases: **N/A**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable Arbitrator Paul Eric Seal, of the Commission, in the city of Chicago, on July 26, 2018. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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. [x] Should penalties or fees be imposed upon Respondent?
N. [ ] Is Respondent due any credit?
O. [x] Other Statutory Loss

FINDINGS

On **November 20, 2017**, Respondent was operating under and subject 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 **$30,889.04**; the average weekly wage was **$595.04.**

On the date of accident, Petitioner was **63** years of age, married with zero **(0)** dependent children.

Petitioner has received all reasonable and necessary medical services.

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

Respondent shall be given a credit of $0 for TTD, $**0** for TPD, $**0** for maintenance, and $**0** (medical) 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 concludes that the petitioner did not prove by the preponderance or greater weight of the evidence that he sustained an accident that arose out of and in the course of his employment on **November 20, 2017**. As a result, the claims are denied and all other issues are moot.

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

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

Signature of Arbitrator

September 24, 2018
Date

SEP 24 2018

STATE OF ILLINOIS)
)SS.
COUNTY OF COOK)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

MICHAEL STRODE,
Employee/Petitioner,
v.
NATIONAL EXPRESS CORP.,
Employer/Respondent

Case # **17** WC **036099**

19IWCC0331

FINDINGS OF FACT AND CONCLUSIONS OF LAW

The parties agree that on November 20, 2017, the petitioner, Michael Strode, and the respondent, National Express Corporation, were operating under the Illinois Workers' Compensation Act, and that their relationship was one of employee and employer. They also agree that the petitioner was married with no dependent children. Furthermore, the parties agree that timely notice of the alleged accident was given to the respondent.

At issue is: (1) Whether an accident occurred which arose out of and in the course of the petitioner's employment with the respondent; (2) Whether the petitioner's current condition of ill-being is causally connected to the alleged work injury; (3) Whether the petitioner is entitled to payment of medical bills; (4) Whether the petitioner is entitled to Temporary Total Disability benefits; (5) Whether penalties and fees are appropriate; and (6) Whether a statutory loss amount is proper as the nature and extent of the petitioner's injury.

FINDINGS OF FACT

This matter was tried on July 26, 2018, on both parties' motion and on Petitioner's Petitions for Penalties and fees.

The petitioner testified that he was 64 years old and had been employed by the respondent since October 2015 as a commercial bus driver. (TA 10) He drove a modified minivan, in which he drove wheelchair-bound passengers. (TA 11) The petitioner testified that he had been driving that type of minivan since approximately three months after he was hired. (TA 11) These vehicles are equipped with a sliding door on the passenger side to allow for passengers in wheelchairs to enter and exit via a ramp. (TA 13) The ramp folds down to the ground once the door is opened. These vehicles are equipped with automatic transmissions. (TA 26) The petitioner testified that his typical workday was from 1:30 p.m. to about 11:15 p.m. (TA 30)

On November 20, 2017, the petitioner drove a client to her home. Once he arrived, he stopped the minivan, got out, opened the sliding door and lowered the ramp. He undid the safety belts off the wheelchair, and the client got out of the minivan. (TA 13) After placing the ramp back up inside the van, the petitioner stood next to the door and attempted to close the sliding door. (TA 14) The door stuck and would not close – so, he attempted to close the door two more times. The petitioner testified that on the fourth time, he guided the door with his left hand while pushing it with his right hand. (TA 14-15)

The petitioner stood at arbitration to demonstrate how he closed the door. He used a motion moving both his arms across his body and did not move his feet or move below his waist when showing how he got the door to close.

After closing the minivan door, when the petitioner tried to step up in the minivan, he felt a pinch in his groin area. (TA 16) He then got in the minivan and continued to work the rest of the day, another four hours until 10:30 or 11:00 p.m. when his shift ended. (TA 16-17) The petitioner then drove the minivan

back to the garage where the rest of the buses were located. He did not report any problems with the minivan to the garage attendant. He did not report the incident to anyone on the respondent's staff.

The petitioner worked a full day on November 21, 2017. (TA 18) On November 22, 2017, he drove to work and spoke with his supervisor about the incident two days earlier. He was sent to Concentra Occupational Health Center for an evaluation. The petitioner testified that it was recommended that he go to an emergency room. (TA 20; PX1)

On November 23, 2017, the petitioner remained at home. He testified that he cooked and hosted Thanksgiving dinner for his family. (TA 34) On November 24, 2017, the petitioner went to Presence St. Mary's Hospital, and he presented with groin pain. He underwent an ultrasound and surgery was recommended – including possible orchiectomy due to the deterioration of his right testicle. (PX2)

Initially, the petitioner refused the orchiectomy. He then underwent a testicular exploration with a reduction of his testicle. (PX2) The next day, further surgery was recommended, and the petitioner underwent right orchiectomy. (PX2; PX3) He was discharged from the hospital November 28, 2017. (PX2) He returned to work full duty on December 11, 2018. (TA 23)

On March 8, 2018, the respondent had the petitioner examined under section 12 of the Act by Dr. Jeffrey Branch at Loyola University. (RX4) Dr. Branch opined that the petitioner's diagnosis was a testicular torsion and testicular necrosis requiring orchiectomy. He further opined that the petitioner's described work incident did not cause his acute condition and that his delay in seeking medical care ultimately resulted in the necrosis of the testicle requiring removal. Dr. Branch found that the petitioner had achieved maximum medical improvement and could work full duty. (RX4)

CONCLUSIONS OF LAW

In connection with the Arbitrator's Decision regarding (C) Whether an accident occurred that arose out of and in the course of the petitioner's employment with the respondent, and (F) Whether the petitioner's current condition of ill-being causally related to the injury, the Arbitrator concludes as follows:

The Arbitrator finds that the petitioner failed to meet his burden of proving by the preponderance or greater weight of the evidence that he suffered an accident that arose out of and in the course of his employment with the respondent for which compensation is payable. The Arbitrator further finds that the petitioner failed to meet his burden of proving that his current condition of ill-being is related to a workplace injury.

It is the petitioner's burden to prove by the preponderance or greater weight of the evidence each and every element of his claim – including that he sustained an accident arising out of and in the course of his employment with the respondent. Preponderance of the evidence is evidence which is of greater weight or more convincing than the evidence offered in opposition to it; it is evidence which as a whole shows that the fact to be proved is more probable than not. ***Parro v. Industrial Commission***, 630 N.E.2d 860 (1st Dist. 1993); ***Central Rug & Carpet v. Industrial Commission***, 838 N.E.2d 39 (1st Dist. 2005)

The petitioner's claim that he suffered a testicular injury while closing a van door, and that his injury necessitated the removal of his testicle, is not supported by the medical records in evidence. The petitioner testified that he injured himself on November 20th. He finished working the last half of his work shift. He worked his full shift November 21st. On November 22nd, he sought his first medical attention. He testified that it was recommended that he go to an emergency room. The next day, he remained at home cooking and hosting Thanksgiving dinner.

The petitioner did not testify that he used a significant amount of force to get close the minivan door. When showing how he closed it, he moved his arms and did not twist of move his torso or lower body and did not move or re-set his feet. The petitioner testified that he felt a pinch in his groin when he got back up into the minivan.

Dr. Branch opined that the petitioner's alleged mechanism of injury was not a competent cause of his ultimate condition of ill-being. He further opined that the petitioner's several-day delay in seeking medical treatment, and his four-day delay in following up on same, caused him to lose his testicle. Dr. Branch's medical opinions regarding mechanism of injury and causation are unrebutted comport logicially with the petitioner's testimony.

In any event, considering all of the medical records in evidence and the record in its entirety, the Arbitrator finds that the petitioner failed to bear his burden of proving by the preponderance or greater weight of the evidence that he sustained an accident that arose out of and in the course of his employment with the respondent for which compensation is payable, and he failed to prove a causal connection to his current condition of ill-being.

Therefore, compensation is denied, and 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 up	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

DONOVAN NALLEY,

Petitioner,

19IWCC0332

vs.

NO: 13 WC 21598

THE AMERICAN COAL COMPANY,

Respondent.

DECISION AND OPINION ON REVIEW

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

The Commission modifies the Decision only to the extent that it determined the duration of Petitioner's being temporarily totally disabled and defined the scope of the prospective medical treatment recommended by Dr. J.T. Davis, an orthopedic surgeon at the Orthopedic Institute.

Entitlement to TTD benefits was a disputed issue during the arbitration hearing, but the Decision of the Arbitrator did not address whether Petitioner was entitled to TTD benefits for any time from the date of accident through the date of the arbitration and, if so, for how long was Petitioner so entitled. The Commission, in consideration of the evidence, finds Petitioner is

entitled to TTD benefits commencing June 24, 2013 and continuing through the date of the arbitration hearing, August 9, 2018.

Petitioner sustained injuries related to his employment on March 20, 2013 but was not prescribed any work restrictions until June 24, 2013. On that date, Dr. Davis restricted Petitioner's work activities to those that constituted light duty. It was Petitioner's unrebutted testimony that Respondent was unable to accommodate the restrictions placed upon his ability to work.

Dr. Davis, who had been treating Petitioner's complaints involving his right shoulder, came to believe that Petitioner's cervical spine was causing Petitioner's symptomology and, based on this belief, recommended, on July 11, 2013, that Petitioner be seen by a neurosurgeon who specialized in the cervical spine and also undergo a repeat MRI of the cervical spine as well as an EMG/NCV study. He believed further treatment to Petitioner's right shoulder was unwarranted until a relationship between Petitioner's symptoms and his cervical spine could be eliminated. No suggestion was found in Dr. Davis' treating records that Petitioner was to have returned to him absent him undergoing a cervical spine evaluation. His recommendation was never authorized and resulted in Petitioner's treatment being halted.

Petitioner went without treatment until he returned to Dr. Davis on October 5, 2017. Dr. Davis reexamined Petitioner as Petitioner had the same complaints as he had in 2013. Dr. Davis again recommended Petitioner undergo a repeat MRI of the cervical spine and an EMG/NCV study or, alternatively, an examination by a neurosurgeon who specialized in the cervical spine. Those recommendations, again, were not acted upon.

The Commission finds, based on the testimony of Petitioner and Dr. Davis as well as Petitioner's treatment records, the condition Petitioner presented before the Arbitrator on August 9, 2018 to be causally related to his March 20, 2013 accident, particularly in light of the lack of treatment he received after July 11, 2013. The Commission also finds Petitioner presenting to his arbitration hearing in a condition not dissimilar to the condition in which he presented to Dr. Davis on October 5, 2017, which itself was not dissimilar to how he presented to Dr. Davis on July 11, 2013, as evidence that his condition has not yet stabilized, a necessary prerequisite to terminate TTD benefits.

The Commission, given the circumstances particular to this case, is disinclined to find that Petitioner was at MMI as of July 11, 2013 based on Petitioner's not treating his injuries from that date until October 5, 2017 as Respondent argued. The Commission finds Petitioner did not treat his injuries over that period of time simply because Respondent refused Dr. Davis' recommendation to have Petitioner examined by a neurologist, an examination that Dr. Davis deemed necessary before further treatment could be contemplated.

Petitioner has satisfied his twin burden of demonstrating both that his current condition of ill-being, including his being temporarily totally disabled, is causally connected to his March 20, 2013 accident and also that he remained continuously temporarily totally disabled from June 24, 2013, through August 9, 2018.

The recommended treatment to address Petitioner's current condition of ill-being is to have him evaluated by a neurosurgeon who specializes in the cervical spine. That recommendation was repeatedly made by Dr. Davis. Dr. Davis indicated that he would defer to the treatment recommendations of the neurosurgeon. The Commission finds Dr. Davis' recommendation to be causally related to Petitioner's March 20, 2013 accident as well as both necessary and reasonable to address the residual complaints that resulted from that accident.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent shall pay to the Petitioner the sum of $984.84 per week for a period of 267-4/7 weeks, that being the period of temporary total incapacity for work under §8(b), and that as provided in §19(b) of the Act, this award in no instance shall be a bar to a further hearing and determination of a further amount of temporary total compensation or of compensation for permanent disability, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $341.00 for medical expenses under §8(a) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent authorize the referral of Petitioner to a neurosurgeon who specializes in the cervical spine for an evaluation and, if reasonable and necessary, for the treatment of his cervical spine.

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

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

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

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

DATED: JUN 28 2019
DLS/mav
O: 05/07/19
46

Deborah L. Simpson

Thomas J. Tyrrell

Maria Portela

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

19IWCC0332

NALLEY, DONOVAN
Employee/Petitioner

Case# **13WC021598**

AMERICAN COAL
Employer/Respondent

On 10/2/2018, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 2.33% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

3101 PRINCE LAW FIRM
TYLER N DIHLE
404 N MONROE ST
MARION, IL 62959

1723 LITCHFIELD CAVO
GREGORY KELTNER
222 S CENTRAL AVE SUITE 200
ST LOUIS, MO 63105

19IWCC0332

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

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

Donovan Nalley
Employee/Petitioner

v.

American Coal
Employer/Respondent

Case # **13** WC **021598**

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 **August 9, 2018**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. [ ] Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?

B. [ ] Was there an employee-employer relationship?

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

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

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

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

G. [ ] What were Petitioner's earnings?

H. [ ] What was Petitioner's age at the time of the accident?

I. [ ] What was Petitioner's marital status at the time of the accident?

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

K. [x] Is Petitioner entitled to any prospective medical care?

L. [x] What temporary benefits are in dispute?
[ ] TPD [ ] Maintenance [x] TTD

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

N. [ ] Is Respondent due any credit?

O. [ ] Other ______

FINDINGS

On the date of accident, **3/20/2013**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$76,813.36**; the average weekly wage was $**1,477.18**.

On the date of accident, Petitioner was **42** years of age, *single* with **1** dependent children.

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

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

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

ORDER

Respondent shall pay reasonable and necessary medical services of $341.00, as provided in Section 8(a) of the Act. Further, Respondent shall pay for future medical benefits as ordered by Dr. J.T. Davis as provided in Sections 8(a) and 8.2 of the Act

At this time the Arbitrator makes no findings related to TTD pending future medical benefits awarded pursuant to Dr. Davis' recommendations.

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

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

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

Signature of Arbitrator

9/28/18
Date

ICArbDec19(b)

OCT 2 - 2018

STATE OF ILLINOIS
ILLINOIS WORKERS' COMPENSATION COMMISSION

DONOVAN NALLEY,	)	
	)	
Petitioner,	)	
	)	Case No: 13 WC 21598
v.	)	
	)	
THE AMERICAN COAL COMPANY,	)	
	)	
Respondent.	)	

FINDINGS OF FACT

On March 20, 2013, Petitioner was employed as a Roof Bolter for the Respondent. He was riding on a mantrip through the mine when he struck his head on the roof after experiencing rough terrain and malfunctioning shocks. In an attempt to keep his head from repetitively hitting the roof, Petitioner lifted his right arm above his head and held it to the ceiling to try to keep himself planted in his seat. After striking the roof several times, Petitioner stated that he was knocked unconscious. After regaining consciousness, Petitioner stated that he exited the mantrip, reached down to pick up his tools and lunch box—weighing nearly 30 lbs— and when he did, felt a sharp pain shoot through his back, right shoulder, and neck. Petitioner was taken to Harrisburg Medical Center for treatment. (PX 4). X-rays of Petitioner's right shoulder were obtained, as well as a CT scan of his head, cervical spine, and lumbar spine. (PX 4). Petitioner's x-ray of his right shoulder showed mild changes of osteoarthritis, but no facture or dislocation. (PX 4). Petitioner was diagnosed with right shoulder sprain, cervical sprain, and lumbar spine strain, and was referred to his primary care physician, Dr. James Alexander. (PX 4).

On March 21, 2013, Petitioner followed up with a nurse practitioner, Loni Banks, at the office of Dr. James Alexander. (PX 5). An x-ray of Petitioner's right shoulder was taken, which revealed no evidence of any osteoarticular abnormality. (PX 5). Petitioner also received a corticosteroid injection and was placed on work restrictions to include only above ground light-duty work. (PX 5). Petitioner followed up with Banks on March 26, 2013. (PX 5). Petitioner was to continue work restrictions and was sent to obtain an MRI of his right shoulder. (PX 5).

On April 2, 2013, Petitioner followed up with Dr. Alexander. (PX 5). Dr. Alexander examined Petitioner's right shoulder and also interpreted an MRI obtained. (PX 5). Dr. Alexander opined that the MRI showed supraspinatus tendonosis but no tear. (PX 5). Dr. Alexander's assessment was that Petitioner had shoulder cuff tendonitis and adhesive capsulitits of the right shoulder. (PX 5). Petitioner was to continue light-duty work and was completely restricted from bolting roofs with his right arm. (PX 5). Petitioners was also referred to a physical therapist at ApexNetwork Physical Therapy, on site at the American Coal Company. (PX 5), (PX 6).

At the request of respondent, Petitioner was also referred to Dr. Matthew Collard at the Orthopedic Specialists in St. Louis, Missouri. Petitioner followed up with and received 2-3 cortisone shots

from Dr. Collard while continuing physical therapy at Apex Network Physical Therapy. (PX 1), (PX 6). Petitioner participated in physical therapy for the period of 04/04/13-06/12/13, with a total of 26 visits. (PX 6). At the conclusion of physical therapy, Petitioner had a reduction of pain, but continued to have a restrictions in his range of motion into flexion/abduction/ER/IR and decreased strength. (PX 6). Dr. Collard authored several reports, all of which document a shoulder injury, specifically, shoulder strain, arthralgia and adhesive capsulitis. (RX 4). Petitioner testified that he returned to work full duty on or around June 20, 2013. Consequently, within an hour of his shift, Petitioner stated that his right shoulder began hurting so bad that he could hardly use his right arm. As a result, Petitioner saw Dr. Alexander on June 24, 2013. (PX 5). Dr. Alexander opined that Petitioner had a right shoulder sprain and cervicalgia. (PX 5). Petitioner was referred to Dr. J.T. Davis at the Orthopedic Institute. (PX 5).

On June 24, 2013, Petitioner was treated by Dr. Davis. (PX 1). Dr. Davis examined Petitioner and reviewed the MRI scan acquired by Dr. Alexander. (PX 1). Dr. Davis opined that Petitioner suffered from partial bursal-sided rotator cuff tearing with some potential nerve root impingement in his right extremity. (PX 1). Petitioner was again placed on light-work duties, including: no repetitive lifting, pushing or pulling, and a 10-pound lifting restriction. (PX 1). Petitioner was also sent off for additional diagnostic studies to include a nerve conduction study and a MRI scan of his cervical spine. (PX 1).

On July 11, 2013, Petitioner followed up with Dr. Davis. (PX 1). Dr. Davis concluded that Petitioner's nerve study was normal. (PX 1). Petitioner's MRI scan, however, showed some disc bulging and narrowing of the space available for the nerves that exit the spine. (PX 1). Dr. Davis opined that the next plan of treatment was to have Petitioner formally evaluated by a neck specialist to get their medical opinion on how much, if any, of the cervical spine and any nerve irritation was contributing to his symptoms prior to performing surgery on the right shoulder. (PX 1).

Respondent would not agree to pay for the evaluation by a neck specialist, so the deposition of Dr. Davis was taken in anticipation of a 19(b) hearing. (PX 1). Dr. Davis opined that Petitioner's shoulder injury was caused by the work accident on March 20, 2013. (PX 1). Dr. Davis also provided reasoning for his recommendation to have a neck specialist evaluate Petitioner prior to performing surgery on the right shoulder. (PX 1). Dr. Davis further opined that Petitioner was unable to work because of his injury suffered in the work accident. (PX 1).

Petitioner testified that because of his injuries he currently unable to work. Petitioner testified that he still has problems lifting anything with his right arm and is unable to lift anything above his head. Further, that he experiences a burning pain, and has limited mobility with his right arm. He also experiences stiffness in his neck that prevents him from being able to turn at times. Petitioner also addressed why he was seen at Harrisburg Medical Center on September 10, 2012. Petitioner testified that he was seen on September 10, 2012, for a work-related accident. He testified that Respondent sent him to Harrisburg Medical Center after he was hit on the head by a rock fall at the mine. Petitioner testified that there was bruising, but no injuries reported by his treating physician.

Petitioner testified that the injury, occurring on September 10, 2012, did not prevent him from working full duty at the mine nor cause him to experience pain in his neck or shoulder. Further,

that leading up to the March 20, 2013 work accident, he did not experience any problems with his neck or shoulder and was working full duty.

CONCLUSIONS OF LAW

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

The Arbitrator finds that Petitioner's current condition of ill-being is causally related to the work injury. All of the medical testimony provided in this matter points to March 20, 2013 as the cause of Petitioner's condition of ill-being. Dr. Davis' records and deposition show that the injury at the American Coal Company was the cause of Petitioner's injury. Dr. Rotman, one of Respondent's Section 12 examiners, agreed on cross examination that Petitioner suffered a neck injury and that Dr. Davis' referral to a neck specialist was reasonable. (RX 6).

The Arbitrator finds Dr. J.T. Davis to be credible. Dr. Davis is the only physician to have seen the Petitioner in the last five years. Further, the Arbitrator notes the conflicting opinions of Respondent's Section 12 examiners, and thus assigns them less weight.

"J" Were 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 all of the treatment provided to Petitioner was reasonable and necessary. The Arbitrator finds that Respondent has not paid all appropriate charges for such reasonable and necessary medical services; and as such, finds that the Respondent must pay for all reasonable and necessary medical services including a referral to a cervical spine specialist as directed by Dr. Davis.

"K" What temporary benefits are in dispute?

The Arbitrator makes no findings regarding TTD pending treatment ordered by Dr. Davis.

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: Up	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

KEITH YARMER,

Petitioner,

19IWCC0333

vs.

NO: 17 WC 2053

CITY OF CHICAGO,

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 credit under §8(j) and penalties under §§19(k)/19(l), and attorney fees under §16, 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, medical expenses, 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).

Petitioner worked for Respondent as a plumber and injured his right shoulder while tightening a bolt. The Arbitrator denied Petitioner's Petition for Penalties and Fees based on his conclusion that Respondent did not act unreasonably in terminating benefits based on the opinion of its §12 medical examiner, Dr. Primus. We note that Dr. Primus indicated that Petitioner had pre-existing bone-on-bone arthritis in his right shoulder. Under such circumstances we agree with the Arbitrator that Respondent did not act unreasonably in challenging causation and suspending benefits. Therefore, the Commission affirms and adopts that portion of the Decision of the Arbitrator.

The Arbitrator also granted Respondent credit in the amount of $58,138.78 under §8(j) of the Act based on Petitioner's testimony that group health insurance paid for shoulder replacement surgery. We do not believe that is a sufficient basis on which to award credit under the Section. Section 8(j) provides in pertinent part (820 ILCS 305/8(j)):

> In the event the injured employee receives benefits, including medical, surgical or hospital benefits under any group plan covering non-occupational disabilities contributed to wholly or partially by the employer, which benefits should not have been payable if any rights of recovery existed under this Act, then such amounts so paid to the employee from any such group plan as shall be consistent with, and limited to, the provisions of paragraph 2 hereof, shall be credited to or against any compensation payment for temporary total incapacity for work or any medical, surgical or hospital benefits made or to be made under this Act. *** This paragraph does not apply to payments made under any group plan which would have been payable irrespective of an accidental injury under this Act. Any employer receiving such credit shall keep such employee safe and harmless from any and all claims or liabilities that may be made against him by reason of having received such payments only to the extent of such credit.

As we interpret the statutory language quoted above, there are three requirements which must be established before credit can be awarded under §8(j). First, group insurance must have paid medical benefits; second, the employer paid into the group policy; and third, the group policy must preclude medical payments for injuries sustained in work-related accidents. In this matter, Petitioner's testimony only addresses the first criterion, that group insurance paid some medical expenses. There is nothing in the record establishing either of the other criteria *i.e.,* that the employer paid into the policy, and that the policy precludes payments for medical expenses associated with work-related conditions of ill-being. As the claimant has the burden of proving all the elements of his or her claim, the employer has the burden of proving that it is entitled to credit under §8(j). In this instance, Respondent has not met its burden of proving it is entitled to §8(j) credit. Therefore, the Commission vacates the Arbitrator's award of $58,138.78 in §8(j) credit and includes that amount into the award for medical expenses.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent shall pay to the Petitioner the sum of $1,255.32 per week for a period of 104&3/7 weeks, commencing April 8, 2016 through April 10, 2018, that being the period of temporary total incapacity for work under §8(b), and that as provided in §8(b) of the Act, this award in no instance shall be a bar to a further hearing and determination of a further amount of temporary total compensation, medical benefits, or of compensation for permanent disability, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay the sum of $79,527.78 for medical expenses under §8(a) of the Act, subject to the applicable medical fee schedule under §8.2.

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

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

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

DATED: JUN 28 2019

Deborah L. Simpson

Barbara N. Flores

Marc Parker

DLS/dw
O-6/20/19
46

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF 19(b)/8(a) ARBITRATOR DECISION

19IWCC0333

YARMER, KEITH
Employee/Petitioner

Case# **17WC002053**

CITY OF CHICAGO
Employer/Respondent

On 8/3/2018, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 2.16% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0391 HEALY SCANLON
KEVIN T VEUGELER
111 W WASHINGTON ST #1425
CHICAGO, IL 60602

0010 CITY OF CHICAGO
D TAYLOR CHITTICK
30 N LASALLE ST 8TH FLR
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)
- [x] None of the above

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)/8(a)

Keith Yarmer
Employee/Petitioner
v.
City of Chicago
Employer/Respondent

Case # 17 WC 02053

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Jeffrey Huebsch**, Arbitrator of the Commission, in the city of **Chicago**, on **April 10, 2018**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. [ ] Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?

B. [ ] Was there an employee-employer relationship?

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

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

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

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

G. [ ] What were Petitioner's earnings?

H. [ ] What was Petitioner's age at the time of the accident?

I. [ ] What was Petitioner's marital status at the time of the accident?

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

K. [x] Is Petitioner entitled to any prospective medical care?

L. [x] What temporary benefits are in dispute?
[ ] TPD [ ] Maintenance [x] TTD

M. [x] Should penalties or fees be imposed upon Respondent?

N. [x] Is Respondent due any credit?

O. [ ] Other ______

FINDINGS

On the date of accident, **3/25/2016**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

On this date, 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 **$97,915.45**; the average weekly wage was **$1,882.98**.

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 reasonable and necessary charges for all reasonable and necessary medical services.

Respondent shall be given a credit of **$86,800.56** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$86,800.56**.

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

ORDER

Respondent shall pay Petitioner temporary total disability benefits of **$1,255.32/week for 104-5/7 weeks**, commencing April 8, 2016 through April 10, 2018, as provided in Section 8(b) of the Act.

Respondent shall pay reasonable and necessary medical expenses of **$21,389.00**, pursuant to the medical fee schedule, as provided in Sections 8(a) and 8.2 of the Act and as is set forth below.

Petitioner's claim for penalties and attorney's fees is denied.

In no instance shall this award be a bar to subsequent hearing and determination of an additional amount of medical benefits or compensation for 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 3, 2018
Date

AUG 3 - 2018

FINDINGS OF FACT

Petitioner has been employed by Respondent, as a plumber in the Water Department, for 23 years. His job is a physical one, working on City watermains, fittings, service hook ups and supply pipes. He uses various tools and equipment.

Petitioner is right handed. Petitioner testified that prior to March 25, 2016 he had no right shoulder issues. He had no prior medical treatment for his right shoulder. On the date of accident, Petitioner was 60 years old.

The Parties stipulated that Petitioner sustained accidental injuries that arose out of and in the course of his employment by Respondent on March 25, 2016. Petitioner was tightening fittings and he hurt his right arm. He pulled on a nut, his shoulder went back and snapped and he felt pain in his right shoulder. The accident occurred on a Friday, so Petitioner did not seek medical care immediately. He thought that he would get better over the weekend. Petitioner testified that it was common to suffer minor injuries as a plumber for the City of Chicago, so he did not seek medical treatment until two weeks after the injury.

When his pain did not resolve, Petitioner sought care. Petitioner was directed to Respondent's occupational clinic, MercyWorks. (PX 1) The April 8, 2016 note from MercyWorks indicates Petitioner provided a history of pain in the right shoulder while tightening a bolt with a wrench. It was noted that Petitioner had not suffered any problems with the right shoulder in the past. An examination revealed decreased range of motion. Petitioner was prescribed a sling and medication, placed on light duty, and instructed to return to the clinic. (PX 1)

Petitioner testified that Respondent was unable to accommodate his light duty restriction, so he was taken off work. Respondent began paying TTD.

Petitioner returned to MercyWorks, as instructed, on April 15, 2016, continuing to complain of pain. Medication was prescribed and Petitioner was instructed to continue his light duty restrictions. Petitioner was next evaluated on April 22, 2016. At that time, an MRI was prescribed and Petitioner was instructed to begin physical therapy and remain on light duty. (PX 1)

An MRI was performed on April 29, 2016. The MRI was positive for supraspinatus and subscapularis thickening and signal abnormality, effusion, associated partial maceration of the labrum, severe degenerative joint disease, and biceps tenosynovitis with fluid in the biceps tendon sheath. (PX 3) On May 3, 2016, a MercyWorks physician reviewed the MRI results and recommended Petitioner start prednisone, prescribed medication and instructed Petitioner to remain on light duty. (PX 1)

At the next visit at Mercy Works, on May 11, 2016, Petitioner was referred for an orthopedic evaluation. (PX 1)

On May 23, 2016, Petitioner was evaluated by Dr. Edward Forman of Illinois Bone and Joint Institute. (PX 3) Dr. Forman performed an examination, reviewed the MRI results, and diagnosed right shoulder impingement with biceps tendonitis. Dr. Forman performed a cortisone injection, prescribed physical therapy, medication and instructed Petitioner to continue light duty restrictions. (PX 3)

Petitioner testified he began physical therapy. An initial June 1, 2016 note from Presence Resurrection Medical Center reveals a history that "patient was tightening bolts with a ratchet and felt a 'pop' with immediate pain. Patient figured it would get better, but 1 week later still had pain." (PX 6)

On June 28, 2016, Petitioner returned to IBJI and was seen for follow up with Dr. Daniel Newman. At that visit, Petitioner continued to have decreased range of motion and Dr. Newman did another cortisone injection, recommended continued therapy and off work. (PX 3)

Petitioner's next visit with Dr. Newman was on July 26, 2016. Petitioner was given another cortisone injection, instructed to continue physical therapy and to remain off work. On August 23, 2016, Petitioner returned to Dr. Newman complaining of continued pain. Another cortisone injection was done. (PX 3) Dr. Newman also discussed surgical intervention and recommended continued off work. (PX 10) Petitioner had repeat injections on September 20, 2016, October 18, 2016, and November 15, 2016. (PX3). Dr. Newman noted the injections would temporarily relieve Petitioner's right shoulder pain, but the pain would return when the medicine wore off. (PX 3)

On December 13, 2016, Dr. Newman noted Petitioner was not making any progress, with continued weakness and decreased range of motion. Dr. Newman wrote that while surgery was discussed, he did not think Petitioner was a "great candidate" for surgery, as he did not think it would get him back to his previous job. Instead, Dr. Newman discharged Petitioner from care with restrictions of one handed work only. (PX 3)

Petitioner testified that Respondent was unable to accommodate his restrictions. Petitioner was then referred for a second opinion to Midwest Orthopedics at Rush by a nurse case manager (retained by Respondent) who had been following Petitioner's care.

In a January 10, 2017 letter to Kimberly Landfair, Case Manager, Dr. Gregory Nicholson notes he was asked to perform a second opinion only examination of Petitioner. Dr. Nicholson noted a history that Petitioner injured his right shoulder on 3/25/2016 while torqueing wrenches and felt immediate pain. Dr. Nicholson also confirmed that Petitioner did not have any prior issues with his right shoulder before this incident. After reviewing the MRI films, medical records and performing an examination, Dr. Nicholson stated that while Petitioner had pre-existing arthritis, he was able to function very well until the work injury. While Petitioner's work did not cause the arthritis, it did exacerbate a preexisting condition, such that he cannot work. Failing conservative care, Dr. Nicholson recommended a total shoulder replacement to relieve the pain, improve function and return to work. (PX 4)

Petitioner testified that Respondent did not approve the proposed surgery. Instead, Respondent sent Petitioner to a §12 examination with Dr. Gregory Primus on June 12, 2017. Dr. Primus issued a report outlining his opinions. Dr. Primus testified via evidence deposition on February 21, 2018. Dr. Primus relied only upon his report in testifying. He did not bring his file, copies of submitted medical records, or a copy of the IME letter, which apparently propounded some questions to the doctor and likely contained information about the claim. (RX 1)

Dr. Primus claimed Petitioner was "tightening a water main fitting and had increased pain." (Primus Dep, p7) He then remarked "[t]here did not appear to be any unusual environment he was working in or added hazard in the work place when this episode occurred." (Primus Dep, p 25) Dr. Primus later stated "[t]here was no accident, incident, or other identifiable traumatic event that lead to increased pain in his shoulder...but simply the onset of right shoulder pain while doing his normal and typical job duties." According to Dr. Primus,

Petitioner's shoulder injury was "not related to the work accident." (Primus Dep, pgs. 11-12) As a result, Respondent denied any further benefits.

Petitioner returned to Dr. Nicholson on August 2, 2017. (PX 4) In a report to Respondent's nurse case manager, Dr. Nicholson again recommended shoulder surgery and endorsed causation. (PX 4)

On September 14, 2017, Petitioner underwent a right total shoulder replacement, under the supervision of Dr. Nicholson. The "Indication" portion of the operative report states: "63 year-old right hand dominant male with progressive loss of function, increasing shoulder pain over the last 3-5 years." (PX 4) He then underwent a course of physical therapy through the Fall of 2017. Petitioner's next visit with Dr. Nicholson was November 28, 2017. (PX 10). At that time, Dr. Newman noted decreased range of motion and prescribed a home exercise program, medication, and off work. (PX 4)

Petitioner's last visit with Dr. Nicholson was March 6, 2018. Dr. Nicholson reevaluated Petitioner, recommended a strengthening program, off work, and instructed Petitioner to return to the clinic in six months. (PX 4) Petitioner's next visit with Dr. Nicholson is on September 4, 2018. (PX 12)

At the time of trial, Petitioner testified he continues to experience pain and limited range of motion of the shoulder as a result of this injury.

Petitioner submitted the following medical expenses without objection concerning reasonableness and necessity:

PX7 Midwest Orthopaedics at Rush - $13,148.00
PX8 Rush University Medical Center - $58,138.78
PX9 University Anesthesiologist - $4,160.00
PX7 Presence Resurrection Medical Center - $4,081.00

CONCLUSIONS OF LAW

The Arbitrator adopts the above Findings of Fact in support of the Conclusions of Law set forth below.

Section 1(b)3(d) of the Act provides that, in order to obtain compensation under the Act, the 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(b)3(d).

To obtain compensation under the Act, Petitioner has the burden of proving, by a preponderance of the evidence, all of the elements of his claim (O'Dette v. Industrial Commission, 79 Ill. 2d 249, 253 (1980)), including that there is some causal relationship between his employment and her injury. Caterpillar Tractor Co. v. Industrial Commission, 129 Ill. 2d 52, 63 (1989)

Decisions of an arbitrator shall be based exclusively on evidence in the record of proceeding and material that has been officially noticed. 820 ILCS 305/1.1(e)

WITH RESPECT TO ISSUE (F), IS PETITIONER'S PRESENT CONDITION OF ILL-BEING CAUSALLY RELATED TO THE INJURY, THE ARBITRATOR FINDS:

Petitioner's current condition of ill-being, to wit: status post total right shoulder arthroplasty, is causally related to the injury.

The Arbitrator bases this finding on the credible testimony of Petitioner, the medical records and the opinion of Dr. Nicholson. Dr. Nicholson's opinion that the work incident of March 25, 2016 exacerbated the preexisting osteoarthritis in Petitioner's right shoulder, such that it became symptomatic, leading to disability and medical treatment including the right TSA procedure, is persuasive and best comports with the evidence adduced.

Dr. Primus' opinion is not persuasive. Dr. Primus's opinion was based on the improper premise that Petitioner had "increased pain" at the time of the March 25, 2016. This does not comport with the Record. Petitioner's unrebutted testimony was that his right shoulder was asymptomatic, pain free, untreated and undiagnosed before the injury. Furthermore, Dr. Primus's opinion is based on the incorrect premise that the act of torqueing a wrench while installing a water main is not an "increased risk" incidental to Petitioner's employment, but rather a normal everyday task and as such, any injury that results from that everyday work activity is not compensable under the Act. This is a legal opinion, and also an incorrect statement of the law. There is a nexus between the work activity of tightening a fitting and the injury, making it a compensable exacerbation of the preexisting arthritis condition in Petitioner's right shoulder. See: Sisbro v. Industrial Commission, 207 Ill.2d 193 (2003) and Swartz v. Illinois Industrial Commission, 359 Ill.App.3d 1083 (2005) Finally, the persuasiveness of Dr. Primus' opinions is lessened by his failure to have his file with the medical records and correspondence that he received for the IME available at his deposition. Whether this deficiency was due to ineptitude or gamesmanship, it does not serve to bolster the doctor's opinion.

The Arbitrator believes that Petitioner is a stoic individual, who suffered many minor injuries as a plumber for Respondent. He did not seek immediate care for his injury, thinking that it would resolve. He did not give a detailed history of the work injury to MercyWorks (albeit relating the onset of pain to the act of tightening a bolt with a wrench) because he is not litigation savy and thought that he would get better and get back to work. The "Indication" history in the operative report is inconsistent, but not fatally so to Petitioner's case. The Arbitrator observed Petitioner's demeanor during direct and cross examination and finds his testimony to be credible.

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:

Petitioner submitted the following medical expenses related to his right shoulder without objection concerning reasonableness and necessity:

PX7 Midwest Orthopaedics at Rush - $13,148.00
PX8 Rush University Medical Center - $58,138.78
PX9 University Anesthesiologist - $4,160.00
PX7 Presence Resurrection Medical Center - $4,081.00

The Arbitrator finds that the medical treatment services provided to Petitioner were reasonable and necessary to cure or relieve the effects of the injuries and are causally related to the injury.

Accordingly, medical bills are awarded as follows:

Midwest Orthopaedics at Rush: **$13, 148.00**
(DOS: 9/14/2017 and 9/26/2017)

University Anesthesiologists : **$ 4,160.00**
(DOS: 9/14/2017)

Presence Resurrection Medical Center: **$4,081.00**
(DOS: 9/18/2017 – 11/22/2017)

TOTAL: $21,389.00

This award of bills is made pursuant to §§8(a) and 8.2 of the Act. Respondent is entitled to a credit for all awarded bills that it has paid.

The submitted bill from Rush University Medical Center for the TSA procedure was paid by group (Blue Cross of Illinois Policy No. CTY000290165). Respondent shall hold Petitioner harmless from any claim for reimbursement by Blue Cross/Blue Shield in the amount of $58,138.78 and shall have no further liability, in accordance with Perez v. Illinois Workers' Compensation Commission, et al. TFN, Inc. d/b/a Wendy's, Inc. 2018 Ill. App. (2d) 170086WC (2018).

WITH RESPECT TO ISSUE (L), WHAT AMOUNT OF COMPENSATION IS DUE FOR TEMPORARY TOTAL DISABILITY, TEMPORARY PARTIAL DISABILITY AND/OR MAINTENANCE, THE ARBITRATOR FINDS:

Petitioner was unable to work from April 8, 2016 through the date of the hearing, April 10, 2018. The Arbitrator finds that Respondent is responsible for temporary total disability benefits in the amount of $1255.32 per week for 104 5/7 weeks for said time period, based upon the Arbitrator's finding above regarding the issue of causation.

It is noted that Respondent paid TTD through August 4, 2017 and disputed TTD benefits after August 4, 2017.

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

The Arbitrator denies Petitioner's claim for penalties and attorney's fees.

Respondent can rely on the opinions of Dr. Newman (Petitioner is at MMI, 12/13/2106) and Dr. Primus' opinion (no causal connection, don't do TSA procedure) in denying benefits.

Respondent's disputes in this claim are found to be not unreasonable and not in bad faith.

WITH RESPECT TO ISSUE (N), IS RESPONDENT DUE ANY CREDIT, THE ARBITRATOR FINDS:

Respondent is entitled to a credit for all bills paid.

Petitioner agreed on cross examination that group paid for the TSA procedure, thus Respondent's liability for the Rush University Medical Center bill for the TSA procedure is limited by the holding in Perez v. Illinois Workers' Compensation Commission, et al. TFN, Inc. d/b/a Wendy's, Inc. 2018 Ill. App. (2d) 170086WC (2018).

STATE OF ILLINOIS	)	
	) SS.	
COUNTY OF COOK	)	

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

ROMANOS ZYKUS,

Petitioner,

19IWCC0334

vs.

NO: 12 WC 32132

MAKO LINES, INC., AND ILLINOIS STATE TREASURER
AS *EX OFFICIO* CUSTODIAN OF THE ILLINOIS WORKERS' BENEFIT FUND

Respondents.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Injured Workers' Benefit Fund herein and notice given to all parties, the Commission, after considering the issue of the nature and extent of Petitioner's permanent disability and being advised of the facts and law, changes the Decision of the Arbitrator as stated below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

Petitioner was a truck driver employed by Respondent, Mako Lines. On August 27, 2012 he was involved in a motor vehicle accident in which the truck he was driving rolled over on its left side. Mako Lines did not have workers' compensation insurance at the time of accident, did not appear at arbitration, and did not seek review of the Decision of the Arbitrator. Petitioner testified he lost consciousness and awoke while paramedics were pulling him out of the driver's side window. He was taken by ambulance to a hospital where he was admitted for three days. Upon discharge, the final diagnosis was multiple trauma due to motor vehicle accident, with secondary diagnoses of acute left-rib fractures, probable left-lung contusion, acute kidney injury, mild hyponatremia, multiple soft-tissue injuries, dilated 3rd ventricle and lateral ventricles out of proportion to cerebral atrophy due to hydrocephalus, mild superficial punctate leratitis of the left eye, and mild rhabdomyolysis. He had surgery to remove foreign matter from his elbow area. He was to follow up with Dr. Rosenblatt for hydrocephalus.

Petitioner presented to Dr. Rosenblatt on September 14, 2012. Dr. Rosenblatt noted that "there were no clinical signs of head trauma. His CT brain revealed only ventriculomegaly, no evidence of ICH or SAH. He remains neurologically intact." Petitioner then reported dizziness, tingling in his forehead, unsteady balance, nausea with vomiting 1-2 times a day, and insomnia. After his examination, Dr. Rosenblatt's assessment was "communicating Hydrocephalus vs. NPH. Although his Hydrocephalus is unlikely directly related to the accident, he appears to be symptomatic. The onset following a mild head injury is somewhat atypical." He recommended insertion of a VP shunt. Petitioner declined to have the shunt inserted and no treatment for the Hydrocephalus was provided. On January 13, 2013, Petitioner presented to Dr. Kudirka at Palos Medical Group. He noted that the hydrocephalus was likely chronic, which might need additional neurological follow up in the future.

The Arbitrator awarded Petitioner 100 weeks of permanent partial disability benefits representing loss of the use of 20% of the person-as-a-whole. In arriving at his permanency award the Arbitrator noted that Petitioner sustained "multiple fractured ribs, a laceration injury to the left elbow with surgical repair and noted fracture of left radial head and a closed head injury with hydrocephalus." In looking at the entire record before us, the Commission finds that the Arbitrator erred in finding that Petitioner sustained his burden of proving that his condition of hydrocephalus was causally related to his accident.

Nevertheless, again looking at the entire record, the Commission concludes that the permanency award of loss of 20% of the person-as-a-whole is not excessive given the multiple serious injuries Petitioner sustained even without considering the condition of hydrocephalus. In so finding, the Commission notes that Petitioner never had any treatment for hydrocephalus. Therefore, the Commission affirms the award of the Arbitrator. However, we note small clerical errors in the calculation of the benefit rates in the award section of the decision, which we hereby correct.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondents shall pay to the Petitioner the sum of $624.67 per week for a period of 35 weeks, that being the period of temporary total incapacity for work under §8(b), and that as provided in §8(b) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondents pay medical expenses submitted by Petitioner in Petitioner's Exhibit 11 under §8(a) of the Act, subject to the applicable medical fee schedule in §8.2.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondents pay Petitioner $562.20 per week for a period of 100 weeks, as the injuries sustained caused the permanent partial loss of the use of the person-a-as-whole to the extent of 20% thereof under §8(d)2.

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

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

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

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

DATED: JUN 28 2019

Barbara N. Flores

DLS/dw
O-6/20/19
46

Marc Parker

Concurrence in Part and Dissent in Part

I concur with the majority that the Arbitrator erred in finding that Petitioner sustained his burden of proving that the condition of hydrocephalus was causally connected to his work-related accident. However, I respectfully dissent from the majority in not reducing the permanent partial disability award based on that error.

In my opinion by affirming the permanent partial disability award, the majority underestimates the potential seriousness of hydrocephalus. Petitioner's condition of hydrocephalus was deemed sufficiently severe that Dr. Rosenblatt recommended surgery to implant a shunt to drain the excess abnormal fluid on Petitioner's brain. In addition, Dr. Kudirka noted that the condition was likely chronic and Petitioner could require neurological follow up and evaluation in the future. The record suggests that Petitioner's hydrocephalus is a potentially significant condition. Therefore, finding that that condition was not causally related to the accident should require downward modification of the permanency award.

Therefore, I respectfully dissent from the majority in affirming the Arbitrator's permanent partial disability award. Based on the finding that Petitioner's condition of ill-being of hydrocephalus was not causally related to his work-accident, I would have modified the permanent partial disability award to reduce it from loss of 20% of the person-as-a-whole to loss of 15% of the person-as-a-whole.

Deborah L. Simpson

DLS/dw
46

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

19IWCC0334

ZYKUS, ROMANOS Case# **12WC032132**
Employee/Petitioner

MAKO LINES INC AND ILLINOIS STATE TREASURER AS EX-OFFICIO CUSTODIAN OF THE ILLINOIS WORKERS' BENEFIT FUND CUST
Employer/Respondent

On 1/17/2019, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 2.46% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in 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 F ALT
221 N LASALLE ST
SUITE 2014
CHICAGO, IL 60601-1413

0000 MAKO LINES INC
1407 CATON FARM RD
CREST HILL, IL 60441

0000 MAKO LINES INC
7555 CAMBRIDGE RD
DARIEN, IL 60561

6143 ASSISTANT ATTORNEY GENERAL
KRISTIN A LEASIA
100 W RANDOLPH ST 13TH FL
CHICAGO, IL 60601

19IWCC0334

STATE OF ILLINOIS)
)SS.
COUNTY OF COOK)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

ROMANOS ZYKUS,
Employee/Petitioner

Case # 12 WC 32132

v.

Consolidated cases: ______

MAKO LINES, INC. AND
ILLINOIS STATE TREASURER AS
EX-OFFICIO CUSTODIAN OF THE INJURED WORKERS BENEFIT FUND CUST.,
Employer/Respondent

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **ROBERT M. HARRIS**, Arbitrator of the Commission, in the city of **CHICAGO**, on **NOVEMBER 28, 2018**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below and attaches those findings to this document.

DISPUTED ISSUES

A. [ ] Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?

B. [x] Was there an employee-employer relationship?

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

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

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

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

G. [x] What were Petitioner's earnings?

H. [x] What was Petitioner's age at the time of the accident?

I. [x] What was Petitioner's marital status at the time of the accident?

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

K. [x] What temporary benefits are in dispute?
[ ] TPD [ ] Maintenance [x] TTD

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

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

N. [ ] Is Respondent due any credit?

O. [x] Other **HOLD HARMLESS**

FINDINGS

On **8/27/12**, 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 $**18,740.00 total for weeks worked (20)**; the average weekly wage was $**937.00**.

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.

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 and Respondent were operating under the Workers' Compensation Act and their relationship was one of employee and employer.

Petitioner sustained accidental injuries arising out of the and in the course of his employment with Respondent on 8/27/2012.

Petitioner provided Respondent timely and sufficient notice under Section 6 of the Act.

Petitioner proven his current condition of ill being is causally related to the accident injury.
Petitioner has proven entitlement to medical expenses under Section 8(a) of the Act. Accordingly, Respondents shall pay Petitioner medical expenses for all unpaid medical bills as indicated in Petitioner's Exhibit number 11 pursuant to Section 8(a) and the medical fee schedule under Section 8.2. Respondents shall further hold Petitioner safe and harmless from any and all claims of payment and/or reimbursement from any source or providers, including any liens, (e.g., Great American Insurance for payments it made through its accident-occupational health policy).

Respondent shall pay Petitioner temporary total disability benefits of $625.00 per week for a period of 35 weeks, from August 28, 2012 through April 30, 2013 pursuant to Section 8(b) of the Act.

Respondent shall pay Petitioner permanent partial disability benefits of $563.00 per week for a period of 100 weeks, as the injuries sustained caused the permanent partial loss of use to the person as a whole to the extent of **20%** thereof under section 8(d)2.

19IWCC0334

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

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

Signature of Arbitrator Robert M. Harris

Jan. 17, 2019
Date

JAN 1 7 2019

19IWCC0334

STATE OF ILLINOIS)
)
COUNTY OF COOK)

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

ROMANUS ZYKUS,)
)
Petitioner,)
) Case No. 12 WC 32132
v.)
) Arb. Robert Harris
MAKO LINES, INC. AND ILLINOIS)
STATE TREASURER AS EX-OFFICIO)
CUSTODIAN OF THE INJURED)
WORKERS' BENEFIT FUND,)
)
Respondents.)

NATURE OF CASE

Romanos Zykus, (Petitioner) incurred multiple injuries when the truck he was driving flipped over after the load shifted. He was pried out of the truck and taken to a hospital, admitted for treatment and had extensive medical treatment thereafter. Petitioner filed an Application for Adjustment of Claim and this was amended to add the Injured Workers Benefit Fund upon learning that no Respondent Make Lines had no workers' compensation insurance coverage in place at the time of the accident. Petitioner's primary language and the language spoken at the hearing was Russian through an interpreter. Petitioner spoke little, if any, English. Respondent Mako Lines did not appear at trial nor did it send any attorney to represent it at trial.

STATEMENT OF FACTS

Petitioner testified he answered an ad for a job with Mako Lines (Respondent). Petitioner believes he may have filled out some paper work. Petitioner testified Respondent owned the truck and the truck was stored at the company grounds. The truck indicated Respondent's name for identification. The trailer was a 53-foot trailer and also had Respondent's name on it. Petitioner testified Respondent paid for the gas and was responsible for truck repairs.

Petitioner testified his work day started with his arrival at the company wherein he would enter the company to pick up the keys and was specifically instructed by the company dispatcher where to go and how to go. Petitioner was given a set hour to arrive at work. Petitioner was instructed to make pickups from other places for deliveries. Petitioner could not work for any other employer while driving for Respondent nor could he use the truck for any personal use. Petitioner worked forty hours a week and sometimes more. Petitioner could be terminated by the Respondent. Petitioner thinks his hourly pay was $18.00 or more and he had worked for Respondent for several months before the accident. At the end of the work day Petitioner had to bring the truck back to the Respondent's property for overnight storage.

On or about August 27, 2012, Petitioner had a load of motors in Respondent's truck and the load shifted and both the trailer and truck flipped over. Petitioner was pinned in the truck. Emergency staff had to cut the truck open and Petitioner was taken to Alexian Brothers Hospital. Petitioner was admitted for about four days, received emergency treatment and thereafter had extensive treatment for several months after the accident. Petitioner received no total temporary disability benefits and his medical bills were processed through an accident/occupational health insurance policy (Great American). Petitioner received $200.00 per week through occupational health and the carrier now seeks reimbursement of both payment of weekly benefits and medical bills. Petitioner did not return to work for Respondent and he was out of work for about the next eight months and under medical care.

MEDICAL

Alexian Brothers Hospital: Petitioner was admitted August 27, 2012. Alexian's diagnosis on discharge was:

Left side rib fractures 4th, 5th and 6th; Probable pulmonary contusion to left lung; Acute kidney injury; Hydrocephalus (brain fluid buildup).

Petitioner also underwent surgical removal of loose bodies in the left elbow for open injury to epicondyle in extensor with avulsion of extensor tendons. Dr. Karnezis noted a fracture of the radial head not shown on MRI. Medical, Dr. Karnezis, Dr. Zurek, Palos Medical Group Dr. Chmell all mainly repeated above diagnosis.

Respondent did not offer any evidence to challenge or rebut this evidence.

CONCLUSIONS OF LAW

As this is a Benefit Fund Case all issues were placed in dispute. Petitioner provided a certification from NCCI confirming that Mako Lines, Inc. "do not" show policy information was filed showing proof of Workers' compensation insurance.

Accident:

The Application was amended to indicate the date of accident as August 27, 2012. There is no contrary evidence to dispute accident on the claimed date of August 27, 2012. Petitioner was performing work on behalf of his employer as a truck driver which is the nature of his employer's business and the accident arose out of and in the course of his work and while driving. The Arbitrator finds Petitioner sustained injuries that arose out of and in the course of his employment with Respondent on August 27, 2012. Respondents offered no contrary evidence to challenge or rebut Petitioner's claim of an accident pursuant to his trial testimony.

Operating under the Illinois Workers Compensation's Act and employer/employee relationship:

Petitioner testified he responded to a help wanted ad posted by Respondent. Petitioner testified regarding his employment that he was told when to start daily, where to report, where to pick up the truck, where to go, how to go, job duties, and the truck he drove was owned by Respondent, the truck identification on the truck and the trailer indicated Respondent. Petitioner testified he could not drive for any other employer but Respondent or use Respondent's truck for personal use. Petitioner could be terminated by Respondent. Further, Respondent's business nature was that of truck delivery of various items. Petitioner's injuries arose out of and in the course of driving on behalf of Respondent, while making a delivery. Petitioner was within the intended area of protection of the compensation act.

The Arbitrator finds and concludes, based on Petitioner's credible, unchallenged and unrebutted testimony, that he was an employee of Respondent and Respondent exercised sufficient control and/or had the right to control Petitioner, which all leads to the conclusion of an employer/employee relationship and **not** an independent contractor relationship on the date of

accident, August 27, 2012. See, In *Roberson v. the Industrial Commission (P.I. & I Motor Express)*, 225 Ill.2d 159 (2007, Il. Sup. Ct.):

> An employment relationship is a prerequisite for an award of benefits under the Act, and the question of whether a person is an employee remains "one of the most vexing * * * in the law of compensation." *O'Brien v. Industrial Comm'n*, 48 Ill.2d 304, 307, 269 N.E.2d 471 (1971). The difficulty arises not from the complexity of the applicable legal rules, but from the fact-specific nature of the inquiry. No rule has been, or could be, adopted to govern all cases in this area. *Henry v. Industrial Comm'n*, 412 Ill. 279, 282, 106 N.D.2d 185 (952).
>
> No single factor is determinative, and the significance of these factors will change depending on the work involved. *Luby v. Industrial Comm'n*, 82 Ill.2d 353, 358-59, 45 Ill.Dec. 88, 412 N.E.2d 439(1980). The determination rests on the totality of the circumstances."
>
> **"Nevertheless, whether the purported employer has the right to control the actions of the employee is the single most important factor."**

The Arbitrator finds it significant that Respondents offered **no** contrary evidence or witnesses to challenge or rebut Petitioner's trial testimony claim of his status as an employee or Respondent's right to control.

Notice: Petitioner testified that everyone knew about accident, but specifically, he testified the Respondent's dispatcher was notified and the truck and trailer also had to be removed. The Arbitrator finds that sufficient notice was given to Respondent within the time limits of the Act. Respondents offered no contrary evidence to challenge or rebut Petitioner's claim of notice pursuant to his trial testimony.

Earnings: The Arbitrator adopts exhibit 12 wherein Petitioner worked 20 weeks at an average weekly earnings equal to $937.00 per week. Respondents offered no contrary evidence to challenge or rebut Petitioner's claim of his earnings.

Age and Status: Petitioner was 51years old, married with 0 dependent children.

Causal Relationship: The records shows by a preponderance of the evidence a causal relationship between Petitioner's current condition of ill-being and the work accident of August 27, 2012. There is no evidence to rebut or impeach Petitioner's testimony that he incurred a roll over while driving for Respondent in Respondent's truck. There is some conflict as to the cause

of the rollover; however, there is no dispute that a rollover actually occurred and differences as to the cause of the rollover may be due to Petitioner's inability to speak English. Petitioner testified he had no physical problems prior to this work accident and all of his medical conditions of ill being resulted after the work injury. There was no evidence presented to the contrary. It is well established that prior good health followed by a change immediately following an accident allows for an inference that he subsequent condition of ill-being is the result of the accident ("chain of events" theory). Accordingly, the Arbitrator finds Petitioner has proven by a preponderance of the evidence a causal relationship exists between his work injury and his current condition of ill being.

Temporary Total Disability:

Petitioner testified to being unable to work for approximately 8 months following the work injury. The stipulation sheet claims temporary total disability from August 30, 2012 to April 30, 2013. Petitioner's testimony is corroborated by the records of the Palos Medical Group in that he appeared for an examination in order to return to work on April 8, 2013 and in the next visit, May 25, 2013 the records indicate that he had returned to work about one month ago. Given Petitioner's testimony and the supporting medical records, the Arbitrator finds and concludes Petitioner is entitled to temporary total disability from August 28, 2012 to April 30, 2013 or 35 weeks at the rate of $625.00 per week. There was no evidence to the contrary presented.

Medical: Based on a review of the record, and finding of accident and causal connection, Petitioner has proven entitlement to medical expenses under Section 8(a) of the Act. Accordingly, Respondents shall pay Petitioner medical expenses for all unpaid medical bills as indicated in Petitioner's Exhibit number 11 pursuant to Section 8(a) and the medical fee schedule under Section 8.2. Respondents shall further hold Petitioner safe and harmless from any and all claims of payment and/or reimbursement from any source or providers, including any liens, (e.g., Great American Insurance for payments it made through its accident-occupational health policy).

Permanent partial disability:

With regard to subsection (l) of Sec. 8.1b, the Arbitrator notes no AMA permanent partial disability impairment reports and/or opinions was submitted into evidence. (Dr. Samuel Chmell did author what appears to be a report pursuant to Petitioner's request under Section 12, but there is no AMA Impairment rating in that report). The Arbitrator therefore gives no weight to this factor.

With regard to subsection (ii) of Sec.8.1b, the occupation of the employee the Arbitrator notes the record reveals Petitioner was employed as truck driver at the time of the accident and that he was eventually able to return to a truck driving job. The Arbitrator gives moderate weight to this factor.

With regard to subsection (iii) of Sec. 8.1b, the Arbitrator notes that the Petitioner was 51 years old at the time of the accident. Because of his age, the Arbitrator gives some weight to this factor.

With regard to subsection (iv) of Sec. 8.1b, Petitioner's future earnings capacity, the Arbitrator notes Petitioner returned to a similar job. No evidence was submitted indicating that as a result of this accident Petitioner's earnings capacity was in any way reduced or impaired. The

With regard to subsection (v) of Sec. 8.1b(b), evidence of disability corroborated by the treating medical records, the records of Alexian Brothers Hospital, Dr. Karnezis, Dr. Zurek, Palos Medical Group, and the IME report of Dr. Chmell, were all considered. The Arbitrator has considered the medical records and notes multiple fractured ribs, a laceration injury to left elbow with surgical repair and noted fracture of left radial head and a closed head injury with hydrocephalus. The Arbitrator also considers the IME report of Dr. Samuel Chmell that diagnosed rib fractures, crush injury left arm with multiple lacerations, left elbow and closed head injury. The Arbitrator gives most significant weight to this factor.

Based on the above factors, and the record taken as a whole, the Arbitrator finds that as a cumulative result of the multiple injuries, Petitioner sustained permanent partial disability to the extent of **20%** loss of person as a whole pursuant to Sec. (d)2 of the Act, or 100 weeks of compensation at his PPD rate of $562.20, or the sum of $56,220.00.

Injured Workers' Benefit Fund

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(b) 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.

Robert M. Harris

Arbitrator Robert M. Harris
Dated: January 17, 2019